



# NEW REALITIES FOR GLOBAL HEALTH

Britain and Canada working together

Photo Credit: WHO/Christopher Black

Graham Lister

2013 Canada - UK Colloquium  
Rapporteur's Report

# New Realities for Global Health 2013

## Rapporteur's Report

*Graham Lister*

*Canada-UK Colloquium, 21–23 November 2013*

*Cumberland Lodge*

*Great Park, Windsor UK*

School of Policy Studies, Queen's University

Canada-UK Council



## The Canada-UK Colloquia

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The Canada-UK Colloquia are annual events that aim to promote the advantages of a close and dynamic relationship between Canada and the United Kingdom through the advancement of education in a wider context. These conferences bring together British and Canadian parliamentarians, public officials, academics, business people, journalists and broadcasters, other private sector representatives, graduate students, and others. The organizers focus on issues of immediate relevance and concern to both countries with the aim of exchanging experience and enhancing policy outcomes. One of the main endeavours of the Colloquia is to address these issues through engaging British and Canadian experts in the exchange of knowledge, experience and ideas and the dissemination of their conclusions in a published report. Previous reports can be found at <http://www.queensu.ca/canuk/>.

The first colloquium was held at Cumberland Lodge in Windsor Great Park in 1971 to examine the bilateral relationship. A British steering committee, later to become the Canada-UK Council, was launched in 1986. The School of Policy Studies at Queen's University assumed responsibility for the Canadian side in 1996, succeeding the Institute for Research on Public Policy.

The Colloquia are supported by the Department of Foreign Affairs, Trade and Development Canada and by the Foreign & Commonwealth Office in the United Kingdom, as well as by private sector sponsors. They are organized by the School of Policy Studies at Queen's University, on the Canadian side, and in Britain by the Canada-UK Council, from which an executive board, the Council of Management, is elected annually.



## About the Author

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Graham Lister MSc PhD is an economist and sociologist, visiting professor in health and social care at London South Bank University and senior fellow of the Graduate Institute, Geneva. As partner in an international consulting firm Coopers and Lybrand (now PwC) he established their health consulting practice, working in: the UK, Europe, Africa and South East Asia. In 1999, working with John Wyn Owen he coordinated the Nuffield Trust programme “Global Health: a Local Issue”, this formed the cross sector UK Partnership for Global Health and later prompted the development of the “Health is Global” strategy, for which he wrote some early drafts. He also wrote a health component of UK development policy document “Making Globalisation work for the Poor” and helped organise and acted as rapporteur for the first international colloquium on Health and Foreign Policy in 2004. He supported the development of Global Health Europe and wrote an influential paper with Ilona Kickbusch on European global health policy. He has worked with the WHO and EU on leadership, management and reform in Geneva, Brussels, Beijing and Moscow and as an advisor on the future role of WHO Euro. He is currently tutoring a programme of 10 week online courses he helped the Graduate Institute develop for WHO Heads of Country Offices on Global Health Diplomacy, this is an aspect of the reform of working practices and relationships for WHO. The course book “*Global Health Diplomacy*”, which he edited, brings together contributions from 33 thought leaders and practitioners in this field. He also provides resources for health leadership training through his web site <http://www.buildingleadership-for-health.org/>.



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## Preface

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This Rapporteur's Report summarizes the discussions at the Canada-United Kingdom Colloquium on "New Realities for Global Health : Britain and Canada working together," held at Cumberland Lodge, Great Windsor Park, Berkshire, in November 2013.

The Colloquium is only possible because of the assistance of the Department of Foreign Affairs, Trade and Development Canada (DFATD) and the UK Foreign & Commonwealth Office (FCO). The ambitious program for this year's event also depended on support from Wellcome Trust, Thomson Reuters and PwC. We are deeply appreciative of the help these organizations offered. We are also grateful for the support offered the Colloquium by the prime ministers of Britain and Canada, whose letters of support are reproduced in this Report, together with the Colloquium's response to the two leaders requesting support for three priority actions.

We would also like to offer our sincere thanks to those who were responsible for organizing this year's Colloquium. On the UK side, John Wyn Owen provided remarkable leadership in setting out the broad mandate for the discussion of global health. On the Canadian side, Alan Bernstein offered his invaluable knowledge of the global health community. We are also very appreciative of the counsel provided by Anthony Cary as Honorary President of the UK committee and Mel Cappe as chair of the Canadian committee. We were again the beneficiary of the exceptional logistical support of Maureen Bartram

of the Centre for International and Defence Policy at Queen's. The UK team was as always ably coordinated by George Edmonds-Brown.

We would like to thank Professor Graham Lister, the Colloquium's Rapporteur, for capturing so well the presentations of our speakers and the exchanges among the Colloquium's participants. Finally, a warm word of appreciation to the chair of the Colloquium: John Wyn Owen was not only the intellectual guiding light for this year's colloquium; he also guided discussion over the two days of meetings with assurance and sensitivity.

In the Executive Summary to the Report you will find a set of recommendations and suggestions (Actions We Call For) encapsulating the conclusions that emerged from the Colloquium. We would urge that these thoughts and suggestions be actively considered by policy-makers in both countries.

Kim Richard Nossal, School of Policy Studies, Queen's University

Philip J Peacock, Chairman, Canada-UK Council



PRIME MINISTER - PREMIER MINISTRE

NOV 12 2013

In September 2011, Prime Minister Cameron and I endorsed the Canada-UK Joint Declaration, dedicated to establishing “A Stronger Partnership for the 21<sup>st</sup> Century”. This Joint Declaration is emblematic of the deep and important relationship between our two countries, which has continued to evolve at all levels.

The Canada-UK Colloquium contributes meaningfully to this relationship. Held annually since 1971, it unites in one forum representatives of academia, the public and private sectors, governments, and other institutions, gathered to examine issues central to the concerns of our countries. This year’s theme of “New Realities for Global Health” is of particular relevance to Canada’s leadership of the Muskoka Initiative in support of maternal, newborn and child health.

The Colloquium is unique as a vehicle for bilateral dialogue and collaboration, and for contributing to the development of shared objectives and common public policies.

I am pleased to offer my support to the 2013 Canada-UK Colloquium, and wish all participants a successful event.

Yours sincerely,



10 DOWNING STREET  
LONDON SW1A 2AA

THE PRIME MINISTER

In September 2011 Stephen Harper, the Prime Minister of Canada, and I issued a Joint Declaration dedicated to “A Stronger Partnership for the 21st Century”. We celebrated the bond between our countries forged in peace and war and we committed ourselves to renew and deepen that bond.

One valued contributor to the relationship is the Canada-UK Council whose annual policy colloquia have been held alternately in each country since 1971 with the support of both Governments. These meetings and their follow-ups devoted to questions of shared concern and priority, contribute to the development of public policy in both countries and identify new ways in which the UK and Canada can further their joint objectives.

This year the meeting which will be in the UK from 21-23 November will focus on how Britain and Canada can best work together to address New Realities for Global Health.

The subject is highly topical. The complex field of global health poses economic, development and foreign policy challenges. I am myself chairing a UN Commission looking at successors to the Millennium Development Goals, many of which involve global health; so I am well aware of the many opportunities for Britain and Canada jointly to make a real impact on the global quality of life. I wish the colloquium every success in realising those opportunities.

