Harnessing Canada's Potential for Global Health Leadership: Leveraging Strengths and Confronting Demons

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INTRODUCTION

Canada's foreign policy in matters of global health is inseparable from its domestic political project: the country's emphasis on multiculturalism at home is reflected in its emphasis on compromise and cooperation abroad.

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In the international sphere, the constraining pressures of the global political economy combined with Canada's vast material resources, but modest financial and military strength, situate Canada as a so-called "middle power" (Keating 2002, 9). That being said, Canada's influence in matters of global health have been disproportionately high relative to its position in the international system. This influence can be attributed to the unique combination of Canada's ongoing challenges of nation-building at home, its emphasis on consensus-building and ability to coalesce commitment to multilateralism abroad, its commitment to a rule-based international order, and its longstanding focus on promoting health equity in both realms (Nixon et al. 2018, 1737). While there are many reasons to celebrate Canadian global health policy, Canada's relationship with health, both at home and abroad, is marked by contrasting instances of success and failure. It is only by recognizing the country's strengths in relation to the many challenges that lay ahead that Canada can maintain or even expand its influence and deepen its leadership in global health.

In light of this context, this chapter, written in 2019, assessed the possibility and opportunities for advancing Canadian global health leadership prior to the COVID-19 pandemic. The global trend toward nationalistic policies and away from multilateral commitments suggests that Canada could have taken on a greater leadership role in its international commitments by drawing upon the sources of its global health influence. Global health is especially relevant to Canada in this regard because of its inherent multilateral nature. Within its longstanding commitment to

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multilateralism, Canada draws its power from its reputation as a convener and neutral broker of agreements (Keating 2002, 9). At certain times, moreover, Canada has displayed its commitment to multilateralism by allocating significant amounts of money to fund global initiatives abroad. At other times, when Canada's dedication to its multilateral partnerships diminished, the country's reputation as a leader in the global community diminished as well—even though the funding it allocated for multilateral activities did not. This transformation recently occurred under the government of former Prime Minister Stephen Harper (in office 2006–2015), when Canada pledged a significant amount of money to fund the Muskoka Initiative on Maternal, Newborn and Child Health (“the Muskoka Initiative”), but still took major reputational hits due to the types of policies the initiative contained (Ibbitson and Slater 2010). During this time, Canadian foreign policy was less a tool to pursue global interests than it was a tool to advance domestic political gains. Additionally, the current challenges posed by decolonization efforts at home, some concerning foreign resource extraction and trade practices, and previous violations of international health law continue to tarnish Canada's reputation in matters of global health and impede its ability to emerge as a global leader.

Taken together, these circumstances suggest that to harness the potential of the current opportunities for Canadian foreign policy in global health, the country should return to drawing upon its strengths in both domestic and international spheres to deepen its commitment to multilateral global health activities. To do so, Canada must also simultaneously address the deficiencies that impede its progress on such commitments. Put differently, Canadian foreign policy can consolidate the country's leadership in global health, if only it acted to leverage the power it already has while addressing the sources of its own weaknesses. This aspiration could be achieved if the country focused on: addressing its health problems at home and abroad; resolving the inconsistencies in its global health policy by establishing a more coherent approach to global health; and prioritizing a holistic approach to health in all matters of its foreign policy, thereby addressing the upstream causes of ill-health. By doing so, Canadian foreign policy could improve global health efforts overall, as well as

contribute to Canada's reputation and influence in other matters of global affairs.

The remainder of this chapter will, first, provide a brief account of some major themes in the current state of global health; second, provide a framework to understand Canada's relationship with global health; third, identify and assess the strengths of and opportunities for Canadian global health leadership; fourth, outline the most pressing challenges and obstacles for Canadian global health leadership; and, finally, conclude by identifying some strategies for Canadian foreign policy to capitalize on the present opportunities to push Canada toward achieving its potential as a global health leader.

CANADA IN TODAY'S GLOBAL HEALTH CONTEXT

Even when this chapter was written in 2019, Health was in the process of becoming ever prominent on the global political agenda. From the results of population-based surveys, to the policies of national governments, to the focus of internationally coordinated efforts, health is recognized by many as one of the most important challenges to be addressed in the upcoming decades (Rosa 2017, 18). For Canadians, healthcare is a point of national pride (Hoffman 2010, 18); in the United States (US), recent election polls put healthcare in the top three issues of most concern in domestic policy (Klein et al. 2018); Governments from Peru to Namibia to Slovakia to Thailand have also identified health as a concern of national interest; and by outlining 13 ambitious targets that cover a wide spectrum of population-based health measures in their most recent call to action on the Sustainable Development Goals (SDGs), the United Nations has identified good health and wellbeing for all as one of the global goals to be achieved by 2030 (Rosa 2017, 11). In relation to the other goals, moreover, the World Health Organization (WHO) suggests that promoting health and wellbeing can be the centrepiece of a perspective that highlights the intimate relationship between health and development, underscoring the need for an approach that puts health in all policies (WHO 2015, 9). Economies around the world also reflect the growing concern for health and wellbeing, while signifying one of the many ways that health is related to other sectors of activity. Health expenditure accounts for 9.9% of the global economy, with all countries spending

between 3 and 22% of their gross domestic product (GDP) on health (WHO 2017, 10). Indication from the most recent disease prevalence data suggests that as populations age and countries continue to develop economically, health will continue to play an increasingly prominent role in domestic and global policies and consume an even greater share of the world economy. All the while, much of the world's population continues to live without access to life-saving medicines in socio-economic conditions that facilitate ill-health, resulting in millions of annual deaths by diseases that are preventable with the most basic medical interventions (Benatar et al. 2009, 350).

