4

Palliative Interventions: Canadian Foreign Policy, Security and Global Health Governance

Colleen O'Manique

Introduction

Thirty years ago, 134 representatives of member states of the World Health Organization (WHO) gathered in Alma Ata in the former Soviet Union, and drafted and unanimously adopted the Alma Ata Declaration, 'Health for All by the Year 2000.' The much publicized declaration called for 'the attainment by all citizens of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life', and the cornerstone of achieving health for all, the implementation of a broad-based primary health care vision. What happened next? Certainly some gains in some places were made. But, in the 3 decades that followed, the governance of global health shifted away from the state and World Health Organization (WHO); first toward the World Bank (WB), whose 1993 report *Investing in Health* signalled its growing interest in global health policy. Over the years a much broader network of state and non-state actors – civil society organizations and the G7/G8 – have taken on a more important role in the governance of global health. As neoliberal policies of structural adjustment eroded public health care systems, the discourse of Primary Health Care was replaced with that of economics (cost recovery, willingness to pay, technical efficiencies, opportunity costs); single-disease, vertical interventions became more fashionable, and the understanding of health as a basic right gave way to health as a commodity provided by the market, poor health increasingly disengaged from its social and political roots.

Through these decades, Canada emerged as a significant actor in global health governance, active through both bilateral and multilateral channels, and as part and parcel of the G7/G8. Viewed historically as a nation that 'does the right thing', Canada provided leadership in 2001 to set up the Global Fund for HIV/AIDS, Tuberculosis and Malaria; was a major instigator of the WHO's '3 by 5 Initiative' to provide antiretroviral treatment to

S. J. MacLean et al. (eds.), *Health for Some*

3 million people with HIV/AIDS; and in 2005 passed a bill to make less expensive generic drugs available to developing and least developed countries. Canada's International Policy Strategy of 2005 identified health as a programming priority in Canada's development cooperation programme, consistent with Canada's recent history of health-related development assistance. But a closer examination challenges Canada's reputation as a leader in global health governance. This paper argues that Canada has deviated little from promoting a global health research and policy agenda that focuses on the global health priorities of the G8, while Canada's overarching foreign policy agenda can be shown to undermine the health and security of communities outside Canada's borders.

The HIV/AIDS pandemic, a resurgence of infectious diseases, bioterrorist threats, tainted food scandals, and mounting controversies over trade-related intellectual property rights and access to medicines have put public health more firmly on the foreign policy agenda (Fidler and Drager, 2006, p. 687). Canada claims to be a leader in promoting a foreign policy that has human security as one of its pillars, human security being a broad concept that places the individual at the centre of security, understood as 'freedom from want and freedom from fear', and shifting the focus away from state-centric notions. Rosalind Irwin argues that, in Canada and elsewhere, much of the human security agenda is incommensurable with national security agendas which reflect the unequal Westphalian divisions of political sovereignty and global structural inequalities in power and wealth (Irwin, 2001). It is in this context that Canada's role in global health can be seen as a complicated mix of national 'self-interest' (defined broadly within the parameters of neoliberalism) and 'doing the right thing'; its role consistent with the country's self-image as a middle-power state and its rhetorical commitment to human security and human rights. This chapter begins to examine some of the contradictions between Canadian foreign policy goals and Canada's role in global health governance, focusing on Canada's official development assistance (ODA) in health (including Canada's role in responding to the HIV/AIDS pandemic) and the Canadian government response to the new 'global threats' of SARS and avian influenza.

