

Center for Strategic and International Studies

Online Event

“Optimizing U.S. Global Pandemic Response”

RECORDING DATE:

Tuesday, June 2, 2020 at 3:00 p.m. EDT

FEATURING:

Joan Condon,

Professional Staff,

United States Senate Committee on Foreign Relations

Amb. Jimmy Kolker,

Senior Associate,

CSIS Global Health Policy Center

Andrew Natsios,

*Director of the Scowcroft Institute of International Affairs at the Bush School of Government, Texas
A&M University*

Jim Richardson,

*Director of the Office of Foreign Assistance,
U.S. Department of State*

CSIS EXPERT:

Daniel F. Runde,

*Senior Vice President; William A. Schreyer Chair and Director, Project on Prosperity and
Development, CSIS*

J. Stephen Morrison,

*Senior Vice President and Director, Global Health Policy Center,
CSIS*

Transcript By

Superior Transcriptions LLC

www.superiortranscriptions.com

Daniel F. Runde: Thank you all for joining us today. I'm grateful to partner with Steve Morrison on this event. I'm Dan Runde. I hold the Schreyer chair here at CSIS. Steve Morrison has been a Cassandra-like figure on the issue of pandemics for many years, running the global health policy center here at CSIS, and has contributed major progress on this issue. I'm also grateful to Owen Murphy and Michaela Simoneau who has helped pull this event together.

Everybody on the panel that will follow agrees that the United States needs to prepare and organize itself better for pandemic preparedness overseas, as well as improving our pandemic preparedness here in the United States. There is a spectrum of views on this panel about how we ought to organize ourselves for overseas pandemic preparedness. I am a great fan of all the folks on this panel, but I want to particularly recognize two people.

Joan Condon is a gifted public servant on Capitol Hill. It's very important that we have earnest and capable people like her working on complicated issues in the Congress. And I'm very grateful, and I know Steve is very grateful, that she is willing to come and speak today on some proposed legislation looking at this complicated issue. I also want to recognize Andrew Natsios, who is my friend and mentor. He also has been a Cassandra-like figure on this issue, running a very influential conference and process on pandemic preparedness at the Bush School of Government at Texas A&M. He has been talking about pandemics as a major danger to the global system for at least 15 years, since he was USAID administrator under President Bush 43.

You are going to come away from this conversation hearing a spectrum of views on how to organize ourselves for pandemic preparedness overseas. We are not going to come to a consensus at the end of this discussion. But let me put my cards on the table. My view is that in an age of great-power competition, America's soft power and foreign aid is going to be more important geostrategically, and remains an important part of the condo fees of global leadership that the United States has to pay to remain a global leader.

Anyone who has seen China offer defective ventilators and PPE, and then demands idolatry tweets and credit knows that they are not ready for prime-time leadership. And frankly, I hope they're never ready for prime-time leadership. But we can't just point and criticize. We have to beat something with something else. And much of our something is going to be our foreign assistance, especially as it relates to pandemic preparedness overseas.

Let me say something else: Anything that weakens USAID, America's foreign aid agency, is something we should absolutely avoid. My view is that we should organize our overseas pandemic preparedness along the same lines as the president's malaria initiative, which is coordinated out of USAID and was ably led for many years by Admiral Ziemer. Or Feed the Future initiative, which is also led out of USAID. In the case of Feed the Future, there is also a diplomatic coordinator at the State Department, because there are important roles for the State Department in agriculture and food security diplomacy, just as there are important diplomatic issues related to pandemic diplomacy.

Let me say something else. PEPFAR, led out of the State Department, has been a tremendously successful emergency program – the E in PEPAR is for “emergency” –

which has responded to an emergency for almost 18 years. But PEPFAR, I would argue, should not be the model that we use for pandemic preparedness overseas. Many are going to disagree with me, but that is what I believe. The E in PEPAR did not stand for “eternal.” And there has been a failure to build systems overseas as part of PEPFAR. And we, as the United States, are on the hook for eternity to supply meds if governments, primarily in Africa, won’t foot the bill for HIV meds for their own people. Over time, we’re going to have to change that.

In an ideal world, the coordination of what I described as a USAID-led pandemics function would be supported by an interagency process led and convened by the vice president of the United States, whoever the vice president of the United States is at the time. Ultimately, we’re going to need the White House to influence all the different and large interagency stakeholders. I believe that the State Department on its own will have a hard time convening HHS and other domestic agencies on issues overseas.

Let me stop here and turn it over to Steve Morrison. Again, I want to thank Steve for his partnership on this important conversation. Thank you.

J. Stephen Morrison: Thank you very much, Dan. And thanks for being with us. And thanks also to Clifton Jones and Travis Hopkins on the technical team that put this all together. I’m going to offer some brief framing remarks and then introduce our speakers.

We are in the midst of a historic moment, this coronavirus pandemic and the health and economic crises that have followed it, and the strains that have come out of that that have fed directly into the current racial crisis that we face across this country. We know pandemics change history. They open the door, potentially, to big ideas, to big changes in norms, organizations, and approaches. Pandemics can also roll right over us as we’ve seen so profoundly in America and elsewhere. Here, we have 1.8 million cases out of a total of 6.3 million cases globally, 105,000 dead out of 375,000 around the world, and 42 million unemployed here in the United States, over a billion unemployed across the world. And staggering, astronomical cost to all of this.

So the question before us, the question here today, are we able to rise above the din, above our own immediate urgent concerns and the differences and fears that we all have, to think in big terms and to build a consensus around what it will take to create the true capacities needed to prevent future epidemics – future pandemics, to take full advantage of this moment. As we’ve documented in the work of the CSIS Commission on Strengthening America’s Health Security –and we have with us today Ambassador Jimmy Kolker, one of our commissioners – U.S. approaches on health security at home and abroad have been for a long time stuck in the cycle of crisis followed by complacency and neglect.

One consequence of this cycle is that even after we’ve had significant gains in things like the Global Health Security Agenda, which followed the Ebola outbreak in West Africa in 2014-15, our approach still suffers in this respect from two big gaps. Within the executive branch, there’s no central structure, no strong central structure with authoritative influence over accounts that can coordinate, create integration and coherence, ensure discipline, accountability, and the right results. If we’re to graduate out of the cycle of crisis and complacency, we’ve got to fix this glaring gap somehow. And we’ll be talking today about what the answers to that may be.