*David Cameron*

November 2013

# The Canada-UK Colloquium: New Realities for Global Health



3 December 2013

Dear Prime Minister,

The Canada - UK Council thanks you for your support for our policy colloquium, addressing global health as a major focus for economic development and foreign policy. It is a vital interest for both our countries, reflected in collaboration by our governments and NGOs.

We discussed many issues from global health protection and anti-microbial resistance, the need to continue to support action for neglected tropical diseases and the importance of developing global governance for health, which will be elaborated in the Executive Summary and Report to be published in the New Year. However, we wish to ask for your support for three priority actions:

1. Investment to build on Canada and Britain's successful cooperation for health and wellbeing of mothers, newborn and children, to protect young girls from sexual violence and forced marriage.
2. Partnerships with civil society and the private sector for action on non-communicable chronic diseases such as mental illness, obesity, alcohol and smoking related conditions.
3. Research cooperation between our countries and with partner countries to develop the science of implementing whole society health engagement and health solutions.

In all of the fields we discussed, these health issues must be addressed in our own countries as well as in low and middle income settings. We need to focus on proven, results based developments while also seeking innovative solutions by listening and learning from partners throughout the world applying the successful Grand Challenges approach. We noted "everyone has something to learn and everyone has something to teach".

As has been noted, the Sustainable Development Goals, remind us of the magnitude of the threats to our quality of life in all countries. It will be essential for all countries and peoples to work together, as the UK and Canada will continue to do, encouraged and informed by this Windsor meeting, to build common values at national, multinational and non-governmental levels and better governance for health, wellbeing and sustainable development. We hope that particular attention can be paid to the three action points noted above.

Yours faithfully

# Executive Summary

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## THE LESSONS WE SHARED

Canada and the UK share a long history of successful co-operation for global health. We have working together with other members of the Commonwealth family, with the WHO and other international agencies and partnerships in many different programmes towards the Millennium Development Goals (MDGs). As we approach the renegotiation of international commitments for the 2015 Sustainable Development Goals (SDGs) it is essential to reaffirm our commitment and build on this legacy.

Global health refers to the health of everyone as a human right, with an emphasis on equity within and between countries. Health is a foreign policy and security priority for the UK and Canada, not only because of concerns about the human security risk to our countries but because health is a major driver of economic and social development and a vital component of work in fragile and post-conflict states and cities. Support for women's health and rights are particularly vital to build trust and understanding between peoples and enhance capacity for economic and social development. Cross government strategies, for global health, as in the UK, can help to ensure the coherence and effectiveness of future actions.

Rapid changes in disease patterns due to ageing and environmental determinants including access to water and the affordability of food are a major challenge to sustainability. In future most people in severe poverty (often caused by and a cause of poor health) will live in Middle-Income Countries (MICs), as well as Lower-Income Countries (LICs). These countries face a double burden of continuing infectious diseases and rapidly rising prevalence of Non-Communicable Diseases (NCDs). While global health is influenced by all the proposed SDGs,

there may be only one explicit “Universal Health Coverage” goal. This may mean that the focus of global attention could shift from health to other fields. In these circumstances it is more than ever essential to complete and build on the agenda set by the MDGs.

Global health action programmes include: the G8 Muskoka Initiative, for Maternal, Newborn and Child Health, led by Canada, the Joint Programme for the Control of Neglected Tropical Diseases, supported by Canada and the UK, working with private sector drug donations and civil society groups to distribute them, the Commonwealth initiative to strengthen global health protection; and the International Consortium for Urban Environmental Health and Sustainability. These show the opportunities to build on successful, results-based practice.

Grand Challenges Canada is already working with the UK through the Department for International Development (DfID), on the Saving Lives at Birth Grand Challenge, which has demonstrated how the creative energies of many partners can be harnessed through scientific innovation and knowledge generation by encouraging entrepreneurship and public enthusiasm. Innovation is needed not only in treatments and equipment but also for health systems design, leadership and management. We noted the strengths of UK and Canadian systems but also the potential to redesign whole society systems from the patient’s perspective. This requires the engagement of non-governmental organisations (NGOs) and civil society organisations (CSOs) as well as business interests and all of government.

Governance of health at national and global levels faces a new reality of a world in which many different partners need to work together across national and sector boundaries. Health diplomacy is the basis for working together towards shared values not only exporting best practices but also learning from those parts of the world challenged most by poverty.

## THE ACTIONS WE CALL FOR

We recalled the pivotal role played by the UK Foreign & Commonwealth Office (FCO) in developing the UK’s Global Health Strategy of 2008, with the Department of Health and the Department for



International Development and—in view of the importance of health not only to human security and development policy, but foreign policy as a whole—urge that Departments play an equally active role in coordinating the successor strategy for 2015, linked to the MDG successor strategy. We also note the longstanding commitment shown by the Canadian government to global health and the contribution made by Canadian institutions in this field. We therefore also urge Canada's Department for Foreign Affairs, Trade and Development (DFATD) to support continued collaboration for global health. The actions we propose encompass:

1. Investment to build on Canada and Britain's successful cooperation for the health and wellbeing of mothers, newborn and children, including the Grand Challenges initiatives in this field, specifically:
  - a. Reconfirmation and continued funding of the initiatives.
  - b. Extension of the programme:
    - i. to protect young girls from sexual violence and forced/child marriage.
    - ii. to focus on the development of the whole child in the first 1000 days, to ensure optimal brain development.
  - c. Extension of learning networks to share experiences in UK, Canada, the Commonwealth and other countries that are addressing these issues.
  
2. Partnerships with civil society and the private sector for action on non-communicable chronic diseases such as mental illness, and the diseases associated with tobacco use, harmful use of alcohol, unhealthy diet and physical inactivity:
  - a. A global funding programme following the G8 London Summit on Dementia.
  - b. Development of learning networks to share experience of cost effective ways of addressing the behavioural causes of NCDs e.g. obesity, alcohol, smoking.

- c. A Grand Challenges programme to support innovative partnerships between public sector, civil society groups and the private sector on these issues.
  
3. Research cooperation between our countries and with partner countries to develop the science of implementing whole society health engagement and health solutions.
  - a. Establishment of a global learning network to share ideas in this field.
  - b. Support for leadership development for community health systems.
  - c. A Grand Challenges programme to support social innovation for health.
  
4. Measures to strengthen global governance for health:
  - a. UK /Canada learning networks for global health diplomacy.
  - b. Support for global health diplomacy networks for Commonwealth partners.
  - c. Development of similar networks in relation to other SDG fields.
  
5. Renewal and extension of global health protection collaboration programmes.
  - a. Participation with other Commonwealth Countries in the International Consortium for Urban Health and Sustainability.
  - b. Canada/UK partnership for training and career development for public health laboratory staff.
  - c. A Grand Challenge programme to encourage innovative ways of improving the capture of basic birth and death data.

6. Renewal of support for the Neglected Tropical Diseases (NTDs) programme, which supplies drugs donated by pharmaceutical firms through CSOs and the Queen Elizabeth Diamond Jubilee Trust work against trachoma:
  - a. Financial support to close the funding gap, for the delivery of NTD drugs.
  - b. Greater recognition and support for companies providing free drugs and the CSOs that deliver them.
  - c. Support for the ongoing Dengue Fever vaccines and treatment research programmes and collaboration in Trachoma research.