Canadian foreign policy: a snapshot

Mainstream accounts circulating in policy circles give an uncritical view of Canada as a 'moral leader' on the international stage, our foreign policy fostering the conditions for human security abroad while ensuring the security of Canadians at home. Canada's post-war foreign policy has been shaped, at least in part, by an ambiguous and shifting concept of human security. Prior to the Second World War, Canadian foreign policy (CFP) closely mirrored Britain's, but Canada's post-war engagement with the creation of international institutions cemented its reputation (at least in the eyes of

the Canadian public) as an enlightened and able middle power. In the post-war years CFP has been conditioned by Canada's proximity to the United States and the country's heavy dependence on foreign investment, Laura MacDonald (1997, p. 175) and others arguing that its history has been, to a large extent, the story of successive attempts to manage economic integration with the United States while maintaining some degree of independence. The deliberate strategy of strengthening Canada's middle-power status was a means of establishing a degree of autonomy from the superpower next door; it was not radical, and, while criticisms of US foreign policy existed, they tended to be muted. The emergence of Canada as an able middle power may well have been shaped by the vision and ideals of its political leaders and a Canadian public who were forming a national identity as 'the world's helpful fixer', a vision of their country more perceived than real, in Chapnick's (2005, p. 152) view. The active attainment of middle-power leadership was also strategy of preventing Canada's legacy as a British colony from falling into its destiny as an American one.

In Canada, the notion that state security rests with broader peace and prosperity outside its borders is not new, its antecedents going back to 1944 and Mackenzie King. In his words, 'Security from war is indeed essential, but real security requires international action and organization in many other fields – in social welfare, in trade, in technical progress, in transportation, and in economic development' (ibid., p. 84). But it was Lester Pearson who has been largely credited with solidifying Canada's image as a state that promotes human security on the world stage. Pearson's reputation as an international peace broker and peacekeeper emerged from his instrumental role in the formation of the UN, tenure as President of the UN General Assembly, and his Nobel Peace Prize in 1957 for his proposal to create a peacekeeping force during the 1956 Suez Crisis. Political leaders have since linked human security to national security as a principle of Canadian foreign policy. Former Prime Minister Pierre Trudeau stated in a 1969 speech that 'It is in our national interest to reduce the tensions in the world, tensions which spring from the two-thirds of the world's population who are poor whereas the other third is rich and the tensions which spring from this great ideological struggle between the East and the West.' Lloyd Axworthy's time as Minister of Foreign Affairs (beginning in 1996), under Jean Chretien's tenure as Prime Minister, marks Canada's central roles in the campaign to ban anti-personnel landmines, the creation of the International Criminal Court and Canada's chairship of the Kimberly Process in 2004. Axworthy was also instrumental in drafting the blueprint for the 'Responsibility to Protect' and in the establishment of the International Commission on Intervention and State Sovereignty (ISCC). He was an active campaigner against the use of child soldiers and the international trade in light weapons.

During the decade of the 1990s the concept of human security became more popular in the discourses of global development, promoted by civil

society organizations, policy and research institutes and western governments alike. Strong civil society organizations in Canada have been instrumental in pushing the human security agenda, a logical extension of 'Canadian values' that are said to be reflected, for example, in Canada's universal health care system and welfare state policies of redistribution. With regard to ODA, Cranford Pratt (2001) has argued that an important determinant between 1966 and 1975 was the government's increased responsiveness to poverty at home, this responsiveness a result of the strong and active campaigning of human rights, social justice and church groups. But he adds that the government's central preoccupation with advancing Canadian international economic and political interests has historically diluted the humanitarian focus on Canadian aid, reversing an earlier trend that suggested increasing government responsiveness to human values (ibid., p. 73). Other critical commentators view Canada's high-profile activities on the international stage as 'quick wins' that have served to increase Canada's status and prestige both at home and abroad. David Black (2006, p. 55) characterizes the discourse of human security as palliative and system-maintaining; although Canada's iteration of human security encompassed both 'freedom from fear' and 'freedom from want', which were encapsulated in the UNDP's discourse-shifting global report of 1994, by 1999 the Department of Foreign Affairs and International Trade (DFAIT) had dropped 'freedom from want' in favour of a narrower 'freedom from fear' approach. In the same year, Canada adopted 'projecting Canada's values and culture' as one of the three pillars of its foreign policy platform, the other two being ensuring global security and the security of Canadians, and promoting the prosperity of Canadians and global prosperity. Kyle Grayson (2004, p. 54) makes the argument that the discourse of human security has provided Canada with 'brand recognition'; that the issues that Canadians have focused on – anti-personnel landmines, child soldiers, small arms transfers – are not divisive, require no sacrifice, and are shared by people across the political spectrum: '... while the Canadian human security agenda has been able to brand itself as transformative, the ways in which it has conceptualized contemporary security issues has done far too little to address the underlying global, political, social and economic inequalities that make these possible.'