The second is money. There needs to be a commitment to long-term, multi-year sustained funding that creates capacity among partner nations, and measures outcomes with those partners in low-income countries. And there needs to be a commitment through U.S. leadership and continuous high-level diplomacy to create new international funding mechanisms in which other wealthy donors pool their resources, leveraged by U.S. leadership. In our commission work, that translated into a proposal for a major challenge fund under World Bank auspices.

Answering these questions in our current environment and achieving a bipartisan consensus, which is so essential, is certainly not going to be easy. The pandemic opens a big window, but we need to be very cognizant and very realistic of how difficult our current environment is. We're as deeply divided as a country as we've ever been, in the midst of a highly toxic electoral cycle. No solution to the problem we're talking about today, however, can be achieved by any single party. And it has to be a bipartisan approach.

The White House has disbanded the senior directorate responsible for global health security and biodefense. That's a problem we have to think about. CDC and USAID remain essential institutions, both in their respective roles and contributions, to any of U.S. global health policy approach. Yet, each of those institutions feel that they are insecure and under siege. It's a difficult moment to begin engaging those institutions around institutional and organizational changes, where they may fear that they are going to lose out.

There's grave concern over the administration's decision to end funding and terminate the U.S. relationship with the World Health Organization. And I should mention also there's widespread absence of trust in the White House and in executive branch intentions, a fear that any initiative that emanates from the White House or State Department may be used to gut important health programs at USAID and CDC, and/or the World Health Organization. These realities notwithstanding, I think what we're proving here today is that a very constructive and civil dialogue is indeed possible, as we'll see here today.

I'm very encouraged and pleased that Senators Risch, chairman of the Senate Foreign Relations Committee, and two Democratic members of that Committee, Senators Murphy and Cardin, have put forward bipartisan legislation, Senate Bill 3829, the Global Health Security and Diplomacy Act of 2020.

With us today is Joan Condon, senior staff at the Senate Foreign Relations Committee, architect of this bill. She's with us today to lay out the rationale, elements, and the way forward for the bill. She played an integral role in consulting widely and crafting this legislation that attempts, on a bipartisan basis, to answer the question of how do we better organize ourselves into the future in global health security, with what purpose, and with what authorities and funding? I'm encouraged – and I differ from Dan here – that she draws on the PEPFAR model, which has been a historic success in foreign aid to meet a dangerous pandemic, HIV/AIDS, and which has proven its resilience over the last 17 years, even in the midst of a series of crises and stress points.

This legislation also expresses a sense of Congress that the National Security Council should have a standing senior-level lead for pandemic response. And it references the existing executive order on global health security, EO 13747, which includes a

strong role for the Department of State. That EO was crafted in the Obama administration, and carried over and retained by the Trump administration. And it's referenced in this legislation and other legislation by Representatives Connolly and Chabot. Lastly, I want to emphasize the importance in the Risch bill calling for the establishment of an international trust fund under World Bank auspices, intended to incentivize partner countries to invest at higher levels in their own capacities. This is a very important recommendation.

I am pleased that we're also joined today by three very prominent experts who remain vitally engaged from different perspectives on the question in front of us. Let me just say a few words. Ambassador Jimmy Kolker is a member of the CSIS commission, brings his vast experience as assistant secretary for global affairs at HHS in the Obama administration, as deputy head of PEPFAR during George W. Bush's administration, and head of UNICEF HIV/AIDS work for a number of years, and a distinguished career as a foreign service officer in the State Department, serving as ambassador in Uganda, as well as Burkina Faso.

Jim Richardson, who joins us, he heads the – he's the director of the Office of Foreign Assistance at the Department of State, previously served at USAID as coordinator of the transformation task team. He is the lead at the State Department in crafting the president's response to outbreaks, Initiative PRO. That effort has not yet reached the point, he tells me, where the president has signed off and so Jim is not free to speak to the specifics around that initiative. He's here today, and has kindly agreed to be with us, to share his perspective on S. 3829, and the broader considerations on what kind of approach makes sense looking forward.

Finally, Andrew Natsios served as USAID administrator in the administration of George W. Bush. He's director of the Scowcroft Institute of International Affairs. He's at the Bush School of Government at Texas A&M University, where he plays a lead role in the very important work undertaken at the university there on global health security. I want to thank all of our speakers who are here today.

We're going to hear from Joan for about ten minutes, walking us through the legislation. Then we're going to come back to our three speakers. They'll offer some quick remarks – three to four minutes each – around the legislation and broader considerations. And then we'll have a conversation. And we'll weave into that conversation remarks and questions that come forward from you in the audience. So thank you all for your patience. Joan, thanks so much for being with us today. The floor is over to you.

Joan Condon: Well, thank you so much, Steve and Dan. You're a tough act to follow. You've set out the issue at hand quite well. And I appreciate you arranging this, and I appreciate the patience of my fellow panelists for dealing with a dreaded congressional staffer, and for everyone taking the time to dial in today. I think, again, you've laid out the context quite well. The COVID-19 pandemic has reawakened us all to a stark reality that infectious diseases do not respect borders. They're designed to spread, and they're very good at it. And so a threat anywhere is a threat everywhere.

I say reawakened because this is not our first aha moment, and it certainly won't be our last if we don't figure out a way to get ahead of these threats. Long before COVID, before Zika, before Ebola, USAID and CDC were investing considerable time and energy in preparedness and response. And I thank Dan for highlighting that.

And I'm sure we'll hear more about that from Ambassador Natsios. USAID, for example, has done an outstanding job in building disaster risk reduction capabilities everywhere from the Pacific to the Caribbean. And though there have been numerous efforts to advance global health security through the GHI, through the executive order that Steve referenced, through the Global Health Security Strategy recently submitted to Congress, each of these efforts has struggled to sustain interest, to secure dedicated funding, and to withstanding the sucking sound of other sector-specific initiatives.