We, the members of the 2013 Canada-UK Colloquium, will continue to play our part in encouraging others, the stakeholders in Britain and Canada and the global community, to work together towards public support for and implementation of the actions we have outlined in this Summary.

Graham Lister,

Rapporteur of the 2013 Canada-UK Colloquium:

New Realities for Global Health

# New Realities for Global Health 2013

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*Graham Lister*

The 2013 Canada-UK Colloquium brought together 50 leading experts in global health and foreign policy, from our two countries and participants from Africa, India and East Asia (see List of Participants). Our meeting in London and at Cumberland Lodge in Windsor Great Park provided the opportunity to reflect on the new realities of global health and foreign policy, share lessons and identify policy action to build on UK-Canadian successful collaborations in global health and our common interests and concerns. This report summarises the ideas we shared in preparing for the meeting and in presentations to the meeting, the main themes that emerged from our discussion and the priority actions we identified.

## PREPARATION AND BRIEFING

The Colloquium received letters of support from David Cameron the UK Prime Minister and Stephen Harper the Prime Minister of Canada. Both letters refer to the Joint Declaration dedicated to “A Stronger Partnership for the 21<sup>st</sup> Century” signed in September 2011, to be renewed in February 2014.<sup>1</sup> This encouraged us to seek new ways of

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1 UK Foreign & Commonwealth Office and Department of Foreign Affairs, Trade and Development Canada, “A Stronger Partnership for the 21st Century. Available at <http://blogs.fco.gov.uk/nicolearbour/2011/09/23/canada-uk-joint-declaration-a-stronger-partnership-for-the-21st-century/>.

building on the successful partnerships between our countries in global health, as the 2015 Sustainable Development Goals (SDGs), introduce new challenges alongside those set by the Millennium Development Goals (MDGs).

A background note (Annex 1) reflected on the new realities of global health and foreign policy and the changing context of global health, which were discussed in a briefing session attended by UK delegates. The main points that emerged were: that Canada and the UK government recognise global health as a foreign policy objective, both to protect health in our own countries and to aid others. The new realities for global health mean that we must address Non-Communicable Disease (NCDs) as well as infectious disease in both our own countries and globally. Many more partner countries, agencies and groups must engage in this task. This means that we need to move beyond a “Health in All Policies” approach to an “All in Global Health” approach, rethinking health systems at national and global levels and assisting others in this task. International collaboration for action to address global risks such as Anti-Microbial Resistance and new and re-emergent diseases will be essential.

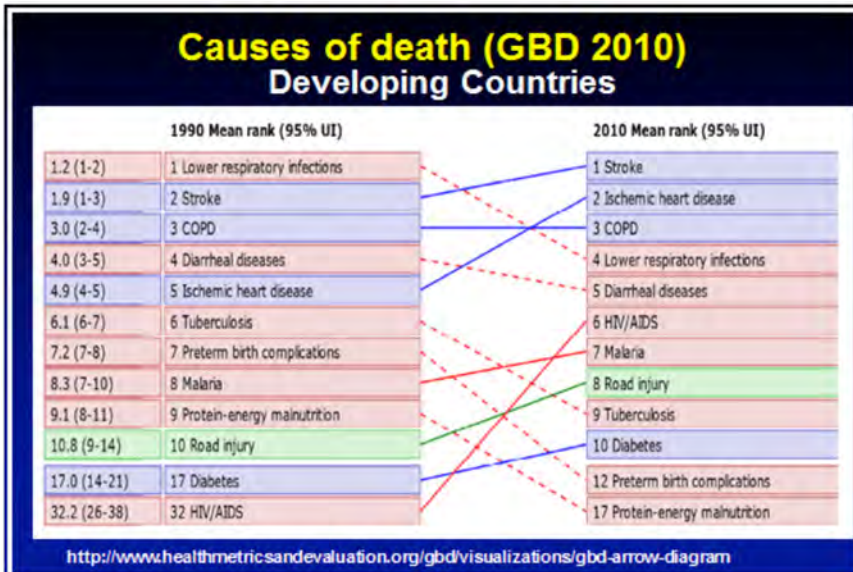
The briefing for the Canadian delegates at the House of Commons, by the British Canadian All-Party Parliamentary Group, introduced speakers from the three major UK Parties. The discussion emphasised that in the UK, as in Canada, the national health system is regarded as an iconic symbol of our values at home and abroad. The ageing of populations, demands that we take a whole person view of our care needs, and indeed a whole society approach to meeting needs.

At the offices of PricewaterhouseCoopers (PwC), we were provided with an introduction to health as a key component of the economy of our countries and indeed the world. In introducing the PwC report “NHS@75: Towards a Healthy State,”<sup>2</sup> we were further encouraged to

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2 PricewaterhouseCoopers, “NHS@75: Towards a Healthy State,” 2013. Available at: <http://www.pwc.co.uk/government-public-sector/health-care/nhs75/nhs75-towards-a-healthy-state.jhtml>.

think about those factors that enable whole society engagement with health and wellbeing, as essential requirements for affordable, high quality health and care in the UK and in other countries.



Dr Alex Ezeh and Professor Reddy provided insights from Kenya, India and their perspectives on global health. They noted that the major trials faced in Low and Middle Income Countries (LICs and MICs) were: first the growing inequity in access to healthcare and inequality in health outcomes, second the rapid growth in Non-Communicable Diseases (NCDs), such as: mental illness, heart disease, diabetes and lung cancer, while also faced with the burden of infectious diseases and the health issues associated with poverty and poor communications. It was noted that NCDs are growing faster in LICs and MICs than in the UK or Canada, they account for over 65% of deaths worldwide. The third issue faced was the need to develop the skills, confidence and leadership to take country ownership of their health systems and policies.

While the MDGs, which provided a focus for action on global health and recognition of the importance of health as a component of “soft power,” have increased health aid, it is important to stress that the Goals have not yet been met in many countries. Continued investment is required to address the threat of HIV/AIDS, TB and Malaria, to

improve maternal and infant mortality and child health and to address the threat of further zoonotic, drug resistant and vector borne diseases.

Vertical, disease focused, health and doctor centred health systems offered by many aid agencies must be matched by horizontal , cross government and society systems to meet the needs of people whose health may be undermined by poor nutrition, poverty and inadequate water supply and housing and no opportunity for access to hospital based doctors. This calls for what can be described as a “diagonal” approach to health systems design, combining access to healthcare with cross society action on the determinants of health.

This approach is required at both national and global levels. In the twentieth century all nations shared their vulnerability to global health concerns, in the twenty-first century we must also act on shared values for global health recognising that “Universal



is local without walls.” MICs and LICs must find their voice in the international arena, to help redesign global health governance, to develop common policies and investment for health, including measures to develop and share: knowledge, technologies and financing. They must also participate in arenas such as the World Trade Organization, the International Labour Organization and the UN to develop global governance for health to address the trans-national determinants of health, such as trade, migration and communications.

