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THE INTERNATIONAL JOURNAL OF CLINICAL PRACTICE

EDITORIAL

Global health, global responsibilities

Recently, the WHO Director General Margaret Chan said in a speech to the Bill and Melinda Gates Foundation 2011 forum that stunning gains have been made in reducing malaria mortality and that now eradication is within sight in at least 10 endemic countries (see Figure 1).

Such assertions would have been impossible, a mere dozen years ago. What has happened in the meantime is well-known: a multi-fold increase in resources for priority diseases and a reconfiguration of the donor aid architecture, marked by the decline of some traditional donors and the rise of philanthropy and literally hundreds of non-governmental organizations.

However, something more fundamental has occurred and that is the displacement of 'international health' by 'global health'. The impetus for this includes globalisation itself, past failures to deal with priority diseases, terrorism and bioterrorism and, the fear of newly emerging infectious disease – that may occur naturally, accidently or deliberately. This evolution has meant that the reductionist and linear thinking which have typified relationships between rich and poor countries, donors and recipients, policy-makers and policy-takers, and, development aid and expected outcomes have faltered and given way to the realisation that health is global and that we are all part of a whole. Scientists are increasingly seeing events like epidemics and pandemics as 'bursts of activity in a larger system, intelligible only when studied in the context of many examples of the same phenomenon. They are turning their attention to how and why the parts fit together and to the rules that govern interconnections and coherence' (1).

Global health envisions the world cast in a net of interconnectivity – where disease knows no borders, where mobility is easy and where experience shows that much more is achieved by acting in partnership than going it alone. Some of the new 'partnerships' such as WHO's Roll Back Malaria Partnership (RBM), Stop TB, the Global Alliance for Vaccines and Immunization (GAVI), the Global Fund have come to be seen as 'the most promising form of collective action in a globalising world' (2). Working together in partnerships extends to new frontiers in multidisciplinarity and cross-cutting programming. In the case of malaria control 'there has been a concomitant shift from time-limited, centralised efforts – often relying on single interventions – towards a more decentralised, continuous effort using multiple approaches. Malaria is no longer seen primarily as a biomedical problem, but rather as a complex ecological system in which humans, mosquitoes, and parasites are interconnected' (3).

Canada Although cooperative partnerships are today recognised as the most effective way to meet global health challenges, there is enormous variance in the quality of responses by industrialised nations. Review of Canada's suggests a worrisome performance over recent years and a country out of step with its peers.

Particularly striking is its obstructionist stance on climate change negotiations. Despite the known linkages between global warming and global food security, changing patterns of diseases and vector-borne infec-