So how do you resolve a recurring problem like this? And how do we get ahead of the next pandemic? It appears that we have a lot of tools at our disposal. We have the international health regulations to serve as a guide. We have the global health security agenda to advance actionable commitments. We have the Global Health Security Index and the joint external evaluations to help countries identify gaps. And we have tremendous capacity at USAID, CDC, and among our implementing partners. What we lack is an aid architecture that is led by a single accountable entity who can ensure that all partners are working from the same playbook each and every day at the country level, that focuses resources in areas where there was both measurable need and commitment, and that it is backed by sufficient resources so we can ensure that this effort doesn't come at the expense of broader development and global health imperatives.

Of course, change is hard. And there's going to be a lot of feelings around what's being proposed. Legislating change might be even harder still. And so a serious legislative proposal will always have three elements. It'll have bipartisan support in Congress. It'll have champions in the executive branch. And it will have community consultation and buy-in. And I assure you to this end that the chairman is, in fact, serious. He understands the risk he has assumed as a fiscally conservative Republican from Idaho in cycle leading on a bill that would authorize \$3 billion to help other countries prepare for and respond to infectious disease threats in the midst of a pandemic that has decimated local economies here at home and claimed more than 105,000 American lives. He's serious, he's committed, he's even enthusiastic, which makes my job a lot harder. But he knows that this is very important, and that it's time.

And so in developing this legislation reached out to the four corner authorizers who build upon other legislative efforts, including the Connolly-Chabot and the Murphy-Romney bills, even while taking a different approach. We shared the drafts with the administration. We solicited and incorporated input from aid and global health experts, advocates, and implementers. Ten weeks and 26 drafts later, we landed on a bipartisan bill that seeks to advance common-sense solutions to real problem. And so perhaps now we should talk about what the bill does do and what it doesn't do.

The bill does call for a comprehensive strategy, which is typically a good place to start. The strategy must have clear goals, objective, and lines of responsibility to better guide U.S. foreign assistance investments in global health security overseas, eliminate duplication and waste, and enable partner countries to close capacity gaps, advance the global health security agenda, and uphold commitments under the IHR. Similar to the Connolly-Chabot and Murphy-Romney bills, it does recognize that the NSC plays the central role in convening the interagency and ensuring continuity across both domestic and international-facing agencies. It does encourage the president to appoint a senior person to fill that role, and it – but it does not require

the president to fill that position because Congress doesn't have the constitutional authority to organize the executive office of the president.

Similarly, it does recognize the roles and responsibilities of the NSC, the Department of State, and USAID, set out in Executive Order 13747 in advancing the global health security agenda. It does not codify the EO, because these structures need to be adaptable over time. Now, where the other bills focused on the architecture or the whole of government strategy that ties domestic and international efforts at the higher level, the Risch-Murphy-Cardin bill goes further by focusing on the organization and execution of U.S. foreign assistance efforts overseas. It would create a coordinator at the U.S. Department of State to serve as the single accountable entity that I mentioned for ensuring that U.S. foreign assistance resources to combat new and emerging infectious diseases overseas are carefully planned, seamlessly coordinated, and effectively implemented.

It would not give the coordinator authority of USAID's existing programs for AIDS, TB, malaria, polio, food aid, maternal and child health, nutrition, and so on. And it would not give the coordinator over CDC's direct appropriations. It would seek to create a deputy coordinator position at USAID, ensure that USAID has a seat at the table on any future emergency response taskforce, codify USAID's delegated authority to serve as the program lead on disaster response and addressing second-order development impacts, and codify USAID's disaster surge capacity. It would not fold USAID into the Department of State. It would prioritize resources for developing countries with measurable gaps in global health security, as identified by the Global Health Security Index and the joint external evaluations, who are committed to upholding commitments under the IHR, including for global health data transparency.

It would prioritize country ownership and long-term sustainability, including by aligning efforts around national action plans and setting expectations of domestic resource mobilization, co-financing, and budgeting for results. It would authorize the U.S. to participate in CEPI and call upon the secretaries of state and treasury to negotiate the establishment of a fund, much like the global fund, through which donors, partner countries, and the private sector can align around shared principles and finance resolutions. It would not replace the World Health Organization. And finally, it would authorize appropriations for the first time in 11 years for a forward-leaning global health initiative intended to help us get ahead of the next pandemic. It is not our answer to the separate but equally important request for COVID-19 supplemental funds, but it is forward looking.

So over the past week there have been a lot of questions asked about whether the bill that was introduced on the 21st is simply a rubber-stamp for a discussion draft of a white paper that was circulating through the interagency before being published on the 22nd. And it's a fair question. After all, there are some striking similarities and the timing was pretty close. But I've been on the hill for nearly 21 years and I've never seen Congress simply rubber-stamp a draft proposal without first putting their mark on it, no matter who's in the White House. As I described earlier, this bill was developed over several weeks of consultations, building upon efforts in the House, then in the Senate, and recommendations specifically from the advocacy community.

And though the bill and the white paper were developed separately, I'm not at all surprised to see that they've landed in a similar place. After all, the bill was modeled after PEPFAR and The Global Fund, while incorporating some important lessons learned, including about sustainability, and making that transition from emergency response to long-term country-led solutions. And I'm proud to say that I've been involved in PEPFAR and The Global Fund since the passage of the very first authorization. And so I was able to look at those lessons learned and try to put them on paper in relation to this new initiative. Though there have been some bumps along the way, many would suggest that PEPFAR is the most successful U.S. global health program in history. And that, again, is why this serves – that has served as a model.

I'm encouraged to see that the administration's embrace of that model, along with recognition that there needs to be more done in order to get ahead of infectious disease threats overseas, and it's not an accident that the bill was introduced before the white paper was leaked. As with any initiative, it's important for Congress to lay a marker, make it clear where we agree, and provide guidance in the areas where we might disagree. And that's what this bill does. I expect that over the coming weeks we'll continue to work together to chart a path forward in a way that takes account of the vast experience and expertise of the community, implementing agencies and partners, as well as lessons learned from past efforts.

And so I thank you for your time. And I'm really looking forward to a healthy discussion.

J. Stephen Morrison: Thanks so much, Joan. That was terrific. Very comprehensive. And congratulations on the bill.

I'm going to ask Ambassador Jimmy Kolker to speak first here. Jimmy, thank you for being here.