But, as Canada's foreign policy has distanced itself from 'freedom from want', little has changed in the discourse of enlightened internationalism. Canada's most recent International Policy Statement (IPS), under the title 'A Role of Pride and Influence in the World,' released in April 2005 as the government's first integrated international policy framework, lays out the 'vision' and 'action plan' in four areas (diplomacy, development, defence, and commerce) to guide the activities of DFAIT, the Canadian International Development Agency (CIDA) and the Department of National Defence (DND). Canadian civil society groups have responded to the contradictions contained in the documents. Far from an 'integrated' approach, it is only

within the development document that human security is mentioned at all: 'The obligation to address poverty is seen as subsidiary and instrumental to the pursuit of Canada's particular interests in promoting its own prosperity, reducing threats to global terrorism, and responding to regional insecurity,' states the Canadian Council on International Cooperation (CCIC). With the election of the Conservatives and Stephen Harper as Prime Minister in January 2006, the IPS guides only the parts of CFP consistent with a stronger relationship and harmonization of foreign policy with that of the United States. Under Harper, any pretence of embedding human security in CFP has been further eroded by an agenda that shifts the focus to antiterrorism and support for Canadian business interests overseas. Agencies involved in border control, antiterror and security have received budget increases while Canada's military role in Afghanistan has become the government's flagship foreign policy issue, eating up a significant proportion of Canada's ODA. Between 2001 and 2004, about 28 per cent of total new aid resources was targeted at Iraq and Afghanistan, with Afghanistan in 2007 the single largest recipient of bilateral aid.

The geopolitical and domestic context of CFP began to shift long before the Harper government took power, however. On the domestic front, change began around the early 1990s, with successive provincial and federal governments overhauling welfare states and promoting economic and political restructuring along neoliberal lines. While acknowledging its achievements, Canada's human security agenda has directed little attention to the political and economic forces that undermine human security; it has essentially been 'system maintaining', in Black's words, viewed in isolation from national security agendas, and the changing global distribution of wealth, resources, and life chances. It is in this context that health has recently become securitized, defined as a threat to global order. Global health has been mentioned explicitly as an issue in Canadian foreign policy in the 2002 Romanow Commission Report on the Future of Health Care in Canada. The Report states that health promotion in other countries has been an afterthought in Canadian foreign policy, but that now 'we have an opportunity to ensure that access to health care is not only part of our own domestic policy but also a prime objective of our foreign policy as well' (Romanow, 2002, p. 240) and that Canada should use its leadership role in the world to help improve health and health care around the world. Tony Clement, Canada's Federal Minister of Health, had these words for the meeting of the World Health Assembly on 14 May 2007:

> When it comes to global health, more and more we talk in terms of health security. And in Canada's view, our strongest asset is shared knowledge, cooperation our smartest strategy ... Whether it comes to continuing our work internationally to safeguard our societies from a pandemic; contribute to the drive for developing desperately needed vaccines; or sharing

> our success in developing new policy to protect our people and environment, Canada will always stand as a ready, willing and compassionate partner, as we work together, toward a healthier and more secure world for all. (Canada's Statement to the World Health Assembly, 2007)

Global health and Canada's ODA

Many Canadians remain committed to a strong national public health care system, and to the legacy of Canada in the world (whether perceived or real) as an enlightened middle power committed to social justice. ODA is the normative arm of foreign policy, a mechanism for revealing 'Canadian' values and the underlying humanitarianism of CFP, yet the Canadian government is explicit in its articulation of the links between Canada's ODA and 'security' and prosperity at home. The stated mandate of the Canadian International Development Agency is 'To support sustainable development in developing countries in order to reduce poverty and contribute to a more secure, equitable, and prosperous world; to support democratic development and economic liberalization in the countries of Central and Eastern Europe and central Asia; and to support international efforts to reduce threats to international and Canadian security' (CIDA, 2006). And the benefits to Canadians? 'The aid program plays an important role in Canada's global reach and influence; provides a concrete expression of values Canadians cherish, such as humanitarianism, democracy and human rights; provides security, control of population movements and immigration, as well as protection from global diseases; builds long-term relationships with some of the fastest-growing economies in the world; and helps make the world more secure for Canadians' (ibid.).