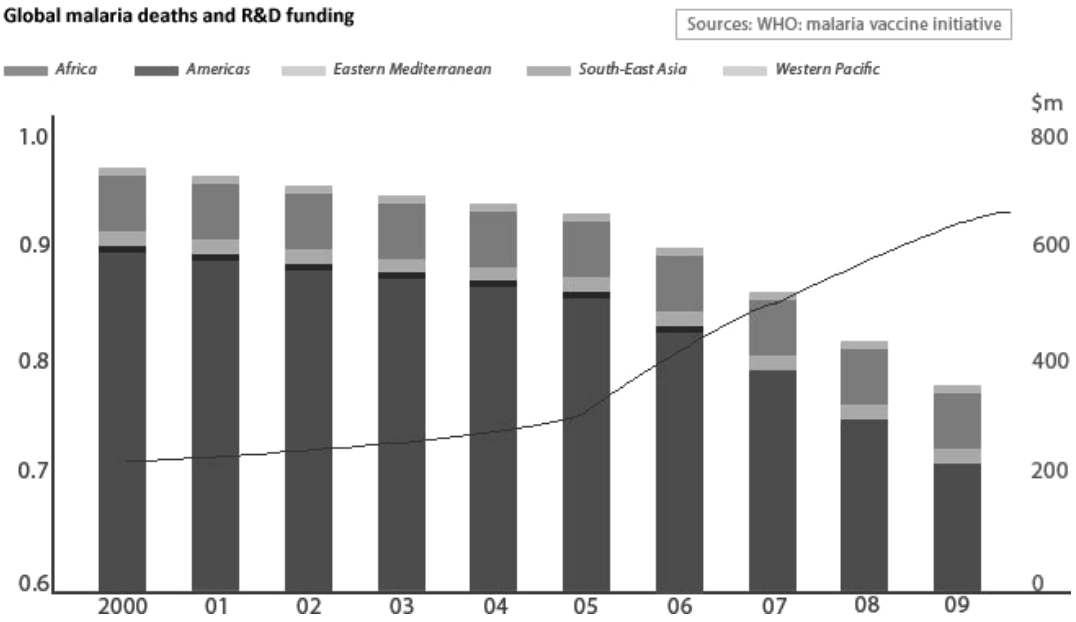

Figure 1 Global malaria deaths and R&D funding

tions (malaria for example), Canada has sought to cast doubt on the underlying science and openly lobbied against the Kyoto Protocol. Other nations agreed to cut greenhouse emissions by 5.2% of 1990 levels by 2008–2012; the United Kingdom and Germany, for instance cut emissions by 27 and 26 per cent respectively. In Canada, they rose by 17 per cent. On December 13, 2011 at the Durban Climate Change Conference in South Africa, Canada drew sharp criticism at home and abroad for pulling out of the Kyoto Treaty at the last moment. United Nation climate chief, surprised by the action said Canada had a legal and moral obligation to future generations yet continues to significant increase its carbon emissions.

Another instance of Canada's failure to act as good world citizen relates to its export of asbestos to lower incomes countries where there are few if any regulations to protect workers and the public. The linkages between asbestos and lung disease and cancer have been well defined; the World Health Organization reports that 125 million people globally are exposed to asbestos in the workplace and that more than 107,000 people die every year from asbestos-related lung cancer, mesothelioma and asbestosis (4). According to the Journal of the Canadian Medical Association, the Government has sought to protect the asbestos industry through 'the shameful political manipulation of science' (5). In 2011, Canada successfully lobbied for the third year running, against the listing of asbestos as a hazardous chemical at the United Nations, Rotterdam Conference – again, the only developed country to do so. Prime Minister Stephen Harper's response to global opposition to trade in asbestos is 'this government will not put Canadian industry in a position where it is discriminated against in a market where it is permitted' (6).

Recent domestic social policy decisions have also drawn international scorn. For example, Canada has not met its international obligations as a signatory to the United Nations Convention on the Rights of the Child as it relates to early child care (ECC). According to most experts, and the 'new neuroscience', ECC is one of the most cost-effective means of improving the health, emotional well-being and life success of adolescents and young adults (7). A review of 25 OECD countries undertaken by UNICEF (8) of early childhood services, shows that based on a set of 10 minimal benchmarks, Canada has the worst record in providing early child care meeting the needs of children. After years of preparation between Ottawa and the provinces and territories, the current administration cancelled a county-wide plan for early childcare.

Another instance of ideology trumping science that has drawn international scorn is the government's replacement of Statistics Canada's long-form national census with a voluntary census. Health researchers link population data with clinical information to describe how socio-economic status affects health which in turn helps shape health policy. As vulnerable groups such as the poor, immigrant, disabled or First Nations communities are much less likely voluntarily fill out the questionnaire, they will be less likely to be taken into account by policy mak-

ers (9). Leading scientists and science journals worry that the government is not simply anti-science (10), but anti-information (11).

Canada's Development aid in support of Global Health. Many of the ideas and values that help guide development aid and which supports global health today are concretised in the 2005 Paris Declaration on Aid Effectiveness, to which all OECD countries were signatories. It stresses the need to focus on the poor and to achieve measureable results through harmonised international efforts that are aligned with local priorities and institutions.