What may be the most distinct feature of these trends, situated in and reflective of broader trends of increasing global interconnectedness, is that disease, in its origins and outcomes, is increasingly transnational (Benatar et al. 2009, 353; Nagi et al. 2019, 1). Political shifts toward nationalism and isolationism contradict this reality, while other global issues have direct and severe implications for health—climate change being the most eminent (Watts et al. 2018, 581). Addressing these transnational sources requires transnational responses and global efforts are required to enact meaningful change. As emphasized by global experts, moreover, this change must come about by challenging the upstream political and economic sources of ill health, lest the accomplishments be unsustainable, superficial, or ephemeral (Benatar et al. 2009, 371; Hunsmann 2016, 810–814). From notions of basic human decency, to humanitarian convictions of social justice, to ideas of ethics and morality, to returns to national security and economic efficiency, justifications for action abound.

As a result of globalization, moreover, the distinction between global and domestic health has been blurred as the health of Canadians is increasingly affected by transnational factors. In such an interconnected world, “local health *is* global health,” since the determinants of both domestic individual and population health now have increasingly international characteristics (Nagi et al. 2019, 1). These determinants of health are not only affected by the complex relationships among countries, but also span and transcend multiple dimensions of Canadian policy. For example, due to the transnationalization of risk, Canadian health security depends on global preparedness to respond to epidemics, as microbes and diseases have little concern for national borders. Emergent global health threats, such as that posed by antimicrobial resistance, further highlight Canada's dependence on a cooperative international community (Rogers Van Katwyk et al. 2016, 2; Årdal et al. 2016, 297; Hoffman

et al. 2015, 868). Unleashed by economic globalization, moreover, the power of multinational corporations has been enhanced by the internationalization of production and the increased mobility of finance capital. This power now places enormous pressure on domestic regulations and has spurred the rise of precarious and non-standard employment situations for Canadians. Since employment and work conditions are a strong determinant of health outcomes, this trend has a direct influence on the health of Canadians (Labonté et al. 2015, 12). Corresponding with both trends, environmental restructuring, including the depletion of local resources as a result of global production, affects the health of Canadians by transforming local physical and socioeconomic conditions (Nagi et al. 2019, 6). Canada cannot go it alone to address these determinants of its population health. These health problems—characteristic of a modern and interconnected world—are problems that cannot be addressed by independent national governments: coordinated global efforts are required. On the other side of the coin, Canada's domestic and foreign policies, as well as Canadian business practices like trade and resource extraction, affect the health of populations in other countries. Knowing that, like Canada's situation in the interconnected world, addressing health in these countries requires international collaboration, Canada has the responsibility to participate in efforts to improve health at the global level.

Most of this information is not news. But in identifying and challenging some of the global causes of ill-health, tremendous progress has been made in the last three decades. In fact, the world has achieved more health gains over this period than any other in human history (Hoffman and Frenk 2015, 19). With a cautious sense of optimism, this progress should be taken as evidence that change is possible. There remains, however, much to be done. All actors, including Canada, have a part to play in the global response, with special responsibility afforded to those countries in positions of privilege—positions which are fortified by the very forces that are responsible for many of the ailments that plague the current time. The current conditions of international affairs provide a chance, it seems, to reflect on the opportunities for increasing the attention and effort paid to bettering the state of global health by addressing both the global causes and consequences of disease. Recognizing the impact of past initiatives and reflecting upon ongoing challenges invites a reconsideration of the role that Canada, with its history of global health leadership and as high income country (HIC) in a position to effect real

and meaningful change, can and should play in addressing transnational health inequalities.

CANADIAN FOREIGN POLICY, MULTILATERALISM, AND GLOBAL HEALTH

Canada's commitment to multilateralism is a distinguishing feature of the country's foreign policy; indeed, compared to other countries of similar stature, a disproportionate amount of Canadian foreign policy takes place inside the realm of its commitment to multilateral institutions and associations (Keating 2002, 10). Because of this reality, most of Canada's relationships with the international community has been conditioned by the country's engagement in multilateral partnerships, such as its longstanding participation in the United Nations, North Atlantic Treaty Organization, G7, G20, Francophonie, APEC, and World Trade Organization (Keating 2010, 10; Canada 2019b). Additionally, and of even greater significance in relation to global health, many multilateral partnerships and institutions have been conditioned by Canadian foreign policy. Taken together, the examples mentioned in this chapter add substance to the claim that Canada has an exceptional institutional reach in global politics.