We were given insights into how community, national and international action for global health can be mobilised by the inspiring presentations from young social entrepreneurs from Medsin (Medical Students International).<sup>3</sup> They showed us how they were achieving their goal of making “global health a local issue” They demonstrated how

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3 Medsin: Global Health: Local Issue. See <http://medsin.org/>.

they support and undertake education, advocacy and action on a wide range of global health issues. Specific case studies included action to hold mining companies to account for the healthcare of South African miners with TB/HIV,<sup>4</sup> sexual health and rights for young people,<sup>5</sup> and young people's action for a healthy planet.<sup>6</sup>

A reception at Fort Belvedere hosted by Mr and Mrs Galen Weston brought the Canadian and UK delegates together and allowed us all to catch up with old friends and new acquaintances.

Over dinner at Cumberland Lodge we were addressed by Lord (Nigel) Crisp who talked about "Turning the World Upside Down."<sup>7</sup> His talk underlined several themes that had emerged during the briefing: that global health is no longer solely an element of development strategies for Low Income Countries, it is about the engagement of all global citizens in their common health goals. It is not true that infectious diseases are solely the concern of LICs and MICs, while NCDs are solely rich country diseases. NCDs are growing faster in LICs/MICs. Nor should we think that health system redesign and the involvement of communities is only for LICs/MICs, while rich countries can meet health and care needs by simply employing more doctors and more technology. We all need to rethink our health and care systems as whole society approaches, engaging and enabling all to take ownership of their health. This involves "turning our world upside down," not only to learn from patients and community organisations but also for

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4 Jonathan Smith, *They Go to Die: A TB/HIV Human Rights Film*. See <http://www.kickstarter.com/projects/theygotodie/they-go-to-die-a-tb-hiv-and-human-rights-film>.

5 See <http://sexpression.org.uk/>.

6 See <https://healthyplanet.org/>.

7 Nigel Crisp, *Turning the World Upside Down: The Search for Global Health in the 21st Century* (2011). See <http://nigelcrisp.com/book.html>.



high income countries to learn from middle and low income partners. Examples which demonstrate this were introduced: from Jamaican community care and treatment for psychotic patients,<sup>8</sup> to patient-led dialysis services in Sweden,<sup>9</sup> mother-to-mother support for mothers-to-be with HIV/AIDS in Southern Africa.<sup>10</sup> Other examples of shared learning include the “Health House” approach developed in Iran and shared with the public health service of the Mississippi Delta.<sup>11</sup> Everyone has something to teach and everyone has something to learn.

## IDEAS SHARED AT THE COLLOQUIUM

In introducing the formal colloquium programme, our Chairman, Professor John Wyn Owen, stressed that global health refers to the health of everyone in our countries and in the world community. He recalled the long history of successful cooperation between our countries in this field. Canada and the UK have been working together with other members of the Commonwealth family, with the World Health Organization (WHO) and other international agencies and partnerships in many different programmes. As we approach the fundamental renegotiation of international commitments for a set of post 2015 development goals, including the 2015 Sustainable Development

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8 Claire Hilton, “Psychiatry in Jamaica,” *Psychiatric Bulletin* 20 (1996):437-439. Available at: <http://pb.rcpsych.org/content/20/7/437.full.pdf>.

9 Agneta Pagels, Marie Wang, and Yvonne Wengstrom, “The Impact of a Nurse-led Clinic on Self-care Ability, Disease-specific Knowledge, and Home Dialysis Modality,” *Nephrology Nursing Journal* 35:3 (2008): 242–48. Available at: <http://hdl.handle.net/1893/1075>.

10 Mothers2Mothers. See <http://www.m2m.org/>.

11 Ann Puderbaugh, “Iran’s Health Houses Provide Model for Mississippi Delta,” *Global Health Matters Newsletter* 8:6 (November/December 2009). Available at: [http://www.fic.nih.gov/NEWS/GLOBALHEALTHMATTERS/Pages/1209\\_health-house.aspx](http://www.fic.nih.gov/NEWS/GLOBALHEALTHMATTERS/Pages/1209_health-house.aspx).

Goals (SDGs), it is more than ever essential to reaffirm our commitments and build on our history of success, noting “the future has no place to come from but the past.”

### **Global Health Foreign and Security Policy**

Morris Rosenberg provided a Canadian perspective on the links between health and foreign policy and Kate Smith provided a UK perspective, Professor David Heymann acted as discussant. They agreed that health is a foreign policy and security priority for the UK and Canada, not only because of concerns about the human security risk to our countries but because health is a major driver of economic and social development. Health equity and in particular women’s health and education are important in developing stable communities. Lack of health services can be both a symptom and a cause of unstable states and cities that can provide havens for terrorism and illegality. Access to health services, particularly for women is a vital component of work in fragile and post conflict states and cities as “a golden thread of development.”

Foreign policy for health has shown a shift from North-South bilateral cooperation to place greater emphasis on mutual, multilateral, network relationships supported by soft law agreements, depending on common norms and standards rather than hard law commitments. The Canadian-led G8 Muskoka, Maternal, Newborn and Child Health Initiative<sup>12</sup> follows this trend in encouraging country ownership of programmes, South-South cooperation and shared learning between partners. The initiative focusses on development of in country skills and capacity rather than external technical support. This in turn requires national governance structures and leadership coupled with the

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12 Foreign Affairs, Trade and Development Canada, “Maternal, Newborn and Child Health.” Available at <http://www.acdi-cida.gc.ca/acdi-cida/ACDI-CIDA.nsf/eng/FRA-127113657-MH7>.

ability to hold agencies and governments to account for progress and use of resources.

Canada has a long-standing commitment to global health and Canada’s international development program allocates a high proportion of its financing to these issues, but it has not followed other countries in developing a cross cutting national strategy. While closer coordination would be desirable, it is not clear whether a government strategy would achieve this. There may, however, be lessons to be shared from the UK consultative process to produce and apply the “Health is Global” strategy. It was noted that in global health, “Canada is a leader, but could do more if coordinated.”



The UK is playing a leading role in defining the post 2015 development framework, but this does not diminish commitment to the MDGs or support for the Muskoka Initiative. The strategy and UK emphasis on preventable deaths also guides work with the World Health Organization (WHO), Global Fund (GF) and multiple Global Public Private Partnerships for Health (PPP) helping to address specific diseases, strengthen national health systems and harnessing non state

agencies and groups to address the health needs of the poor as both the UK and Canada health equity is a major goal.

Health diplomacy promotes the ethical and moral standards that underlie global health, raising international awareness of the need for action and framing global health policy issues in terms of equity and human rights. While national health security is also a concern that might generate greater investment, it is important to establish a balanced approach to global health as a common challenge for all sectors and as an issue of principle. At community level, health diplomacy must focus on increasing health literacy, to empower people to take action to protect their personal health and the health of their community. A national strategy for global health can bring together the many different elements required to address global health across government and society.

Health diplomacy was also discussed as an aspect of science diplomacy, in which the UK and Canada are seen as world leading. Indeed the Canada-UK joint declaration, “A Stronger Partnership for the 21st Century,” called for “the use of existing initiatives and mechanisms to foster collaboration, facilitating the translation of our advanced knowledge into life-changing therapies that will benefit our patients, healthcare institutions and industries.” Initiatives to encourage further research and development have included: the G8 Science Ministers’ Statement on global challenges issued after the Lough Erne Conference in June 2013 focussed on antimicrobial resistance,<sup>13</sup> the G8 Health Minister’s London meeting on dementia in December 2013,<sup>14</sup> and the WHO Global action plan for the prevention and control of NCDs

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13 G8 Science Ministers Statement, 13 June 2013. Available at: <https://www.gov.uk/government/news/g8-science-ministers-statement>.