Amb. Jimmy Kolker: Well, thanks. Thanks, Steve and Dan, and thanks to the fellow panelists. I'm very humbled to be in the company of such distinguished people who are engaged, as a retiree. I was a member of the CSIS commission, as Steve said, ending the cycle of crisis and complacency in U.S. global health security. And my first reaction to the Global Health Security and Diplomacy Act was that it does respond to the first three of our recommendations, that Steve alluded to. It restores global health security leadership at the White House and the NSC. It talks about multiyear funding for the global health security agenda. And it establishes a pandemic preparedness challenge fund at the World Bank, though a little bit different from what the commission imagined which was mostly oriented to be International Development Association, IDA, grants for the poorest countries. The proposal in the bill that Joan talked about includes a U.S. pledge of 10-33 percent of a fund that resembles – has a board – advisory board and so on closer to The Global Fund than IDA. But it's an interesting proposal, and I think it needs to be discussed and looked into.

I will mention briefly, even though we don't have a copy of the president's response organization, that it does seem relevant that there is also a fund that's proposed in what the leaked documents, or the information that we have about that fund, and that that would be an assumption that there would be a number of funders without necessarily a U.S. pledge or a U.S. annual contribution. So that's something that I think we need to look at as we consider the various proposals.

I got into global health work because of PEPFAR. And PEPFAR really worked. I was ambassador to Uganda. Uganda was a showpiece during the first few years. And we achieved, I think, pretty remarkable results. And there are four things that I think made PEPFAR successful. The first was that it was the president's emergency plan that had presidential identity and leadership. I hope that whatever comes out of the coronavirus crisis and the taskforce that we now have – that Vice President Pence is leading, that we will have presidential leadership and presidential branding of the U.S. follow up and the U.S. institution that's going to be leading our response, both domestically and globally.

The second key to PEPFAR's success, and probably the very most important one, was its multiyear commitment of big money. That was the key to motivating all partners, and allowed us to set multiyear targets, to have real accountability for long-term programs. And I think this is an advantage of Senator Risch's bill. The third PEPFAR key to success was bipartisan support. And although originally the PEPFAR proposal was developed without a lot of input in the White House, the authorizations, as Joan mentioned, were quite inclusive, and talked to lots of stakeholders, both in and out of government.

And so the Risch bill having been developed with bipartisan support and with stakeholder support, still USAID and CDC, to some extent, have suspicions about where we're going on all of this. I think those need to be aired. But it does seem to me that the sense of a critical mass of people interested in the topic have been heard and had their views reflected in the Risch bill as one of its strengths.

And finally, the fourth strength of PEPFAR was that it relied on embassies and ambassadors for implementation. I had a vested interest in that. I'd been dreaming of actually being held accountable for something. But I realized what the difference was.

This was a program of national scale up. And in that context, the question of should this be in the State Department or not is, I think, a key one. And I would argue that the answer to that is yes, as proposed by the legislation. And that's because, to me, health diplomacy is the difference between what USAID and CDC do very well, which are pilot programs, centers of excellence, proof of concept. These can be done by U.S. technical experts, by contractors. But what we're looking for now is whole of government national scale up.

And I think that diplomats do have a comparative advantage in looking at what's the agenda of the government, how do we put this public health issue onto that agenda, and who within the government – whether it's the security forces, because this is a security issue, or if it's the Ministry of Agriculture, because it's a wet health issue, or if it's the Ministry of Health, with whom the CDC has a – often an embedded liaison relationship – all of those actors are under chief of mission authority. And I think there's a very appropriate role for the State Department there.

And right now the State Department has two offices that are responsible for global health. But neither the Office of Global AIDS Coordinator, which houses the Office of Global Health Diplomacy, nor the Bureau of Oceans, Environment, and International Scientific Affairs which has an international health and biosecurity unit and is responsible for environment, science and technology officers overseas – neither of

them actually has a table – a seat at the table on health security discussions up until now. And it does seem as though the proposal for a senate-confirmed coordinator for global health security and diplomacy is the right way to go to put that person, as Hamilton would say, in the room where it happens.

Finally, the question of who's responsible with domestic reply, I do think we do need to look at how we're strategically aligning the domestic reply with our responsibility for instructing embassies. We, in this crisis, let ourselves down a little bit because there was not a proactive move by embassies to gather information or to leverage other countries' resources in fighting the coronavirus. And without that, it does seem to me that we're not aligning the resources that we need best.

I also want to go back to the key importance of multi-year big money. The Global Health Initiative, which was President Obama's attempt to merge existing programs, such as maternal and child health, almost all USAID programs, with the PEPFAR program – keeping the PEPFAR program intact, but using that momentum and that strength to leverage other programs – but with no new money, meant that the comparative advantages weren't really multiplied through that program. And indeed, because it was administered at USAID, that program did not succeed in getting the Office of Global AIDS Coordinator, CDC, or their counterpart implementers in the field to actually buy in, because there was very little incentive to do so.

And I have to say, I work very closely with USAID in all of my professional capacities. But there has been resistance in recent years. If money is appropriated through the appropriators for State and Aid, which are different than the appropriators for CDC and HHS, and if it came through the appropriations for USAID, that money was very, very reluctantly shared with CDC. During your time, Mr. Natsios, we were in much better shape, I have to say, from the public health point of view, in having a really cooperative relationship with a lot of inter-agency agreements. Those have almost all dried up. And the ability of CDC to get money for things like tuberculosis and malaria, let alone global health security, has been very difficult in recent years.

And finally, I'll just say that it does seem as though the multiple authorizations and appropriations need to be – I'm glad that the consultations with all those committees by Senator Risch and you, Joan, and your colleagues. But that – it's a huge hurdle, which our CSIS study represented. We found that there were about 16 different committees, subcommittees in the House and Senate that all had a role in global health security. And getting the CDC authorizations and appropriations was much more difficult, in fact, than getting ones for state and USAID in recent years.

I'll just add one more thing. It's great that you represented CEPI, the Coalition for Epidemic Preparedness Innovation, and put that into the bill. I think that's been a key player that we haven't taken full advantage of or been able to leverage adequately on vaccine development because the U.S. hasn't been a participant. So thanks. I'm sorry to go on so long with very detailed views, but those are my reactions. Look forward to the discussion.