To convey the opportunity for Canadian foreign policy in global health multilateralism, it is helpful to quickly break down the definition of the term 'multilateralism.' The nominal definition, which is commonly accepted, suggests that multilateralism is the coordination of policies among three or more states. A qualitative definition of multilateralism, though, is more widely contested. Qualitatively, multilateralism is sometimes defined as the relations among three or more states on the basis of certain principles of ordering relations, where the principles "specify appropriate conduct for a class of actions, without the particularistic interests of the parties or the strategic exigencies that may exist in any specific occurrence" (Ruggie 1992, 571). Following from this first qualitative definition, multilateralism would also depend on shared and intersubjective understandings of indivisibility and diffuse reciprocity. This first qualitative definition, though, is demanding and occludes instances of international action conventionally understood as multilateral. Furthermore, this definition omits any reference to collective action or decision making, which are conventionally understood as essential components of

multilateral arrangements. Arising from these critiques, a second definition suggests that multilateralism is “a primary institution that requires that three or more actors to employ agreed upon rules to facilitate collective decision making and action” (Graham 2015, 165).

Looking at these definitions, it may be true to say that to be considered multilateral, institutions do not necessarily need to meet the conditions of the first definition in their response to global problems, but some global responses require that the conditions be met in order for the problem to be addressed effectively. That is, sometimes the threats posed by global problems and the benefits posed by global responses are indivisible, and those global responses further provide diffuse reciprocity, but depend on the subjugation of particularistic interests and the sacrifice of strategic exigencies to the common good. In these cases, it would appear that the appropriate global response ought to be multilateral in nature. This understanding resembles somewhat of a functionalist outlook by suggesting that multilateralism can provide mutual benefit by allowing the achievement of results that would otherwise be unachievable through unilateralism or bilateralism. Put differently, some global problems cannot be solved except through multilateral action. A prime example of this type of problem is climate change. Also within this vein, though, are transnational global health challenges, including climate change-related health implications (Watts et al. 2018, 581). With recent and ongoing aversions to this form of cooperation, evidenced by the increasingly nationalistic tendencies of a growing number of countries, multilateralism is enduring a sort of crisis (Brunnée 2018; Smith 2018). Nonetheless, the transnational and immediate threat posed by several global health challenges highlights the continued relevance of multilateralism, while also highlighting the need to do it better.

MIDDLE POWER STATUS AND BEYOND: CANADA AS A CHAMPION IN GLOBAL HEALTH

Canada as a Middle Power

Canada’s diversity is often cited as a source of national pride and political strength (Murphy 2015). The country’s ongoing domestic political project continuously draws on its history of consensus-building, compromise, and cooperation at home. This tradition has established what is often referred to as “the Canadian cultural mosaic” (contrasted with “the

melting pot” of the United States). The Canadian cultural mosaic is comprised of many surviving Indigenous nations and continuous waves of landed settlers. Canada’s openness to immigration is evidenced by the ongoing influx of immigrants, which is one of the main drivers of Canadian population growth—as many as one-fifth of Canadians are born abroad (Canada 2017b). Amidst growing anxieties regarding the failure of multicultural enterprises in places like Europe and the US, it is remarkable that Canada continues to achieve such a high degree of social cohesion (Malik 2015, 10). Moreover, with such a diverse range of cultures, traditions, and heritages within the Canadian demography, strong feelings of global citizenship have resulted in a strong talent pool of Canadian global health leaders. Canada’s recent classification as the 10th most globalized country in the world in terms of trade relations, population mobility, and openness, and the sheer volume of Canadians who have achieved high statuses as global health leaders substantiate these claims (Swiss Federal Institute of Technology Zurich 2016; Nixon et al. 2018, 1737).

The finesse derived from governing such a diverse population at home loosely translates into Canada’s focus and strengths abroad. The principles of compromise, cooperation, and consensus building that operate at the domestic level are reflected in Canada’s commitment to global citizenship, multilateral cooperation, alliance building, and collective action in its foreign policy (Nixon et al. 2018, 1737). With its longstanding commitment to these values, Canada has a track record of promoting and upholding a peaceful world order by emphasizing the norms of equity, human rights, and the rule of law in the international system (Henrikson 2005, 68). Within the international system, Canada’s politico-economic situation, with its modest economic and military resources, earns its status as a middle power. This status means that when compared to the world’s great powers, like the US, Canada has more interests than its situation permits it to achieve. That is not to say that it cannot nor does not achieve its own interests, but rather that Canada has to rely on means other than the paths that great powers are able to take, such as sharply defined courses of unilateral action, to realize its interests. In contrast to the options that great powers have, Canada must rely on its multilateral participation as the primary source of its international influence (Henrikson 2005, 69–70). This reliance on multilateralism is an essential characteristic of middle powers. Other countries that share this situation are Australia, Norway, and Sweden, among others.

Potential Avenues for Canadian Global Health Leadership

When it exploits its situation as a middle power, Canada can wield significant influence attained by and exercised through its multilateral partnerships and associations. In matters of global health, moreover, Canada's ability to leverage its middle power status has resulted in instances where the country has punched above its weight relative to its modest economic and military resources. Canada's disproportionate ability to influence matters of global health is evidenced by its ability to initiate, convene, coalesce, and broker global health agreements. Four past examples that serve to illustrate the potential for Canadian leadership in matters of global health can be found in the areas of global health promotion, global health and human rights, tobacco control, and global health security.