14 G8 Health Ministers’ Statement, 12 December 2013. Available at <http://dementiachallenge.dh.gov.uk/2013/12/12/g8-dementia-summit-agreements/>.

2013-2020, agreed at the World Health Assembly 2013,<sup>15</sup> as well as contributions to research on Neglected Tropical Diseases, discussed at greater length below.

The importance of health diplomacy to foreign affairs led the Colloquium to ask the Department of Foreign Affairs, Trade and Development Canada (DFATD) and the UK Foreign & Commonwealth Office (FCO) to consider providing ongoing briefing on health issues and to foster closer ties between our diplomatic services and those health experts, who might now be called health diplomats.

### **Rapid Global Health Transitions**

Professor Sir Andy Haines and Professor Prabhat Jha led our discussion on this topic with the Hon Dr Keith Martin's support as discussant. Andy Haines identified the key changes in global health conditions as:

- Population increase and shifts from rural to urban living, resulting in continuing growth in urban slum dwelling (828 million people in 2010) with resulting poor diet and low activity.
- Increasing inequality, leaving the poorest 20% behind in access to food, services and health.
- These factors coupled with the globalisation of marketing (e.g. for cigarettes and alcohol) are leading to a rapid growth in NCDs, particularly for low income groups in MICs and LICs.
- Continuing disruption of our climate and environmental systems, threatening the safe living conditions of us all and in particular the cereal foods and water supplies of the poorest.<sup>16</sup>

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15 World Health Organization "Global Action Plan for the Prevention and Control of NCDs 2013-2020," 13 November 2013. Available at: <http://www.who.int/nmh/en/>.

16 Johan Rockström, Will Steffen, Kevin Noone, Åsa Persson, F. Stuart Chapin, Eric F. Lambin, Timothy M. Lenton, Marten Scheffer, Carl Folke, Hans Joachim Schellnhuber, Björn Nykvist, Cynthia A. de

- Universal Healthcare Coverage is essential to address health needs, as shown by the Brazilian Family Health Programme,<sup>17</sup> but we must also address the underlying causes, including through policies that reduce greenhouse gas emissions and improve health.

Many policies to reduce greenhouse gas emissions can also improve health, examples of the health co-benefits of “low carbon” policies include reduced air pollution as a result of reducing coal combustion or improved efficiency cooking stoves in poor countries, reductions in health outcomes resulting from sedentary lifestyles as a result of increased active travel (walking and cycling).

Prabhat Jha reminded us of the vast improvement in mortality achieved in the twentieth century by the development of medical technology, which had produced many low cost solutions to early death. But while the cost of treatment for many childhood diseases has reduced, the cost of treatment for adult NCDs has greatly increased. This should spur us to continue to fund the knowledge generation required to find and apply cost effective ways of addressing adult mortality in the 21<sup>st</sup> century. Three specific low cost/high impact applications of science were identified:

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Wit, Terry Hughes, Sander van der Leeuw, Henning Rodhe, Sverker Sörlin, Peter K. Snyder, Robert Costanza, Uno Svedin, Malin Falkenmark, Louise Karlberg, Robert W. Corell, Victoria J. Fabry, James Hansen, Brian Walker, Diana Liverman, Katherine Richardson, Paul Crutzen and Jonathan A. Foley, “A Safe Operating Space for Humanity,” *Nature* 461 (24 September 2009): 472–75 (doi:10.1038/461472a). Available at: <http://www.nature.com/nature/journal/v461/n7263/full/461472a.html>.

17 “Flawed but Fair: Brazil’s Health System Reaches Out to the Poor,” *Bulletin of the World Health Organization* 86:4 (April 2008). Available at: <http://www.who.int/bulletin/volumes/86/4/08-030408/en/index.html>.

- Recording and analysis of causes of adult deaths, as in the Indian Million Death Study<sup>18</sup>;
- Generic risk pills for vascular disease, as proposed by Sir Richard Peto<sup>19</sup>;
- Action to control tobacco use, for example increasing excise duties, as suggested by Jha and Peto.<sup>20</sup>

Investment to support these measures with the target of achieving: 100 countries with large populations with reliable representative data on causes of death, 100 million current smokers quit smoking, 100 million existing vascular disease patients on low-cost polypills, could

**Three “hundreds”  
by 2025**

- 1. 100 countries/large populations with reliable representative data on causes of death**
- 2. 100 million current smokers quit smoking**
- 3. 100 million existing vascular disease patients on low-cost generic risk pills**

halve global premature mortality by 2025. This can be called the “Three 100s” strategy.

The cost of achieving Universal Healthcare Coverage and the “Three 100s” strategy would be more than offset by the economic

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18 Centre For Global Health Research, St. Michael’s Hospital and University of Toronto, “Million Death Study,” 2013. Available at: <http://www.cghr.org/index.php/projects/million-death-study-project/>.

19 Eva Lonn, Jackie Bosch, Koon K. Teo, Prem Pais, Denis Xavier, Salim Yusuf, “The Polypill in the Prevention of Cardiovascular Disease,” *Circulation*, *The American Heart Association* 2010; 122: 2078-2088. Available at: <http://circ.ahajournals.org/content/122/20/2078.full>.

20 Prabhat Jha and Richard Peto, “Global Effects of Smoking, of Quitting, and of Taxing Tobacco,” *New England Journal of Medicine* 370 (January 2014): 60–68.

advantages of improved labour productivity and decreased long term health costs and increases in tax incomes (from tobacco, alcohol, sugar, etc.). Moreover, the cost of action to address the underlying causes of unsustainable disruption to our climate and environmental systems may be justified by the economic and social benefits of health improvement.

Our discussion underlined the fact that the cost of treating NCDs could be financially unsustainable for the Canadian and UK health and care systems and even more so for the health systems of LICs and MICs. It is therefore urgent to build and share knowledge of cost effective ways of preventing further increase in NCDs. This can build on existing areas of collaboration such as the Global Alliance for Chronic Disease,<sup>21</sup> and the Movement for Global Mental Health.<sup>22</sup> We should also work with the many professional groups that share knowledge between Commonwealth member countries, following the Commonwealth leaders' statement on NCDs of 2009.<sup>23</sup>

In exploring technical solutions we focussed on the need to develop the science of delivering health through whole society systems. This will include “public diplomacy” measures to support, government, community and individual action for behaviour change (also called social marketing<sup>24</sup>) as well as polypills and technology to support self-care. It was suggested that the Grand Challenges Canada approach could be a useful vehicle, since this provides a way of learning from local experience, rather than emphasising high-income country solutions that

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21 Global Alliance for Chronic Disease, 2013. Available at: <http://www.ga-cd.org/about.php>.

22 Movement for Global Mental Health, 2012. Available at: <http://www.globalmentalhealth.org/about>.

23 On the Commonwealth commitment to making NCDs a priority, see [http://secretariat.thecommonwealth.org/Internal/190698/190851/190859/non\\_communicable\\_diseases\\_\\_ncds/](http://secretariat.thecommonwealth.org/Internal/190698/190851/190859/non_communicable_diseases__ncds/).