David Morrison's (1998) comprehensive review of Canadian development assistance captures the contradictory mix of humanitarian, commercial and political goals that have been pursued by foreign aid. Canada extended international cooperation to all parts of the developing world under the leadership of Maurice Strong in 1966–70, and since that time aid has ebbed and flowed, with the 1980s budget crisis marking the beginning of cutbacks and downsizing to CIDA. Geopolitical and economic context has always shaped the aid regime in Canada and elsewhere, but in contradictory ways. State preferences and policy orientations have not been fixed. The turn toward neoliberalism translated into a greater emphasis on private sector development and a drop in Canada's aid budget; at the same time donor programmes and projects have responded to the various crises induced by austerity measures, adding a 'human face' to adjustment in the 1980s, and today ensuring that even the most marginalized can share in the 'benefits of globalization'. Morrison rejects the deterministic flavour of accounts of development assistance that view it as always deferring to corporate hegemony, demonstrating instead that officials within CIDA and Canada's strong

voluntary and NGO sectors have pushed hard to promote poverty alleviation and sustainable development. Beginning in the 1980s, the discourses of poverty reduction, women and development, environment and human rights became prominent in CIDA and they have continued to shape interventions, to greater or lesser extents. Bill C-293, which was passed in the House of Commons in 2007, established that Canada's ODA must contribute to poverty reduction, take into account the perspectives of the poor, and be consistent with international human rights standards. It is too soon to tell what kinds of changes might emerge from the bill, but the January 2007 Senate Report on CIDA fixes Canada's aid reform securely within the parameters of market liberalism.

Klaudia Dmitrienko and Anne-Emannuelle Birn's (2006) account of the recent history of Canadian development assistance in the health sector in Latin America reflects some of the contradictions and inconsistencies between the 'national interest' and 'human security'. They argue that the role of Canadian aid has been multifold; to forge an independent foreign policy without challenging traditional US hegemony, to develop cordial relations, and to support the general goals and values of the Canadian government. Canada initially distanced itself from Latin America, not wanting to challenge US intervention and hegemony in the region. Involvement in Latin American health was 'more symbolic then substantive'; health aid consisting mostly of the provision of medical equipment and public health training which grew steadily from the mid-1950s and through the 1960s. It was not until 1971 that Canada became a member of the Pan American Health Organization (PAHO), only after attacks on Canada's reputation as a generous nation, and its late decision to join was ultimately based upon whether Canada would benefit from the $500,000 a year membership. Pierre Trudeau's 1968 foreign policy review called for the strengthening of ties to Latin America, leading to an increase in technical assistance in a variety of sectors: rural water and sanitation, nursing and dental health education, health worker training, development of food and drug standards, and emergency preparedness (Dmitrienko and Birn, 2006, pp. 12–18). For Dmitrienko and Birn (2006, p. 12), given Canada's limited economic and military clout, health aid has been a diplomatic tool in the context of bilateral relations, giving the country a voice in the region. 'Providing health and development assistance [was] a means of engendering international prestige and goodwill as well as securing national interests' (ibid.).

Canada was also able to distance itself from American foreign policy in the region by providing aid to Cuba and to Nicaragua. But, in 1980, Canada declined to support Nicaragua for a seat on the PAHO executive, citing that a possible 'shift to the left' in PAHO could have negative effects on policies in the region (ibid., p. 16). Though Canada's approach to Cuba was radically different from that of the United States, John Kirk and Peter McKenna (1997, p. 4) argue that this was because both Canada