A good example of Canada's global health leadership, the WHO's adoption of the Ottawa Charter for Health Promotion in 1986 ("the Ottawa Charter") is just one chapter in Canada's historical commitment to health equity. Canada's focus on health equity emanates from the country's domestic universal health care system, and its willingness to identify and address structural causes of ill-health in a framework that is often referred to as "the social determinants of health." An early example of this approach was the publication of the Lalonde Report in 1974 by then Minister of National Health and Welfare, Marc Lalonde. The report argued that achieving good population health required addressing the key challenges of improving the country's health care system, preventing health problems, and promoting good health. The report is credited to be the first ever government document to call for a broader conception of public health promotion beyond the then-dominant and mostly exclusive biomedical approaches. It is further credited with setting the stage for the Alma Ata Declaration of 1978, which called for an approach to global health promotion centred on primary health care—a model that aims to address global health inequalities (Dugani et al. 2017, 2; Kickbusch 2003, 383–384). Following these developments, in 1986 the Canadian Public Health Association and Health and Welfare Canada hosted the first International Conference on Health Promotion led by the WHO. The conference culminated in the adoption of the Ottawa Charter, which framed public health promotion as "the process of enabling people to increase control over, and to improve, their health" (WHO 1986; Kickbusch 2003, 384). The principles outlined and adopted in the Ottawa

Charter significantly influenced the way other countries approach and practice public health promotion. More recently, Canada's emphasis on health equity was again reflected in the 2008 WHO report on the social determinants of health, which was also supported by numerous Canadian health officials. The 2008 report recommended that to improve global health equity, the world needed to "improve the conditions of daily life; tackle the inequitable distribution of power, income, and resources; and measure and understand the problem and interventions to address it" (Nixon et al. 2018, 1740).

Other times that Canada took charge in matters of global health multilateralism resulted in the successful establishment of the Prohibition of the Use, Stockpiling, Production and Transfer of Anti-Personnel Mines and on their Destruction ("the Ottawa Treaty") in 1996 and the WHO Framework Convention on Tobacco Control (FCTC) in 2000. In 1996, responding to an increased awareness of the effects that land-mines have on non-combatants, combined with an increased awareness of the sheer number of casualties that suffered from their usage, Canada's then-Foreign Affairs Minister, Lloyd Axworthy, called for global action during a convention hosted in Ottawa. His challenge, which was aligned with several calls to action from civil society representatives, resulted in the adoption of the Ottawa Treaty that prohibited the use, stockpiling, production, and transfer of anti-personnel mines (Depalma 1997). In 1998, responding to global epidemic of tobacco related cancer deaths and recognizing that a global response was needed to address the issue, Canada introduced the idea of an international treaty on tobacco control at the World Health Assembly—the WHO's plenary governing body. This recommendation evolved into the Framework Convention on Tobacco Control, which was adopted in 2000 and still currently operates to regulate the global production, sale, distribution, advertisement, and taxation of tobacco (Canada 2004).

Canada has also participated in many notable global health security initiatives. In 2001, expressing a heightened attentiveness to the threat posed by pandemic infectious disease and the potential threats of biological, chemical, and radionuclear terrorism, Canada worked to create an informal partnership with the WHO and seven other countries to strengthen the world's ability to respond to such threats. The creation of the Global Health Security Initiative (GHSI) was a direct result of these efforts. The GHSI continues to operate as a collective venture aimed to strengthen the global preparedness and response to

pandemics and bioterrorism (Global Health Security Initiative 2014). Similarly, Canada was instrumental in supporting the Global Health Security Agenda (GHSA)—a US led international initiative that promotes biosecurity and biosafety by supporting health security capacity building. GHSA enables collaboration among 65 countries, international organizations, and non-governmental organizations (NGOs) to enhance global preparedness against health threats like bioterrorism and antimicrobial resistance. It aims to promote biosafety by improving medical countermeasures, including personnel deployment capacity. Canada recently finished its term in the inaugural steering group of the GHSA (PHAC 2014).

During the 2014–2016 Ebola Crisis—and corresponding to its commitment to its global health security partnerships—the Government of Canada donated over \$35 million to the WHO and other groups to address the spread of the virus, sent a mobile lab unit to Sierra Leone that provided laboratory diagnostic support capable of quickly identifying the virus and expediting the ability to intervene, and offered \$2.5 million worth of personal protective equipment to the WHO (Outhwaite and Taylor 2017, 80). The Ebola outbreak also brought global attention to the work taking place in Canada's National Microbiology Laboratory, which had been researching an Ebola vaccine since 2001. The crisis of 2014–2016 garnered unprecedented international support for the vaccine, and the combined efforts of the Public Health Agency of Canada, the Government of Canada, Norway, WHO, and other international collaborators led to successful clinical trials in the field. The vaccine is now in the process of licensure, and its full-scale production could significantly mitigate the global health threat posed by future Ebola outbreaks. The Ebola vaccine represents an important Canadian research contribution to global health (Plummer and Jones 2017, 1326).