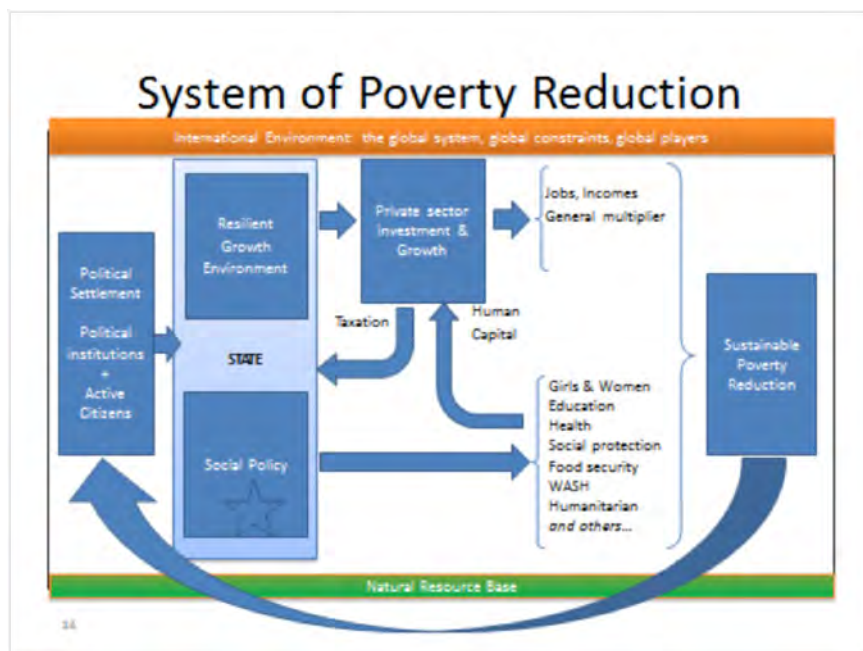
24 Graham Lister, *Value for Money Tools | Smoking, Obesity, Alcohol, Breast Feeding, Bowel Cancer*, National Social Marketing Centre, 2012. Available at: <http://www.thensmc.com/resources/vfm>



may be inappropriate and it is essential to ensure that whole society approaches are owned by governments and communities.

## Supporting Global Health Initiatives

Dr Neil Squires and Dr Stanley Zlotkin led our discussion of global health initiatives, with Ms Margaret Biggs as our discussant. We shared projections that showed that over the next twenty years two-thirds of those living in poverty will live in the middle-income countries of Asia, though there will also be many poor people living on less than \$2 per day living in low-income countries in Africa and elsewhere. Some of the countries in which extreme poverty arises may be both aid recipients and aid donors.



Policies aimed at helping the poorest must refocus on building the capacity of both MICs and LICs through poverty reduction strategies.<sup>25</sup> Developing public health systems, as part of a programme of public service and governance development, will be a contribution to both to poverty reduction and to sustainable economic growth. There are also distinctive strategic goals for global health as a global public good (as set out for the UK in *Health is Global*). While global health is influenced by all the 12 SDGs under discussion, there may be only one explicit “Universal Health Coverage” goal. This may mean that the focus of global attention and aid could shift from health to other fields.

In these circumstances it is more than ever essential to complete and build on the agenda set by the MDGs. Global health action programmes include the G8 Muskoka Initiative. Measures suggested to build on the success of this programme include: strengthening the health and social systems that support the delivery of maternal and child health, reducing the causes of poor maternal and child health by improving the education and health knowledge of girls and improving nutrition and childcare in the first 1000 days of life. Later detailed discussion also focussed on the protection of girls from sexual violence, (including abuse, female genital mutilation and child and forced marriage) and measures to promote healthy brain development of young children. It was also noted that programmes such as this were important in garnering public support for overseas development aid.

While this session focussed on the Muskoka Initiative, there are many other global programmes in which Canada and the UK participate. It was noted that the lessons from this field equally apply to other initiatives, that:

- Country ownership of programmes is essential, for sustainable partnership.
- A whole society approach is required, and the impact on the poorest must be considered.

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25 The World Bank, “Poverty,” 2013. Available at: <http://www.world-bank.org/en/topic/poverty>.

- Leadership and management of systems are essential but sometimes missing components.
- Evaluation should be a component of every programme including sustainability.
- Innovation in systems delivery is as important as innovation in medicines and products.

## **Strengthening Health Systems**

Professor Sir Tom Hughes-Hallet provided an insight into his work in promoting the redesign of health and care services in Essex and Professor Carolyn Hughes Tuohy examined the strengths of the Canadian and UK health systems that might provide lessons for global health partners. These introductions provided different perspectives on system development, one a radical reimagining of health and care from the user's perspective in the UK, the other taking a more conventional view of the systems as they are found in each country. Professor Rifat Atun was our discussant.

An examination of health and care services in Essex started by asking people what health and care they wanted and who should provide it. This led to the thought that best health and care involves minimum direction from providers and maximum empowerment of the user. This could be achieved by a “reverse contract” in which citizens take responsibility for their health and care, choosing from a menu of services available to them with the support of a form of “health trip advisor” to help them navigate the system. Service providers could include the support of family friends and community volunteers as well as more formal elements. Communities would be empowered both to provide care and support and to commission the services they need.

This would develop an entirely different service to that provided by current NHS and social care providers. Instead of services telling the public what they need, users would ask for the service they choose. An exemplar of this is pain relief and end-of-life care; the NHS currently

applies pathways that result in most people dying in hospitals, whereas most would choose the cheaper alternative of dying at home.

The current model of health and care in the UK and Canada is coming under financial stress, the costs of providing what professionals consider patients need without the service users taking responsibility for and choosing health and care service options or lifestyle choices is proving unaffordable. If this message is relevant to our healthcare systems it is even more relevant to MIC/LIC health systems with expenditure per capita between 1/10th and 1/20th of the funds available to the UK and Canada, and where out of pocket expenditure constitutes 70% of total health spending. The best known example of rethinking health and care from the citizen's perspective is the Ethiopian *Woreda* (community) health system, which puts local women at the heart of health and care planning and provision, as championed by Tedros Ghebreyesus, the Minister of Health of Ethiopia.<sup>26</sup>

Carolyn Hughes Tuohy discussed the similarities and differences between UK and Canadian healthcare systems. Both national systems provide universal care and are regarded as iconic symbols of national values. They both use primary care general practitioners as gatekeepers to specialist care and are supported by specialist regional and national services. Both systems fund their public programs through taxation. The Canadian system is funded at a higher level than the NHS, spending 30% more per capita in total; out-of-pocket and private spending are lower in the UK than in Canada, 17% vs 29%. The systems performance shows that while Canadians generally have better health and life expectancy, UK patients get faster and better health services in primary care, though specialist care in Canada is at a high international standard. An evaluation of seven high-performing health systems by the Commonwealth Fund based on 2007-2009 data suggested that

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26 Kelly Ramundo, "The Female 'Army' Leading Ethiopia's Health Revolution," USAID Frontlines Child Survival & Ethiopia Edition (May/June 2012). Available at: <http://www.usaid.gov/news-information/frontlines/child-survival-ethiopia-edition/female-army-leading-ethiopias-health-revolution>.

the NHS would rank second and the Canadian system sixth, with the Netherlands system ranked highest and the US system lowest.<sup>27</sup>

The performance of both the UK and the Canadian system and the relative cost effectiveness of the UK primary care based system has provided a basis for exporting health and care expertise to countries such as India, where some promising initiatives in providing primary care have been undertaken by UK-based providers. Expertise in life sciences is highly developed in both countries and provides further export opportunities. Realising these opportunities requires a better integration of export networks currently focussed on trade and aid with expertise in the domestic health care systems.