J. Stephen Morrison: Thanks so much, Jimmy.

I'd like to turn to Jim Richardson, please.

Jim Richardson: Great. Thanks a lot, Steve. I appreciate the opportunity to join you today, and hear from Joan, and from Dan, and from Jimmy, and others. You know, so I'll just be really brief, but let me start with the facts on global health. I mean, the American people have spent over \$140 billion over the past 20 years building out global health systems around the world. And that's something we should really be proud of. The American people are the leading donor to global health around the world. We beat the next-largest donor by five times. And then when it comes to COVID, you know, President Trump, Secretary Pompeo really have been leading the international response. So far we've committed over a billion dollars to over 100 countries around the world to help combat this pandemic.

But when we really look at the challenge here, as sort of outlined, I think it's really important for us to understand, you know, what are the true challenges facing us not just today in this pandemic, but what are the challenges for the next pandemic, right? This outbreak – this is the first time we've had an outbreak, and it's certainly not going to be the last. So when I take on problems like this – before I took this job I was at USAID. I led the agency-wide transformation. I built seven bureaus, countless initiatives, strengthened the agency from the bottom to the top. And every time I took sort of a basic matrix of problem, solution, and results. Let's all come to an understanding of what the – of the challenges we are trying to resolve, and then let's go ahead and look for what the solutions are, and then let's be very clear about the results, and measure that progress.

I cannot speak to the solution today. As has been mentioned, I'm going to hold off on that. But I really want to talk about the problems and lessons learned, not just coming out of COVID but also coming out of the Ebola crisis, and the Zika crisis. There's been a lot written on this right? The OIG, the GIO, the last administration White House taskforce on Ebola had lessons learned. CGD had lessons learned. There's a lot written about that. And I think that there's a couple key things that we can learn from that, and also learn from this latest COVID.

So let me start with what is unique about this pandemic, and then I'll get into some of the lessons learned about all outbreaks. The one thing that's significantly different this time around is the worldwide nature of this pandemic. And again, I think this is going to become more of the norm rather than the exception. This devastated both the developed and the developing world both, right? This wasn't just about sub-Saharan Africa, which was an important piece of our response and elicited the largest percentage of resources. But it was devastating worldwide. So we need to have a response that isn't just focused on program design inside certain parts of the world but is really taking a holistic view of the challenge and coming up with solutions that match that – those challenges.

So let me talk a little bit some lessons learned, that are really sort of threads that you can see throughout the other outbreaks, as well as COVID. I mean, first and foremost, we need to have a coordinated U.S. government response, right? State, USAID, CDC, DOD, USDA – all of them need to be working together in a coordinated fashion in order to achieve greater impact and results. And we can't wait for a pandemic to hit for us to become organized in that way. So we need to get ahead of the curve. So that's one of the key lessons that have been learned.

Second, we need to make sure that we fill strategic gaps in the international system. Let's just be completely honest, the international system of the WHO and others have

failed us when it comes to outbreaks, right? From Ebola, from Zika, and now from COVID-19, they simply failed to be able to detect, track, and respond effectively to outbreaks. So let's go ahead and build the system that can fill the strategic gaps of The Global Fund, and of the – of the WHO, and others. Because we need to take this seriously, and we need to make sure that we are building something that works in the future.

Couple other key things: burden sharing. The U.S. government spends – is the – as I said, is the largest donor to global health. Forty percent of all global health international development spending comes from the American people. We need other countries to step up as we start really investing in pandemic preparedness and response. We need to make sure that the private sector is involved early and often. We need to make sure that we are mobilizing domestic resources from partner countries. This isn't about us coming in and running – simply running programs, doing everything for every country in the world when it comes to pandemics, right? This is really about helping them mobilize their own resources in order to be able to do that.

And then we need to make sure that we have – uphold global standards and accountability, right? China failed the world when it did not accurately and appropriately provide information about the outbreak. And if we were able to hold China – one, if we knew, right? Two, if we were able hold China accountable? Three, if we were able to have a worldwide travel ban based upon that type of – lack of seriousness around pandemic response, we think the outbreak would, in fact, have been different. So, there are some really common sense lessons learned coming out of this that I think are really important for us to realize in order to ultimately come up with a good solution.

You know, as I said, you want to understand about the challenges, I talked a little bit about that, not going to talk about solutions today. But let me talk about some results. What do we want the world to look like? And I really hope that these are things that the whole community, the think-tank community, the development community, Congress, and the administration can all get behind. First, we need to make sure it protects the safety and security of the American people both here and abroad, right? Bottom line.

We need to make sure it minimizes loss of life and catastrophic economic disruptions. We need to lessen the likelihood that outbreaks evolve into epidemics and pandemics, right? Outbreaks will happen, but if we can see them early and respond, that will make all the difference. We need to increase long-term global health security by bolstering country capacity. there is a piece of that that's incredibly important. We need to mobilize more funding for preparedness, especially when it comes from other donors and recipient countries domestic resources. And ultimately, we need to have a system that upholds international standards of accountability and transparency.

So let me stop there, Steve, and give – leave some more question – time for questions. Thanks so much for allowing me to join.

J. Stephen Morrison: Thanks so much, Jim. Great to have you with us.

Andrew. You need to – you're on mute, Andrew. There you go.

Andrew Natsios: That work now? OK. There are a couple proposals before us. The one before the NSC basically would dismember AID and move the largest bureau with the most funding, with the most success record I might add over 40-50 years, to the State Department. Maybe that's not what was intended, but that's what the notes say from the meeting. Two, it would gut the Office of Foreign Disaster Assistance health accounts in emergencies move back to the State Department. And I might add, 90 percent of the deaths in famines are mostly of children who die of infectious disease before they starve to death, because their immune systems are compromised by the starvation.

So if you separate food and nutrition from public health, you will kill a lot of children. Not intentionally, but that's what the net effect would be. We spent years integrating in the international humanitarian response system health programs and food programs. You cannot separate the two. It would be disastrous if that happened. And I think every single NGO that does this work, every international organization that does it, and every national government that we work with would say the same thing.