These examples serve to illustrate Canada's commitment to a peaceful world order through the promotion of human rights, equity, health security, and the rule of law. They also illustrate the interconnectedness of health and other areas of Canada's foreign policy: promoting global health by addressing its structural determinants requires a review of the many ways that Canada's economic trade policies affect the health of global populations; the Ottawa Treaty on the use of landmines points to the connection between issues of health, military activities, and the environment; the strengthening of Canada's preparedness to pandemics and bioterrorism connects health and security, highlighting the potential for

health threats to spread across borders; and the creation of a framework to globally regulate tobacco highlights the relationship between policies of industry regulation, transnational production and trade, the environment, and global health.

Canadian Financial Contributions to Development Assistance for Health

Canada has also displayed its commitment to promoting global health by targeting (often through multilateral channels) significant amounts of its official development assistance (ODA) toward health-related goals. However, despite calls to increase its ODA since 1969, Canada has made little progress to achieve this goal. Since 1969, Canadian ODA has significantly increased in real terms, but not as a portion of its gross national income (GNI). In 2015, ODA comprised a mere 0.28% of Canada's GNI, well below the OECD average of 0.40%, and even farther below its goal of 0.70%—which was supposed to be achieved by 1975 (OECD 2017). In 2016, this percentage dropped to 0.26% and remained constant at that level through 2017 and 2018. Canada's 2019 budget report projects that its ODA will remain stagnant at approximately 0.26% of its GNI through to the 2023–2024 fiscal year (Canada 2019a). That being said, in recent years, Canada has been able to increase its development assistance for health (DAH) in real terms, in relation to its GDP, and as a portion of the total global contributions to DAH. From 1997 to 2016, Canada's DAH increased more than sevenfold, from \$168 million to \$1.25 billion (adjusted to 2015 USD). Resultantly, Canada's DAH as a share of its own GDP rose from approximately 0.026 to 0.081%, and its share of total global DAH rose from approximately 1.35 to 2.58% during this time period. During this time, moreover, as much as 41% of Canada's DAH was being channeled through multilateral partnerships and institutions (Bhushan 2014, 18; IHME 2019).

While much of Canada's DAH maintained a multilateral character during this period of increased financial contribution, significant changes occurred to the way that these financial contributions were delivered. Comparing the periods of 1997–2008 and 2009–2016 reveals a dramatic increase in the amount of Canadian DAH channelled through NGOs and private foundations. From 1997 to 2008, 47.7% of Canada's DAH went through bilateral partnerships, 27.1% went through UN bodies, and less than 5% went through NGOs and private institutions (Bhushan

2014, 12). From 2009 to 2016, these numbers shifted to 36.6% bilateral, 15.6% UN body, and 25.3% NGO (Bhushan 2014, 12). A significant portion of these changes can be attributed to Canada's large investment in the Muskoka Initiative. At a G8 meeting in 2010, Canada pledged to deliver \$1.1 billion additional funds to the Muskoka Initiative to accelerate reduction of maternal, infant, and child mortality in low and middle-income countries (LMICs). In combination with the \$1.75 billion already promised in baseline funding, the new pledge brought Canada's total contribution in this area to \$2.85 billion (Nixon et al. 2018, 1740).

Canada's dedication to this initiative reflects its longstanding commitment to health equity, especially to gender equity. Of the \$2.85 billion dedicated to the Muskoka Initiative, though, approximately 16% was channelled through Canadian NGOs (Bhushan 2014, 12). While channeling funds through NGOs and private foundations makes it easier to achieve nationally determined interests and priorities—meaning that money can be spent directly toward the goals set by Canadian donors—this additional control can come with some costs: increasing the authority of NGOs runs the risk of displacing locally determined health priorities in favour of meeting goals determined by donors who are not necessarily aware of unique and particularistic local needs. Nonetheless, there is little doubt that Canada's contribution to the initiative was instrumental in saving and improving many lives. The priority of achieving gender equity in health continues to define Canada's approach to global health, which now takes form in Canada's Feminist International Assistance Policy recently adopted by Global Affairs Canada. The new policy was launched in 2017 and coincided with a reallocation of \$150 million toward helping grassroots women's organizations and, in 2019, Canada pledged an additional \$100 million in new funding to support these important initiatives (Canada 2019a). By 2022, Canada hopes to have 95% of its ODA targeting initiatives that advance gender equality and empower women and girls around the world (Canada 2017a, 67).

CHALLENGES FOR CANADIAN GLOBAL HEALTH POLICY

Despite so many achievements and successes, the sources of Canada's strength in global health are being undermined by ongoing challenges to and recent deviations from the country's traditional global commitments. For example: Canada recently shifted its funding for global health initiatives away from its multilateral partnerships; recent findings from the

Truth and Reconciliation Commission—a commission that documented the history and lasting impacts of Canada's residential school system for Indigenous children—reveal that Canada's Indigenous peoples still face many health disparities at home; some Canadian mining companies continue to operate in foreign markets with questionable human rights practices; and recent actions aimed to appease domestic interests have violated international law. While there are many reasons to celebrate Canadian contributions to global health, these challenges threaten Canada's potential to deepen its global health leadership.