and Cuba 'were disconcertingly vulnerable to the twitches of the U.S.', and had a common vested interest in devising strategies to strengthen the sovereignty of each country *vis-à-vis* Washington. Trade dominated bilateral ties and the main reason to pursue bilateral relations was, and has been, to respond to Canadian business interests (ibid., p. 159). During the Trudeau years Canadian aid was granted, but all CIDA programmes were halted in May 1977 with the exception of a few essential medical and scientific programmes administered by the International Development Research Centre, a Canadian crown corporation at arm's length from the government (ibid., p. 112). The official face-saving rationale was that 'CIDA was putting greater emphasis on poorer countries,' when in fact the cuts were in opposition to Cuba's military support to Angola and to guerrilla training for the war against Rhodesia's white minority; relations also cooled as a result of Cuba's support for the Sandinista government and for the FMLN in El Salvador. In 1993, when 'the storm of the century', compounded by the abrupt end of the Cuba-Soviet relationship and sharp downturn in the economy, resulted in a massive humanitarian crisis, a $250,000 proposal by CIDA for medicines and hospital supplies was rejected by the Secretary of State for External Affairs. The decision to provide the (rather paltry) basket of assistance was eventually made after persistent lobbying from Canadian NGOs and church groups and led, in 1994, to an opening of a variety of CIDA avenues in NGO division, industrial cooperation division, and bilateral support.

Today, health tops the list of Canada's most recent stated priorities for ODA, with the focus on prevention and control of high-burden, communicable, poverty-linked diseases, especially HIV/AIDS, improving infant, child and maternal health, improving water and sanitation, and strengthening health systems (CIDA, 2006). The four other priorities are basic education, governance, private sector development, and tsunami relief and construction, while gender and the environment are considered 'cross-cutting' issues. The 2005–06 budget breakdown put disbursements to multilateral development institutions at the top of CIDA's health spending; $450.3 million (43.6 per cent of CIDA's Multilateral Program aid disbursements) was spent on health. Health spending constituted 16.1 per cent of the Partnership branch's $41.2 million budget, which was disbursed through 750 Canadian civil society and private sector organizations overseas. Bilateral aid stood at $218.1 million, with almost half of that – $98.3 million – targeted to African countries, and 20.1 per cent going to health.

Compared with Latin America, Canada's role in global health in Africa has generated a higher public profile, in large part owing to the severity of the HIV/AIDS pandemic in SSA. HIV/AIDS has dominated donor assistance in Africa over the last decade (ibid.). In 1987 CIDA began funding HIV/AIDS programmes, disbursing over $135 million to HIV prevention, education and care between 1987 and 1999, aid largely concentrated in sub-Saharan Africa with some activities in the Caribbean, and through multilateral channels

such as the World Health Organization Global Programme on AIDS (WHO/GPA) and UNAIDS. The initial Canadian response was heavily tilted toward support for biomedical and behavioural programmes, consistent with the global response to AIDS emerging from WHO and then UNAIDS. But soon enough it embraced all the hallmarks of the global multisectoral approach of the 1990s: of gender-sensitive training, 'local ownership', 'mitigating local impacts' and a variety of other AIDS initiatives tied to a 'community base'. The Southern African AIDS Training Program, implemented by the Canadian Public Health Association, was first funded for $13 million by CIDA in 1990, with subsequent disbursements of $24.3 million, and then, in 2002, $31.5 million for 5 years. The programme was viewed as successful and a model to emulate. HIV/AIDS moved deeper into the Canadian spotlight with the appointment of Stephen Lewis in 2001 as the UN Envoy for AIDS in Africa, and with civil society pressure to ramp up aid, especially to SSA. Canada's aid was a drop in the bucket given the severity of the pandemic.