The Risch bill is certainly an improvement over what was proposed to the NSC. And there are some similarities. But I think there's a problem with the thinking behind this. There's some very broad, very interesting conceptual proposals being made without the specificity of what we actually need. The first thing we need is a pandemic early warning system to tell us ahead of time what's going to happen. We are about to issue our fourth white paper from the Scowcroft Institute at the Bush School at Texas A&M, which I direct. We've issued four of these. And we've been issuing them, by the way – (laughs) – going back to 2017. This is not new. We've been predicting that this would happen.

And the newest one is on early warning systems using remote technologies and using social media in order to get information about what's happening on the ground in dictatorships. Famines never take place in democracies, according to Amartya Sen. And I might add, I would argue that pandemics don't start in countries that are full democracies before they get out of control, because dictatorships try to suppress unpleasant information, which is what we saw in China. Which is why we're having to deal with this mess now. The Chinese have early warning systems. They just don't work because they – officials suppress the information from the scientists.

We need a system of using satellite photograph – photography, social platforms of social communication to predict the beginnings of an outbreak that could turn into a pandemic. We already have a model for this. It's called the famine early warning system. It's been operating for 35 years. It's been highly successful in dramatically dropping the number of famine deaths since 1985 when it started. It's in AID. It's used by the whole international system. We should replicate that by creating a pandemic early warning system.

Second, you have to connect the early warning system to an early response system. If you have the information and you don't do anything with it, what use is it? You have to act. Now, China would not accept a disaster assistance response team from the United States, obviously. However, we could have embarrassed them into earlier action if we had known about it through an early warning system.

But we did send – the DAR teams took the lead. The military action reported to the DAR teams. That was a decision made by President Obama. It was the right decision, in my view. CDC took the – was deputy director of the DAR team that went into Liberia, Guinea, and Sierra Leone. And it made a major push to end the pandemic, which it succeeded in doing. And then it just came back from western DRC because there was another outbreak of Ebola there, and it was successful there. Once it left – (laughs) – the Ebola started up again, I might add.

So we already have disaster assistance response teams. They are 30 years old. They have proven themselves. And Congress has poured money into OFDA to develop a large infrastructure of warehouses around the world. We can respond with a DAR team within 72 hours. The only expeditionary mechanism in the federal government other than U.S. military are DAR teams. What does that mean? It means they can support themselves in a remote part of the world. There are not hotels in these places. There are not restaurants in most the places we go to. These people can take care of the staff from the U.S. government and local staff that work for us. And that's very important.

The third thing we need to do is to move away from exactly what PEPFAR and the PMI – I would argue that the most successful program is not the PEPFAR program. It's the PMI program, the Presidential Malaria Initiative, was far less expensive. PEPFAR costs \$80 billion. It is not sustainable over the long term. I wish it were, but it's very expensive. At some point someone's going to say: We're not going to fund this anymore. And then all those people will die who are on antiretrovirals. It's a real risk. We have not indigenized this program. We have not built it into the infrastructure of the country. There's been resistance at the State Department to do that and CDC to do that.

AID has built the Presidential Malaria Initiative into the health systems of the country. It's part of the country capacity building for all of the government, not just in the health ministry. So I think we need to move away from disease-specific programs to a general program of strengthening health systems around the world, in developing countries in particular, which have the weakest institutions, building the institutions so there is in fact sustainability over the long term.

Who should run this? Now, look, OFDA and the Global Health Bureau, their budgets are controlled by State already. If there's a problem, I don't understand why State hasn't dealt with it. Jim Richardson's the head of that office. And frankly, if you don't like what they're doing, you can stop what they're doing. You have done that before. I have to say, it goes on all the time. So I don't know what more – what more control you need. You already have it now. The blue-ribbon commission on biodefense, which was led by senator – former Senator Joe Lieberman from Connecticut and Tom Ridge, this bipartisan commission, proposed in their report that an office be set up, led by the vice president in the White House, a permanent standing office to coordinate domestic and international pandemic response. We have issued a paper in 2018. We called for exactly the same thing.

A lot of outside commissions are not calling for the State Department to do this. Frankly, if you look at the literature on public administration – James Q. Wilson's work, "Bureaucracy"; Harold Seidman's work, which I teach – they say interagency coordination does not work. The empirical evidence shows the whole of government approach leads to paralysis and it fails. And there's 50 years of

literature on this. Why no one seems to read that I don't understand. The reason OFDA is successful in emergency response? The only person that has to approve it is the ambassador to the country and the OFDA office director. It doesn't go through an interagency process. It's been highly successful. There are no people trashing it in the system. It's got broad support in the Congress. Why don't we use existing institutions and not replicate what already exists?

But we need a long-term approach to this. And the way you do that is a locally based clinic system, by merging all of the polio money, the malaria money, the diphtheria money, the measles money, the PEPFAR money into one health account. By the way, the Obama administration attempted to do this. And I didn't always agree with them on many things, but on this they were correct. And special interests groups that are behind each of these special diseases opposed it. The only way we're going to build capacity in the developing world to deal with new diseases is to build health infrastructure that covers all diseases, not just one disease.

So from my perspective, this is not the right approach. The secretary of state can call me – and I watched him do it. He and her. I worked with Colin Powell, I walked with Condi Rice. And I might add, people who think this is a partisan question, it has nothing to do with who the secretary of state is. They call a meeting, and they send low-level colonels from the State Department – or, the Defense Department to go to the meeting. CDC sends low-level people. There was constant infighting between the PEPFAR office – I mean, Jimmy won't admit this, but I watched it – between the PEPFAR office and CDC.

In fact, there was far more infighting between the PEPFAR office and CDC than with AID. And I ordered the staff to be cooperative. And they were cooperative. And I asked the question during the Obama administration: How did that work under Obama? You know what they said? Not at AID. In State, they said the biggest problem is CDC. They do not want instruction from the State Department on how it is. Because CDC says they are the experts. They don't need to take any instructions from the State Department. And I might add, the infighting in all of these pandemics, including Ebola, required White House intervention to deal with – you know, there's infighting right now. There's infighting under Ebola.

It took four months for President Obama to decide who would lead the DAR team. DOD said they would never follow a DAR team led by CDC. And they said they'd be glad to work with a DAR team, and then the State Department said we want to be in charge of the DAR team. So there was all this infighting. Those issues need to be settled by the President of the United States or the Vice President. The State Department cannot address these issues. They don't have the standing to order another Cabinet secretary what to do or what not to do. And I watched that my whole – I've been doing this for 30 years. I watched it in every administration – whether I was in the NGO community, or as an academic, or actually in the government.