Recovering from a Critical Turn in the Harper Era

After the election of a new government, the period of 2006–2015 signaled an important shift in Canadian foreign policy, including in its policies toward global health. Overall, it was the turn away from Canada's multilateral norm that most starkly characterized this period. The government, led by then-Prime Minister Stephen Harper, implemented policies that favoured economic nationalism, putting 'Canada first' in matters of its foreign policies (Canada 2008, 3). This period saw the amalgamation of the Canadian International Development Agency with the Department of Foreign Affairs and International Trade into a new Department of Foreign Affairs, Trade and Development. The merger of these departments allowed for the creation and adoption of foreign policies which were able to advance Canadian trade and investment interests abroad. However, some critics point out that, as a result of these transformations, the coexistence of diplomatic, economic, and development interests in one department sometimes resulted in the suppression of development goals in favour of narrowly defined political and economic self-interests (Huish and Spiegel 2012, 245). Further reflecting the trend toward pursuing more narrowly defined goals, this period saw a decrease in funding toward multilateral activities. Instead, Canada was more selective in the way it engaged with the international community, taking more liberties to pursue unilateral or bilateral action to achieve its goals.

During this time, Canada did increase aspects of its ODA in many important areas. For example, the amount of money Canada allocated to the World Bank's International Development Association increased, Canada committed a 30% increase to its contribution to the Global Fund to Fight AIDS, Tuberculosis and Malaria, and, as previously mentioned, Canada pledged \$2.85 billion to the Muskoka Initiative (Huish and

Spiegel 2012, 245). But despite increasing its funding commitments and taking leadership in certain initiatives, Canada's international reputation suffered during the Harper Era because the substance of the initiatives marked a betrayal of Canada's multilateral past. Considering that Canada was able to garner praise for increasing its contributions to these development initiatives, the resulting reputational damage it suffered can be attributed to the change in its foreign policy attitude. Often cited as evidence of this reputational damage, the first time Canada ever applied for and was denied a seat on the United Nations Security Council occurred after these changes to its foreign policy. Though causation in these situations is never truly clear, the then-in-power Conservative government pushed for a new Canadian identity that prioritized "military aid over peacekeeping, unilateralism over teamwork, free trade over foreign aid," which was not well received by the international community (Mackinnon 2017). Now, with Canada's new Feminist International Assistance Policy, there is an opportunity to reassert Canadian leadership through its global health commitments; but, even with the new pledged of an additional \$100 million for this initiative, Canada's ODA as a percentage of its GNI is still very close to an all-time low (Global Canada 2017, 1). Learning from past challenges, moreover, the question of 'how much money' is only one aspect that must be considered; indeed, it may be the question of 'how that money is allocated' which is a more important consideration in relation to Canada's international reputation.

The idea of a 'Canada first' foreign policy also asserts a nationalistic identity that conflicts with the country's diverse demography, and the task of preserving a sense of unity under the banner of a 'Canada first' foreign policy is not without its challenges. In 2015, Canada was demoted from 3rd to 6th place in the global Migrant Integration Policy Index due to a deviation from its inclusive norm (Migrant Integration Policy Index 2015). More critically, the findings of the recent Truth and Reconciliation Commission underscore the overwhelming effects that colonialism continues to have on Canada's Indigenous peoples. Though Canada is often praised for having an equitable and universal health care system, health disparities at home pose a severe challenge to this claim. Indigenous communities in Canada "continue to live with unacceptably disproportionate burdens of ill health, including higher rates of infant mortality, tuberculosis, child and youth injuries and death, obesity and diabetes, youth suicide, and exposure to environmental contaminants" (Greenwood et al. 2018, 1646). Looking to the upstream causes of this

reality reveals the poor context that many Canadian Indigenous populations live in, resulting from a legacy of colonialism. Progress toward securing and protecting diversity as a source of strength will require a reinvigoration of the Canadian commitment to inclusion and a genuine effort toward fulfilling the promises of the Truth and Reconciliation Commission. It will be difficult for Canada to be a leader in promoting global health equity without simultaneously addressing these issues at home. If Canada wants to maintain its diversity as a source of strength in its global health diplomacy, these examples serve to highlight that continuous and conscientious attention is required to stave off complacency and prevent criticisms of hypocrisy.