Health aid from Canada to countries in Africa deviates little from the list of global priorities set out at G8 meetings and multilateral forums. The Millennium Development Goals (MDGs) were adopted in 2000 at the UN Millennium Summit, and have become the central benchmarks around which the global donor agenda is to revolve until 2015. As host of the G8 Summit in Kananaskis, the Canadian government gave itself credit for getting the G8 to embrace the New Partnership for Africa's Development (NEPAD) and the G8 Action Plan in 2002, a policy framework to place Africa on a path of sustainable development emerging from 15 African heads of state and supported by G8 leaders. Aspects of NEPAD have been praised, particularly those relating to conflict resolution and the alleviation of poverty. But it has come under criticism from African civil society organizations for a lack of democratic consultation in its formulation, as well as for fixing its vision uncritically on increased global integration and unregulated markets (Saul, 2004, p. 4). The MDGs have faced similar criticism. Of the eight goals, three are related directly to health: to reduce infant mortality by two-thirds and maternal mortality by three-fourths, and to stop the spread of pandemic disease (AIDS, malaria and tuberculosis); while four other goals address health's social determinants: to reduce extreme poverty by half, achieve universal primary education, promote gender equality and empower women, and promote environmental sustainability. The eighth goal is to 'develop a global partnership for development, the first principle of which declares the development of "an open trading and financial system that is rule-based, predictable and non-discriminatory, includes a commitment to good governance, development and poverty reduction – nationally and internationally"' (UN MDGs). The MDGs do represent a break from the Washington Consensus, an acknowledgement that human needs cannot be guaranteed through growth alone; that 'public goods' and 'social empowerment' are critical to development and poverty alleviation.

But the partnership becomes synonymous with liberal economics and the externally imposed 'good governance' agenda consistent with the range of development declarations of the new millennium (such as the Monterey Consensus for the financing of Development, and the Paris Declaration), all which reaffirm commitments to trade liberalization, and are unquestioning of the macroeconomic policies that and have been unresponsive to human needs.

A number of high-profile funding mechanisms have emerged to support NEPAD and the MDGs. At the national level, Canada established the $500 million Canada Fund for Africa to support NEPAD; 22 per cent of which is allocated to health, another 28 per cent for agriculture, environment and water, 15 per cent for peace and security, and ICTs 7 per cent (CIDA, Canada Fund). Health initiatives supported by the Canada Fund include $50 million for AIDS vaccine research and development, $50 million for polio eradication through immunization, $12 million for HIV prevention and care targeted at youth, and 1.5 million for childhood development through sport in refugee camps. Since 2000, Canada has committed more than $800 million to global HIV/AIDS, but most of this is through high-profile Global Public–Private Partnerships, consisting of multilaterals such as UNICEF, IFIs, foundations such as Bill and Melinda Gates, the pharmaceutical industry, and public health institutions. Canada has disbursed $550 million to the Global Fund to Fight AIDS Tuberculosis and Malaria (60 per cent of which goes to HIV/AIDS); $100 million to the WHO '3 by 5 initiative' (a programme to provide three million HIV-positive people with ARVs by 2005, which ultimately missed its target), of which Canada was the first and largest donor; and 67.4 million to the UNPF, including over $58 million to sexual and reproductive health and HIV/AIDS among women and girls. $100 million was earmarked for 'gender based responses to HIV/AIDS' and $15 million for the International Partnership for Microbicides. Canada also supports the Global Polio Eradication Initiative (GPEI), and has been among the top five donors since its formation in 1988, providing a total of $152 million. The Global Alliance for Vaccines and Immunization (GAVI) has received $200 million between 2001and 2005 from the Canadian government.

In many countries the government is not capable of managing the scale-up of AIDS treatment due to lack of health care infrastructure, limited financial resources and human capacity, and evidence suggests that high levels of aid have compromised the quality of local governance. The Global Fund, created to finance 'a drastic turn around in the fight against AIDS, tuberculosis and malaria', has disbursed $8.4 billion in 136 countries since its inception. It is a financing instrument that works through 'country coordinating mechanisms' to ensure 'local ownership' and 'participatory decision-making'. Public and private sector organizations can serve as principal recipients of grants (Global Fund website). Like other PPPs, it has been criticized for its narrow focus on treatment and specific

technical interventions, and in some instances for undermining the conditions needed for a sound public health system, and for deflecting attention away from the social determinants of health. Often it is the case that grants from large global funds exceed national health budgets, and the uncoordinated nature of the aid regime creates problems of competition between health personnel working in the beleaguered public system and the aid regime. Governing institutions are challenged by the task of coordinating the complex web of development projects, oftentimes competing, at other times complementary.