Thank you.

J. Stephen Morrison: Thank you, Andrew.

We're running up against our hour mark. I want to be able – we're not going to be able to handle all the questions that have been put forward. I'll give a quick

reference to some and then I want to come back to Joan and allow Joan to speak to some of these issues. We may need to consider reconvening for a fuller discussion of some of these matters. And I just want to put that out on the table. There's a couple of questions that we've seen come forward. Around WHO, of course, there's fear that any – that there may be efforts to basically detach the United States from WHO, divert resources, and create something as an alternative.

So the question to Joan, is that something that your bill protects against? And similarly, is it protective of GHSA. I read the bill as something that was going to give heart and soul to the global health security agenda. There has been reference to CDC. There's not much discussion here. CDC's not represented. Is CDC given rightful prominence in place in the bill that you are putting forward? And with regard to USAID, there's – one question is, is this bill going to put at risk the core funding towards global health programs at AID, including health system strengthening?

The global – the fund that you're proposing, it doesn't have an explicit reference to being a challenge fund. This issue is raised by one of the questioners. Can you comment on that? There's been a lot of reference to China, particular in Jim's remarks, and a lot of reference to early warning in Andrew's remarks about, you know, we are in this phase where we've had this bruising experience with China in the early phase, particularly about this pandemic, and a desire to be able to not have that experience again. Is that something you feel you're going to address?

Last thing I want to say is if this were to move forward, regardless of what happens in our elections – our national elections in the fall, this is something that's going to take time to enact and put in place. These things take time. We know that. You know that, Joan. You've lived through sort of the way PEPFAR was formed up. If we take a longer view, that it's going to take a period of time to work this through, it's going to be in that same period that we're still struggling with an ongoing pandemic. And if we get a safe and effective vaccine, it's going to cost an enormous amount of resources, upwards of 60-65 billion on the production and dissemination. Not that we're going to shoulder all of that, but it's going to be a gargantuan undertaking. So what you're proposing to erect is going to be occurring in a period of enormous stress and strain on these other matters too.

So I just want to come back to you, Joan. That's a lot, I know. But I'd like you to help close things out here in the few minutes that remain. And then if we have enough time, we'll come and ask each of our speakers for one minute on their closing advice to you. So over to you, Joan.

Joan Condon: Well, thank you so much for those very smart, thoughtful, and loaded questions. (Laughs.) I will do my best to address them. And also thank you so much for everybody's input.

I've said all along that this is a collaborative bill, and it is by no means assumed to be in final. So it's important to hear these critiques, these recommendations, and criticisms, and also perhaps where we got it right. So again, I do appreciate the time and the thoughtfulness that is going into these questions.

In terms of WHO, I mean, look, I did not anticipate that last week an announcement as was made would be in fact made. It certainly was not the intent of the legislation

to create an off-ramp for U.S. participation at WHO. I think the bill actually highlights the vital role that WHO has played and should continue to play in being the guardians of the international health regulations, and the clearinghouse of information and best practices. I would not recommend that we seek to relieve them of that role.

Where WHO has, though, stumbled is in actually operationalizing pandemic response. And I think that's where the interest in creating a fund, whether it's a challenge fund, or a trust fund, or a catalytic fund – whatever you want to call it – was to be able to kind of operationalize and be that first responder as an outbreak is occurring, and make sure that we have the resources and the capabilities that are needed when they're needed, where they're needed. Unfortunately, we've struggled with WHO reform. This is not the first time we've looked for WHO reform. Ambassador Kolker can speak with a great deal of authority on our efforts to promote WHO reform in multiple administrations.

It's a bureaucratic beast. But I think it's worth trying to continue to engage and reform WHO, so we can continue to engage. You are right, the legislation is meant to actually hold up the global health security agenda. It's based on the global health security agenda. It's meant to advance the global health security agenda, and really focus our time and energy on filling those gaps that are identified through two important tools, and accessible tools that are part of the global health security agenda.

In terms of threatening the core funding, in the bill there is an attempt to be clear about what is and is not implicated in terms of the resources. There was a lot of back and forth on how best to approach that, and it's something that we encountered when dealing with trafficking in persons sanctions. Is it more effective to say what isn't included, or to say what is included? And so we tried to carve out what is not included, but of course there's plenty of opportunity to refine that further, as needed.

In terms of CDC prominence, they're absolutely right. We did prioritize a coordinator position – a deputy coordinator position for USAID because the resources that we're talking about the coordinator having authority over are in fact under the Foreign Assistance Act, and they are the appropriations that are made available to the State Department and to USAID. However, there is obviously a role for CDC to play. There's no attempt to diminish that very, very important role. And so again, very open to recommendations and so on as it relates to CDC's role.

And in terms of the challenge fund, actually, the idea of this came from recommendations from ONE (ph) and MFAN and others to create a catalytic or a challenge fund. Ultimately, I landed where we were with PEPFAR in a Global Fund-type of situation. But there's lots of opportunity to build in challenge. And I think we actually do use the word in it when we're describing the types of things that they can undertake, but happy to build that out further.

Did I hit everything?

J. Stephen Morrison: Yes. You did. If you could – if you could just say a word about China and about the early warning issues that both Jim and Andrew raised.

Joan Condon: Absolutely. Well, and when it comes down to it, this bill is meant to be about preparedness and early warning. And while we spent a lot of time focusing on response – and USAID does play the vital role in disaster response, and that is preserved and, if anything, strengthened in the bill by codifying the delegated authority to be the first responder in a disaster. But in terms of early warning, that is the problem this bill is trying to solve. We do lose attention very quickly. We're all about early warning in the midst of a pandemic, and then when it's over we forget that that's still a priority and that we have to make sure that we know how to stop the next pandemic from happening in the first place. And so that should be a priority.

Yes, absolutely China failed. China played WHO. They played us. They played everybody in withholding vital information. We know that happened. Now, some of that WHO needs to answer for. Some of that we need to answer for. Lots of people have a lot of answers to give. But when it comes down to it, China did not uphold their obligations under international health regulations to make data transparent and available, so that the rest of us could prepare accordingly. And so there do need to be consequences. I think that's part of an ongoing dialogue. And I'm eager to hear from all of you about how you think we can best approach that.