Taking the two perspectives together one may conclude that a combination of building on strengths but also reimagining whole society health systems from the user and country perspective can provide a valuable contribution to global health.

### **Institutional Structures and Non State Actors**

Dr Peter Singer and Professor Graham Lister (standing in for Professor Colin McInnes who was unable to join us) introduced the session and Professor Obijiofor Aginam as our discussant provided an insight into the development of mega diplomacy.

Peter Singer spoke about global governance for innovation, describing how Grand Challenges Canada had contributed to this process by developing global networks to develop and share innovative ideas and practices. He provided examples of how knowledge and innovation had been supported and ideas put into practice in the delivery of

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27 Commonwealth Fund, "U.S. Ranks Last Among Seven Countries on Health System Performance Based on Measures of Quality, Efficiency, Access, Equity, and Healthy Lives," News Release, 23 June 2010. Available at: <http://www.commonwealthfund.org/News/News-Releases/2010/Jun/US-Ranks-Last-Among-Seven-Countries.aspx>.

# Commonwealth Fund Ranks UK 2nd, Canada 6th (2007-2009)

Country Rankings
1.00-2.33
2.34-4.66
4.67-7.00



	AUS	CAN	GER	NETH	NZ	UK	US
<b>OVERALL RANKING (2010)</b>	3	6	4	1	5	2	7
Quality Care	4	7	5	2	1	3	6
Effective Care	2	7	6	3	5	1	4
Safe Care	6	5	3	1	4	2	7
Coordinated Care	4	5	7	2	1	3	6
Patient-Centered Care	2	5	3	6	1	7	4
Access	6.5	5	3	1	4	2	6.5
Cost-Related Problem	6	3.5	3.5	2	5	1	7
Timeliness of Care	6	7	2	1	3	4	5
Efficiency	2	6	5	3	4	1	7
Equity	4	5	3	1	6	2	7
Long, Healthy, Productive Lives	1	2	3	4	5	6	7
Health Expenditures/Capita, 2007	\$3,357	\$3,895	\$3,558	\$3,837*	\$2,424	\$2,992	\$7,290

Note: \* Estimate Expenditures shown in \$US ppp (purchasing power parity).

Source: Calculated by The Commonwealth Fund based on 2007 International Health Policy Survey, 2008 International Health Policy Survey of Sicker Adults, 2009 International Health Policy Survey of Primary Care Physicians, Commonwealth Fund Commission on a High Performance Health System National Scorecard, and Organization for Economic Cooperation and Development, OECD Health Data, 2009 (Paris: OECD, Nov. 2009).

health services throughout the world. The model involved seed corn funding to award prizes for innovative ideas which may attract private or public sector investment for development and global deployment. Examples include ChipCare—a point-of-care diagnostics device for HIV, the Odon device—an innovation in assisted vaginal delivery in the case of delayed labour and the Global Health Investment Fund, a \$100 million social impact investment fund. These three examples<sup>28</sup> span concepts of social investment, shared value, blended value and social impact investing—drawing in significant private investments by using public funds to share risk in various ways. This is a model of public private partnership that can achieve very high social returns at low public sector cost.

Graham Lister described how the Global Health Programme of the Graduate Institute Geneva<sup>29</sup> was assisting the WHO, the Global Fund and governments and regional bodies around the world to develop learning networks to

establish a shared understanding of global health diplomacy. This was a response to the changing nature of global governance, demanding greater engagement from all departments of government, international

**“Diplomacy” coined in 1796 by Edmund Burke:**

*“All government, indeed every human benefit and enjoyment, every virtue, and every prudent act, is founded on compromise and barter”.*

**Leadership by diplomacy Nelson Mandela 2000**

*“A leader is like a shepherd who follows his flock allowing the most nimble go out ahead whereupon the others follow not realising that all the time they are being directed from behind”*

**Global health diplomacy: Margaret Chan 2008**

*“When the policies that govern the international production, trade, and distribution of food are driven by greed instead of by human nutrition needs, then we should not be surprised when the system generates a crisis of soaring food prices and a crisis of diet-related chronic diseases”.*

At the 2<sup>nd</sup> High-level Symposium on Global Health Diplomacy

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28 Peter A. Singer and Andrew Taylor, “Crowding in Private Investment for Global Health: Social Angels, Shared Value and Social Impact Investing,” Grand Challenges Canada, 2013. Available at: <http://www.grandchallenges.ca/2013/crowding-in-private-investment-into-global-health-social-angels-shared-value-social-impact-investing/>.

29 Graduate Institute Geneva, Global Health Programme. Available at: <http://graduateinstitute.ch/globalhealth>.

and local non-government organisations and businesses. This is a practical demonstration of the shift from health governance to a whole society approach to global governance for health and its determinants. Both Canada and UK have extensive expertise in this field (see, for example, G. R. Berridge's work on diplomacy,<sup>30</sup> the UK Chatham House programme on global health security,<sup>31</sup> and the Canadian Journal of Health Diplomacy<sup>32</sup>); other relevant resources include the UN University International Institute for Global Health.<sup>33</sup> Canada and the UK could help to develop their own learning networks in this field and could support the development of such networks for Commonwealth and other partner countries. This also provides a model of how shared norms, values and understanding can be built for other global public goods as a basis for global governance.

Obijiofor Aginam described the development of diplomacy, from the strictly state centred approach established by the treaties of the Peace of Westphalia of 1648, to the current situation in which diplomacy (building relationships, establishing norms and agreements) occurs at many different levels—national regional and global. Health diplomacy has also developed from agreements between states to the engagement of many different actors at all levels. These actors include UN and other interstate agencies, funding agencies such as the Global Fund, which themselves engage government and non-government agencies, private philanthropic agencies such as the Bill and Melinda Gates Foundation and a wide range of public- private partnerships. States are still central

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30 G. R. Berridge, "Diplomacy: Theory and Practice," 4th ed. (New York: Palgrave Macmillan, 2010). Available at: <http://grberridge.diplomacy.edu/>.

31 Chatham House Global Health Security Programme. Available at: <http://www.chathamhouse.org/research/global-health>.

32 Available at <http://www.ghd-net.org/journal-health-diplomacy>.

33 UN University International Institute for Global Health, Kuala Lumpur, 2013. Available at: <http://iigh.unu.edu/>.



to the process of global governance for health and they will view global health as one of their interests alongside human security, trade and the projection of soft and hard power. However, the process of diplomacy for health is now a much more complex than simply the negotiation of international agreements between states, it demands the engagement of the whole of global society.

## ACTIONS WE CALL FOR

Our meeting also shared ideas and developed proposals for action through workshop sessions to address specific issues as follows:

- NCDs in middle-income countries, chaired by Dr Nick Banatvala and Dr Catherine Hankins.
- Maternal and child health in low- and middle-income countries, chaired by Professor Joy Lawn and Professor John Frank.
- Health protection—global, chaired by Dr Brian McCloskey and Dr Aleks Leligdowicz.
- Neglected diseases, chaired by Professor Alan Fenwick and Professor David Zakus.