To consolidate its status as a global health leader, Canada must also confront the demons in its international affairs. While pursuing a 'Canada first' foreign policy has helped to advance Canadian business interests abroad, certain Canadian companies conduct their operations in ways that reflect poorly on Canada's global reputation. That the Canadian government has permitted—and sometimes even supported—these practices undermine Canada's efforts to promote human rights and the rule of law in the international arena, and hinders Canada's potential to deepen its global health leadership. For example, in their quest for global competitiveness, some Canadian mining companies have been successful in foreign markets, but at the cost of destroying land and exploiting local labour in the process. These companies threaten local environments, political and social stability, and access to clean water and secure employment—all of which are important determinants of health. One example that stands out is the Toronto-based mining corporation Barrick Gold—the largest gold producer in the world. Recently, Barrick Gold had to suspend its operations at the Pascua Lama open-pit mine on the border of Chile and Argentina. The project, first approved in 2007, never fully took off because it became apparent during construction of the mine that Barrick Gold did not accurately predict the full environmental impact of the project. As the full scale of the environmental impact became apparent, the Chilean government suspended operations at the mine (Jamasmie 2018). The adverse environmental consequences of the mine's development, however, were anticipated by locals who protested the project's development in 2006–2007. While on a state visit to Chile in 2007—during the mine's development process and concurrent protests—then-Prime Minister Steven Harper declined a meeting with local environmentalists, opting instead to meet with local representatives

from Barrick Gold in a show of support for Canadian foreign business interests (Gordon 2010, 210–214; Heller 2012, 225–226).

This small gesture by the Canadian government falls into an extended history of troublesome trade practices that have benefitted certain Canadian business interests at the expense of local populations in LMICs. Though Barrick's operations were suspended at Pusca Lama, there remain several other mines controlled by Canadian companies that continue to operate with significant environmental and humanitarian risks (McSheffrey 2016). Development plans made and implemented during the Harper Era prioritized investing in development projects that had partnerships with Canadian businesses—including these Canadian mining companies. By doing so, it fused the priorities of Canada's self-interest and development, hurting Canada's reputation by sending the message to the global community that development was secondary to promoting Canadian business interests. Partnering with certain mining companies was problematic because of their role in dispossessing locals, exploiting labor, extracting resources, and destroying land (Huish and Spiegel 2012, 245). The example of Canadian mining companies is just one, albeit direct, example of how Canadian business operations in foreign markets can displace concerns for local health in particular and damage Canada's international reputation in general—and points to the significant role that the Government of Canada can play in relation to these operations. The announcement of a new Canadian Ombudsperson for Responsible Enterprise to oversee Canadian businesses operating abroad is a good start to rein in these problematic business operations (McSheffrey 2018).

Whether Canada conducts its affairs according to international law also bears on Canada's potential to deepen its global health leadership. Canada has, on two recent occasions, violated international law with its own domestic policies (Tejpar and Hoffman 2017; Habibi and Hoffman 2018). The first occasion was the travel restrictions that Canada imposed during the 2014–2016 Ebola outbreak in West Africa (Tejpar and Hoffman 2017, 368). The 2014–2016 Ebola epidemic was the deadliest Ebola outbreak in history (WHO 2014). On 8 August 2014—five months after Guinea's Ministry of Health first reported an emergency—WHO formally declared the outbreak “a public health emergency of international concern” under the legally binding International Health Regulations (IHR) (WHO 2005). The WHO then made further recommendations pursuant to the IHR for a coordinated response to curb the global spread of the disease (Rhymer and Speare 2017, 11). In violation

of Article 43 of the IHR, though, Canada took it upon itself to implement additional measures—measures beyond those outlined in the IHR and recommended by the WHO—to enact a visa restriction on travellers who had been in Ebola-affected countries within three months of their application (Rhymer and Speare 2017, 12; Tejpar and Hoffman 2017, 370). Article 43 of the IHR states that additional measures are only permitted if they are supported by public health rationales, scientific principles and evidence, or WHO guidance and advice (Tejpar and Hoffman 2017, 371).

The visa restriction that Canada implemented on travellers from Ebola affected countries was founded on none of the necessary criteria. In fact, it contradicted all three. Critics have argued that Canada's response prioritized its public's perception of safety over the public health consensus that travel restrictions do more harm than good (Tejpar and Hoffman 2017, 372). Specifically, travel restrictions are proven to worsen situations both at home and abroad by incentivizing authorities to hide cases to avoid negative economic consequences and by restricting the flow of medical workers and supplies (Nuttall 2014; Belluz and Hoffman 2014). Nor was the travel restriction based on valid science; for example, the three-month timeframe was four times longer than the upper limit of the virus's incubation period and the travel restriction excluded Canadian citizens—as though to suggest that Canadians are immune to the virus (Tejpar and Hoffman 2017, 375; Hayman, n.d.). Finally, the travel restriction was in direct contradiction to the WHO's guidance that explicitly said, "there should be no general bans on trade and travel" (WHO 2014). As a result, Canada's travel ban was perceived negatively. For example, one major American news outlet's headline read: "Canada's Ebola Visa Ban is Dumb, Xenophobic and Illegal" (Belluz 2014). By actively violating international law and undermining its effectiveness, Canada deviated from its traditional commitments to evidence-based policy, international order, and global health leadership—harming its reputation in the process.