J. Stephen Morrison: Well, it's fair to say that, you know, the WHO in no time in the future are going to get an inspection authority negotiated out in order to do this. If there's going to be early detection of what's going on outside our borders, it's going to be enhanced U.S. capacities and will, and enhanced diplomacy around all of this. And if we are – and of course, we dismantled our capacity within Beijing to do that sort of early detection. This is something Ambassador Kolker's described and we've described in other contexts.

Let me turn to – we're getting – we're at the end of our hour. I don't know if Dan's still with us. If Dan is still with us, I'd like him to do sort of the final-final benediction here. But I'm going to ask Jimmy, Jim, and Andrew to offer a minute each of advice to Joan. Thank you.

Amb. Jimmy Kolker: Thanks very much, Stephen. I'm going to pick up where you and Joan left off. First off, I'm encouraged by almost everything Joan said in answer to those questions. And Jim Richardson said that the international system has repeatedly failed us. And certainly when we have to worry, when there's anxiety about epidemic and pandemics, it's when we haven't done as good a job at preventing or responding to them as we should have. But actually, the international system has done some good things, too, with Ebola – the first Ebola outbreak in the DRC, yellow fever just a couple years ago that really threatened to spread. WH-19 tests were, as you know, distributed by WHO.

It is a troubled, difficult organization. As Joan said, I've been fighting to look at reforms. There's plenty more that we could put on the table. I wish that that's the direction we had moved with the challenges now to look at reforms that could have made it better, including an IHR review. Because the International Health Regulations are the way we make China accountable. And both the question of holding China accountable and the idea that the Chinese wouldn't let us in, I'm reminded, as Andy Natsios talked about, H7N9 2013, that 40 CDC people surged to China to work with their epidemiologists to investigate and, in fact, control H7N9, bird flu, much more fatal though not as contagious as SARS.

So it does seem to me that we do have some building blocks in place through IHRs, and through the GHSA, very systematic evaluations and national strategies to make countries accountable and to make the information transparent. So let's use the building blocks that we already have.

J. Stephen Morrison: Thank you, Ambassador.

Jim Richardson.

Jim Richardson: Yeah, no, look, thank you. I appreciate it. I appreciate the time for you to hold this event. Joan is one of the most professional, smartest people I know, so she needs no advice from me. I would just say one thing, that, you know, we've had a lot of conversations about budgets and about programmatic work, and all very important conversations. But again, this accountability question, this how do we set good standards, how do we increase attention across both the developed and the developing world both, how do we make sure that we're including the private sector, how do we make sure that we're mobilizing domestic resources? This isn't just about running development – running a development program, although that'll be an important piece of this. It is about how do we create a system that can – that's a global system – that can detect, track, and counter outbreaks before they become pandemics. Thanks so much.

J. Stephen Morrison: Thank you.

Andrew.

Andrew Natsios: Well, with respect to the private sector, probably the most advanced public-private partnership of any department in the federal government is AID. How did that start? We started it 20 – almost 20 years ago, 19 years ago – called the Global Development Alliance. The last time I checked, it was up to \$20 billion. Twenty-five percent was AID money, 75 percent is corporate and foundation money. Some of the largest corporations in the world work with AID on projects all over the world in public health, in agriculture, in enforcing labor standards. So there is already an existing system – 19 years it's been in existence. And it's won awards.

Second point, WHO has one structure – many structures – but there's one that is the cause of this, and no one's talking about. The regional offices of WHO do not report to Tedros. He doesn't have any control over them. PAHO is supposed to be part of WHO. They do whatever they want to do. He can't fire the people in that. Every other U.N. agency, the director-general, the executive director can fire the regional directors and move them around, and they take orders from them. The regional directors report to the executive committee of 30 countries, which means they don't report to anybody. They're feudal fiefdoms. And – and this is the critical factor – under the rules you have to get the approval of the regional office to do a response to a pandemic. If the regional office does not approve it, the central headquarters cannot do a response. And that's been the case for 70 years now – 60 years now.

It is an outrageous system. And I have – we had an experience in West Africa. The West Africa office of the WHO refused to allow the central office to respond to Ebola, because they said it might hurt the local economies. That office wasn't controlled by WHO. It was controlled by the regional powers that were afraid that this could have

an economic implication. And so the epidemic got completely out of control, and WHO didn't respond because the rules have not been changed. And I might add, I think Tedros – and there are many arguments about what happened – he didn't want to get into a fight with the Asia office of WHO because they don't report to him. You can't have a director-general having a public row with a regional office in his own organization.

That has got to be fixed. And WHO leadership has tried to fix it. And the donors – I mean, the donors and the developing countries will not let that structural reform go through. So I blame the member states for the dysfunction of WHO. WHO has tried to fix a lot of this stuff, and the countries that are members refused to, because they want control. And in my view, that's why we have this mess on our hands.

J. Stephen Morrison: Thank you, Andrew.

OK, we're at close here. First of all, thanks to everyone. Special thanks to Joan. And thanks to Dan for working with us and putting this all together. Michael and Owen, you did a great job. Cliff Jones, Travis Hopkins, John Monts, thanks on the technical team for pulling this all together.

I'm very encouraged that we can have this conversation the way we've had this conversation today. It's around a concrete initiative in the form of what Joan has been able to accomplish in SSRC with Senator Risch, Murphy, Cardin. But behind that also is what Jim is attempting to do. And, Jim, we look forward – we wish you the best, and we look forward to the fruits of your efforts, and the opportunity to discuss those in the same spirit as we're discussing what Joan is bringing forward here today.

This conversation is essential. It's timely. We can't avoid it. We need to have it. And we need to have it in the manner we're having it today, which is constructive and civil discussion around what's at stake. We all – we may differ on some of the fundamentals – AID, versus State, versus this or that. But we share – it seems to me, we all share a common value, a common sense that something more has to be done to protect Americans and to advance global health security beyond our own borders. And this is the moment to really seize to do that.

So thank you all, and I hope – to our audience members – thank you for being with us, and I hope you found this rich and useful. We're adjourned.