While the Canadian government has supported multilateral initiatives to scale up treatment in Africa (to much public fanfare in 2004, changes were introduced to the *Patent Act* and the *Food and Drugs Act* to allow developing countries to obtain more affordable drugs from Canadian generic manufacturers), another arm of its foreign policy has involved the recruitment of health personnel from countries in the global South. Even the WB admits to the desperate shortage of doctors, health care workers and researchers, and the chronic lack of basic health services. The entry of private sector recruitment agencies and the growth of targeted bilateral recruitment schemes have accelerated the pace of specialized labour migration, many from countries at the bottom of the UN scale who show the lowest ratios of per capita health workers and have the most critical health worker shortages. Canada has been a destination country for health professionals who offset the domestic shortage of health workers in Canada. Historically Canada has recruited and received a large number of health workers from the global South, trained at the expense of their governments (Blouin, 2007b).

Supportive donors and effective policies no doubt play a role in improving public health, and this discussion is not meant to paint all Canadian aid with one brushstroke. There is an obvious need for the delivery of health services, including essential medicines. The point is that aid for global health has ambiguous and mixed results, and is palliative to the extent that it fails to address the structural drivers of poor health, and in some cases serves to undermine the governance structures that are needed to improve it. When we turn to Canada's role in pandemic preparedness, national security goals are more explicit, and the disjuncture between human security and national security goals becomes more obvious.

Pandemic preparedness

Canada's recent experience of SARS removed any notion that Canadians were somehow immune to the effects of pandemic disease. When the virus landed in the city of Toronto in 2003, the cracks in Canada's public health system were exposed. The economic impact of SARS in Toronto was tiny compared with that in the Asia Pacific Region, estimated at $40 billion. In Canada, 438 people became infected and 43 died, costing the local

economy almost half a billion dollars, and the health care system about CAN$793 million (Osterholm, 2005, p. 28). Given that the Ontario health care system had difficulty coping, it is hard to imagine anything less than a global disaster if a more virulent pathogen was not immediately stopped in its tracks. Global pandemic preparedness has been part and parcel of the merging of security agendas with global health; a potential global pandemic viewed by commentators on both sides of the political spectrum as a potential destabilizing force. Avian influenza has been under the spotlight as the next coming pandemic, and its potential mutation is being closely watched.

Canada's experience of SARS, and its negative impact on the economy, led to the Canadian state's deeper mobilization around pandemic preparedness. On the international front, Canada has contributed $1 million to support the United Nations System Influenza Coordination; over $15 million over 5 years to the WHO, Food and Agriculture Organization (FAO) and the Office International des Épizooties (OIE) (or World Organization for Animal Health) to support collaborative work on avian and human influenza pandemic preparedness; and over $18 million to projects in SE Asia and China to improve surveillance and outbreak investigation, strengthen laboratory systems, and develop capacity for risk communications and public education. It has also contributed, through PAHO, resources to support the development of national influenza pandemic preparedness plans. Canada's overall contribution totalled $105.5 million as of July 2006 (DFAIT, 2008). Canada is also home to the Global Public Health Intelligence Network (GPHIN), an internet-based early warning system that tracks significant public health outbreaks and disseminates information globally, in seven languages. The GPHIN is managed by the Public Health Agency of Canada's Centre for Emergency Preparedness and Response, which was created in 2002 as the country's central coordinating point for public health security. States the website: 'It tracks topics such as disease outbreaks, infectious diseases, contaminated food and water, bio-terrorism and exposure to chemical and radio-nuclear agents, and natural disasters. It also monitors issues related to the safety of products, drugs and medical devices' (Public Health Agency of Canada).