The second occasion was the legalization of cannabis on October 17, 2018, which also presents an unfortunately missed opportunity for Canadian global health leadership. The legalization of cannabis signaled a progressive turn in Canadian public health as studies have found that prohibitionist approaches to cannabis use not only fail to achieve their goal of reducing use, but also cause substantial public health and societal harm in the process (Spithoff et al. 2015). Canada was the first high-income, the first G7, and the first G20 country to incorporate

this evidence base in its approach to cannabis use (Austen et al. 2018). However, by legalizing cannabis, Canada is in violation of international law (Habibi and Hoffman 2018, 6). Under the auspices of the United Nations, there are currently three prohibitionist international treaties that govern the legality of narcotic substances (the 1961 *Single Convention on Narcotic Drugs*, the 1971 *Convention on Psychotropic Substances*, and the 1988 *Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances*) (Habibi and Hoffman 2018, 3). With Canada's current approach to legalization, it is in violation of all three treaties, even though the new approach upholds the spirit of promoting good health and welfare for the population.

Even though Canada's new approach to cannabis use is a violation of an anachronistic international law for scientifically valid public health reasons, such violations of international law are still harmful to Canada's international reputation and conflict with the "deeply held Canadian desire to make a real and valuable contribution" to the world (Mortillaro 2016; Trudeau 2017). The legalization of cannabis also presents a missed opportunity for Canadian global health leadership. Not only could Canada have pursued a course of action that would have allowed legalization without violating international law, it could have pushed to change the three treaties so that they were better reflective of global health needs (Habibi and Hoffman 2018, 3). This was a perfect opportunity for Canada, with its institutional reach, historical commitment to evidence-based medicine, and tradition of promoting a rule-based international order, to engage with the international community, recognize its responsibility to make international law better when necessary, and champion progressive change.

Though the two examples of Canada's violations of international law are significantly different in their justification, they both show how Canada's domestic actions are tied to its international commitments. It is important for Canada to show its ongoing commitment to maintaining an international order based on the rule of law, since doing so promotes a reputation of trustworthiness and willingness to cooperate and indicates to other countries that Canada is sincere in its commitments.

CONCLUSION

Canada is more connected to the rest of the world than ever before. This connection has blurred the distinction between Canadian health and

global health. As a result, Canadian health is connected to global factors in ways that prevent Canada from addressing the determinants of its population's health alone; Canada needs to maintain and ideally deepen its participation in the global community to help improve the health of its own population. Since Canadian foreign policy affects the health of other countries in the global community, Canada also has a responsibility to partake in global health initiatives. Participating in global health initiatives, therefore, presents an opportunity for Canada to capitalize on a win-win opportunity: by participating in global health initiatives, Canada can improve its own population's health and international reputation, while simultaneously improving health in other parts of the world.

The magnitude of this opportunity for Canada continues to grow: many global health issues require multilateral action to address transnational health challenges that countries cannot address unilaterally. Within the realm of global health multilateralism, moreover, Canada has a disproportional effect relative to its situation as a middle power. This context suggests that Canadian foreign policy could achieve significant influence in matters of global health if it strengthened the country's multilateral global health partnerships. And while the fact that Canada's ODA is near an all-time low suggests that the country can and should enhance its financial contributions to global health efforts, financial support is just one factor in the overall equation of harnessing Canada's potential to deepen its global health leadership. As lessons from Canada's recent experience with the Muskoka Initiative suggest, Canada's actions—including how it directs the money it gives—are as, if not more, important factors. Put differently, the road to improving Canada's commitment to global health would benefit from the mobilization of more resources, but money alone cannot solve today's global health challenges. Canada needs to draw upon its traditional strengths, which have helped the country champion global health initiatives in the past, while simultaneously addressing its weaknesses, which prevent the country from deepening its global health leadership.

In addition to reverting to its tradition as a staunch participant in multilateral efforts plus renewing its financial commitments to ODA, Canada should attempt to revive and strengthen its status as a defender of the rule-based international order and an active promoter of human rights and health equity. Canada's Feminist International Assistance Policy is a good start, but fulfilling this policy's mandate requires addressing the practices that impede the country's ability to reclaim its former status.

Rectifying these past and ongoing practices will also help prevent further criticisms of hypocrisy. For example, Canada can learn from its mistakes during the 2014–2016 Ebola crisis to inform future outbreak responses and can address its ongoing violation of international drug control treaties by pushing for reforms to these outdated instruments. The appointment of a new Ombudsperson for Responsible Enterprise is also a promising step toward deepening Canada's global health leadership, but whether the new Ombudsperson can help the country hold its businesses to a standard that is suitable for a human rights leading country will be a significant test for Canada in the near future. The effectiveness of the new Ombudsperson will depend in part on the rest of the government's sincerity to take seriously its recommendations, considering the global health and human rights implications on the line. Finally, as new reports continue to reveal the extent of Canada's colonial legacy, the country would do well to fulfill its promises as outlined in the Truth and Reconciliation Commission to sincerely address these inequalities as soon as possible.

If Canada is to capitalize on its unique position and deepen its global health leadership, it must leverage its strengths and confront the demons in its international affairs. To fully capitalize on this opportunity, Canada must build on the various sectors of its government, its strong NGOs, and its world-leading research institutions to have a coordinated approach to global health—one that can reckon with the complex forces that comprise today's global health landscape. Such coordination could start with the Government of Canada creating an interdepartmental steering committee, convening a scientific advisory committee on global health, and/or appointing a global health ambassador to oversee the successful realization of Canada's global health aspirations.

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