A recent survey (12) of 38 bilateral and multilateral donors, that measures donor adherence to the Paris Declaration shows that Canada ranks 30/38 overall, that is, clustered near lowest quartile with much less prosperous and influential countries. Canada is not effective in coordinating its activities with either its donor partners or the recipient countries it proposed to assist, according to the survey. It shows that, for the criterion of 'selectivity' which is based on the accepted view that aid has a 'greater development impact where it is needed most – that is, where there are large numbers of poor people', Canada ranks 30/38. It ranked similarly for the criterion of 'prioritisation', with too many programs in too many sectors and regions with too little focus. These two indices suggest that Canada is motivated not by development goals, but rather diplomatic or trade objectives.

Indeed, over the last 2 years, Canada's aid effectiveness has worsened still further as it reduced the number of low-income countries in SSA it provides assistance from 15–8, and redirected aid to Latin America to support of political and trade interests. In contrast, many donors like the United Kingdom sought to target most (90%) of its ODA at poor countries, with the Netherlands, Denmark and Norway taking similar steps (13). A just-completed OECD survey (14) captures differences in level and trends in donor adherence to the Paris Declaration between the years 2005 and 2010 confirms these trends – for example, 61% of UK missions are joint mission compared with 17% in Canada.

Although these findings may not be surprising given Canada's insularity and dismissive view of science, they are bolstered by the government's lack of confidence in aid effectiveness (15) – the notion being it is a waste of resources because it does little more than relieve governments of immediately budgetary constraints while allowing bad policies to persist (15). Furthermore, they are reflective of the Canadian leadership stated view in 2006 that multilateralism is a 'weak-nation policy' (16) Restated at the World Economic Forum in Davos in 2010, the Canadian Prime Minister spoke to his deep distrust of the United Nations and multilateralism and called for 'enlightened sovereignty', defining this as 'the natural extension [abroad] of enlightened self-interest' and 'hinting at its conservative frontier virtues of voluntary associations for shared purposes' (17). These comments startled even the most seasoned observers (17).

The way forward. When Canada makes outlier policy decisions, especially ones that seem to further disadvantage already vulnerable groups, the cumulative effect is to diminish the country's reputation. They also may have the indirect effect of overshadowing otherwise positive contributions to the world community or draw closer scrutiny to practices that might have normally been overlooked. For example, a spate of human rights related issues including the de-funding of human rights groups critical of government policies, the Afghan detainee affair, the renditioning of Canadian Maher Arar, the death of mi'kmaq, John Simon, suggest the government and its agencies such as CSIS and the RCMP, are as willing to tread on the human rights at home as they are to ignore them abroad. This would not be an accurate assessment yet, the overall result is a net loss of international standing. Substantive and effective investments such as the Global Health Fund, Global Health Initiative and the Muskoka MCH have received little acknowledgement and, significant events such as the signing of the UN Declaration on the Rights of Indigenous People in 2011 appear anticlimactic and begrudging.

An effective first step to reversing some of these trends that does not presume more political will than actually exists is to embark upon a global health strategy. The process of developing a strategy would help clarify the benefits of embracing the interconnectivity implied by global health and the costs of continuing to ignore it. Many OECD countries have undertaken the process and experts report that to do so would 'improve health local and globally, bring a better understanding of our current and contemplated global health investments; help create transparency of what our priorities are and how we plan to achieve them; and provide framework and guidance of future collaboration, coordination and cooperation. Ultimately it will improve our international partnerships, help promote our foreign policy goals and the values on which they are based; and improve aid effectiveness and make us ready when crisis hits (18).

Canadian clinicians, researchers, health administrators and medical educators have learned firsthand the direct and indirect costs associated with global health threats, in most dramatic fashion, not only

through the Severe Acute Respiratory Syndrome (SARS) but also from the ongoing HIV/AIDS crisis, the H1N1 and host of other global threats. The impact of these crises on frontline workers has been well documented and helped to sensitise the health community to the nature of global health. Today, there is a strong and capable community of health professionals, health, research, education facilities that want to tackle global health (19). A global health framework would promote strategic thought and action, lead to better decision-making, better performance and response preparedness; it would benefit the very people that contribute to the planning and implementation of activities. It would help the Canadian government to moderate its ideological agenda and address with new realities as global health replaces international health and regain its place as a leader in global cooperation and human rights.

Disclosures

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