Tracking is of critical importance. But who would be the beneficiaries? Neil Ferguson postulates that a virus similar to the one that caused the 1918 pandemic would likely cause a death toll of 62 million, but only four per cent of those deaths would be in the industrialized world (Ferguson, 2006, pp. 2187–8). At this point, access to vaccines, antiviral and other drugs for the most vulnerable groups does not exist, and biological and social co-factors (malaria, HIV infection, malnutrition and compromised immunity) would render certain people more susceptible to contracting the virus. Living conditions in the burgeoning slum areas, overcrowding, and lack of basic hygiene would also augment viral spread. Even if a global

stockpile of antivirals were created, it is not clear today how and under what conditions it would be deployed (WHO Media Centre). And, though new global health regulations oblige countries to report suspicious clusters of novel diseases, a real disincentive to poor country reporting is the devastating socio-economic effects of quarantine that might follow. Little evidence exists to suggest that the first affected countries would be assisted by the international community. The Canadian government has placed far more emphasis on the North American pandemic plan, through the new Security and Prosperity Partnership (SPP) between Mexico, the US and Canada, which is evolving in a less than transparent manner. The website assures us that 'The SPP provides the framework to ensure that North America is the safest and best place to live and do business. It includes ambitious security and prosperity programs to keep our borders closed to terrorism yet open to trade.' The North American approach to pandemic preparedness is to prevent or slow the spread of a strain to North America, sustain infrastructure, and mitigate impact on the North American economy. North America will not be alone in developing a bunker mentality if and when a new pandemic emerges. The new discourses of interdependence and 'mutual vulnerability' that have accompanied threats of SARS and avian influenza have yet to lead to any significant shifts in global health policy. While they have become a more central feature of the foreign policy of nation states, chronic, persistent poor health, malnutrition, access to health's social determinants, and the fragile state of public health systems are not high up on the global public health agenda. And the health impacts of the current governance of the global political economy are not even on the radar screen.

Some concluding thoughts

Canadians may be committed to human security abroad, but are also interested in the maintenance of their own prosperity and standard of living, and their competitive position in the global economy. They are also, in the post 9/11 era, concerned about their personal security and 'threats out there'; the preoccupation with the 'war on terror' nurturing a climate and economy of fear and deflecting attention from the forces that shape human insecurity at home and abroad. A question, then, is to what extent Canada's 'good deeds' are cancelled out by Canada's role in the governance of global trade, investment, environment, and military policy. It is not within the scope of this paper to answer this question, apart from raising a few issues that require further exploration. But my point is that foreign policy in the health arena does not operate separately from other domains of foreign policy, and this is where the analysis becomes more complex.

A common incantation is that nothing can be done about the structural drivers of global health disparities; that the critique remains polemical while lives are being saved though development assistance and access

to life-saving medicines, despite the shortcomings of the current regime governing global health. But strategic and well-selected demands on the Canadian government, the G8 and multilateral institutions can be made. If Canada is serious about global health, then it can reverse its policy on asbestos; it continues its opposition to adding asbestos to the Rotterdam Convention, which restricts trade in toxic substances. Canada is one of the world's leading exporters of asbestos, a clear carcinogen that is banned in Canada, with more than 90 per cent of these exports going to the global South. While the European Union and Australia support the addition of asbestos to The Rotterdam Convention, Canada 'continues to lobby hard against such a move, anxious to protect a lucrative niche selling a highly toxic carcinogen to the world's poor' (McQuaig, 2007, p. 233). It can support Kyoto and rethink Tar Sands development; it can play a leadership role in developing global standards and mandatory codes of conduct on occupational health. It can channel its development assistance toward strengthening public health care systems, and increase its aid budget. It can provide genuine assistance to countries that have little or no pandemic preparedness.

That being said, it is also important to illuminate the pathways between the current governance of global health and other policies that impact health and to ask the question: governance for whom? The unquestioned growth trajectory that is destroying ecosystems and economies on which human life depends is increasingly being challenged. Mark Duffield (2005, p. 155) describes the current order as '… a fragile biopolitical equilibrium that enables a small part of the world's population to live through consuming beyond its means while a larger part is allowed to die chasing the mirage of self-reliance.' Development assistance, for the most part, manages, rather than seeks to remove 'this life-chance lottery' (ibid.). When one measures Canada's performance on the global health stage in this context, its reputation as global champion of human security seems ambiguous at best.

But we may eventually reach the point at which we can insulate ourselves no longer.