The groups worked overnight to produce recommendations for action, which were then reviewed in plenary discussions. Key recommendations for action are set out below in the order of priority indicated by our discussions.

### **1. Continued support and extension of the G8 Maternal, Newborn and Child Health Initiative**

Our discussions throughout the Colloquium focussed on the success of this initiative, halving the number of maternal and child deaths during the MDG period. The working group noted the Canadian prime minister's commitment to continued leadership of this programme and also noted the report of the Commission on Information and

Accountability for Women's and Children's Health,<sup>34</sup> which, while praising the work of this initiative, called for better measures of performance. The Colloquium therefore called for reconfirmation and continued funding of the initiative from Canada and the UK together with measures to improve accountability for results.

It was also noted that action is required to meet the need for training, development and appropriate career structures for nursing and midwifery leaders in this field. This must enable the initiative to stay the course in addressing newborn deaths (2.9 million), under nutrition risks (approximately 3 million) and the unmet family planning needs of an estimated 200 million women. It was also noted that Grand Challenges Canada is currently working with DfID on the Saving Lives at Birth Grand Challenge with great success.

High priority was given to the extension of the initiative with measures to address outcomes missing from the current programme, these include the protection of the health of adolescent girls from sexual violence including: rape, abuse, child/forced marriage and female genital mutilation. A Grand Challenges programme in this field could be considered. And this might also be a topic considered under the forthcoming Canadian Institute for Advanced Research global conference on "The Health and Wellbeing of the World's Children."

Further proposals were to focus on the development of the whole child in the first 1000 days, to ensure optimal brain development. This has been identified as a set of measures: including improved nutrition and training for mothers, that could show a very high rate of return, in social terms for the development of the child and in economic performance (see Laura Ghali et al.<sup>35</sup>)

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34 Commission on Information and Accountability for Women's and Children's Health 2011. See more at: <http://www.pm.gc.ca/eng/news/2011/01/26/commission-information-and-accountability-womens-and-childrens-health>.

35 Laura Ghali, Margaret Clarke and Chelsea Ritchie, "Making the Most of the Muskoka Initiative," Policy Options (December 2010/January 2011). Available at: <http://www.irpp.org/en/po/the-year-in-review-2/making-the-most-of-the-muskoka-initiative/>.

In support of these developments it was further proposed that existing learning networks should be supported to share experiences in the UK, Canada, the Commonwealth,<sup>36</sup> and other countries. It was observed that these factors affect mothers and children in all countries in different ways. These are issues that are gaining increasing recognition as major abuses of women's rights, and determinants of risks to maternal and child health.

## **2. Action on Non-Communicable Diseases**

Noting the rapid rise in non-communicable diseases in all countries and its potentially devastating impact on the cost of healthcare and impact on economic development the colloquium called for urgent action by Canada and the UK to lead and support global action in this sphere. This will require partnerships with civil society and the private sector to address non-communicable chronic diseases such as mental illness, and the diseases associated with tobacco use, harmful use of alcohol, unhealthy diet and physical inactivity.

A global funding programme following the G8 London Summit on Dementia to increase research into prevention, treatments and care and develop learning networks to share knowledge is proposed. Our conclusions are entirely in line with the subsequent joint statement following the summit.

Development of learning networks to share experience of cost effective ways of addressing the behavioural causes of NCDs, including lack of activity, poor diet, alcohol abuse, smoking. This might build on the many groups working in this field, see for example the World Social Marketing Conference Report, Toronto 2013.<sup>37</sup> This proposal supports

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36 Commonwealth of Learning, Healthy Communities. Available at: <http://www.col.org/progServ/programmes/livelihoods/healthyComm/Pages/default.aspx>.

37 World Social Marketing Conference Report, Toronto 2013. Available at: <http://wsmconference.com/programme>.

the 2013-2020 Global Action Plan for the Prevention and Control of Non-Communicable Diseases<sup>38</sup>; but this development could also be supported by a Grand Challenges programme to support innovative partnerships between public sector, civil society groups and the private sector on these issues. This should also support the proposed targets to assist 100 million current smokers quit smoking, and to enable 100 million existing vascular disease patients to improve their health by low-cost polypills, by 2025.

Learning networks with Commonwealth and other partner countries could help to develop national targets in line with current WHO suggestions for voluntary national targets:

- 25 per cent relative reduction in risk of premature mortality from cardiovascular diseases, cancer, diabetes, or chronic respiratory diseases.
- At least 10 per cent relative reduction in the harmful use of alcohol, as appropriate, within the national context.
- A 10 per cent relative reduction in prevalence of insufficient physical activity.
- A 30 per cent relative reduction in mean population intake of salt/sodium.
- A 30 per cent relative reduction in prevalence of current tobacco use in persons aged 15+ years.
- A 25 per cent relative reduction in the prevalence of raised blood pressure or action to contain the prevalence of raised blood pressure, according to national circumstances.
- Halt the rise in diabetes and obesity.

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38 World Health Organization, Global Action Plan for the Prevention and Control of Noncommunicable Diseases, 2013-2020. Available at: [http://apps.who.int/iris/bitstream/10665/94384/1/9789241506236\\_eng.pdf](http://apps.who.int/iris/bitstream/10665/94384/1/9789241506236_eng.pdf).

- At least 50 per cent of eligible people receive drug therapy and counselling (including glycaemic control) to prevent heart attacks and strokes.
- An 80 per cent availability of affordable basic technologies and essential medicines, including generics, to treat major noncommunicable diseases in both public and private facilities.

### **3. Developing the Science of Whole Society System Design**

A recurrent theme of our colloquium was the need to understand health as a product of a “whole society system.” We shared many examples of sharing learning between countries and of developments that engaged different parts of local and central government, non-governmental organisations, civil society organisations, and individuals in health. Indeed one such approach was demonstrated and the London Dementia Summit to which people with dementia were invited and at which the UK approach of engaging people from all walks of life as dementia friend champions was featured.<sup>39</sup>

We therefore call for research cooperation between our countries and with partner countries to develop the science of implementing whole society health engagement and health solutions. This should provide the basis for establishment of a global learning network to share ideas in this field. We note that at present a number of centres are developing ideas in this field but rather than selecting particular leading institutions we suggest convening a conference to define the field and develop networks. This could be supported by a Grand Challenges programme to support social innovation for health.

We also note that the development of whole society health systems requires community leadership skills if they are to be applied in practice.

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39 Alzheimer’s Society, Dementia Friends, “What Is a Dementia Friends Champion?” 2013. Available at: <http://www.dementiafriends.org.uk/article/about-champions/what-is-a-champion#.UqxOXvhFAdU>.

Institutions in the field of health leadership include McGill University, Montreal and the London School of Hygiene and Tropical Medicine. There are also many small initiatives aimed at spreading ideas about health and community leadership.<sup>40</sup>

These proposals respond to calls by Margaret Chan and Lord Crisp for greater focus on research into whole society systems approaches to health.

#### **4. Measures to strengthen global governance for health:**

The colloquium noted that a whole society approach also applies at regional and global levels, as we develop from global health governance to global governance for health. This demands closer engagement of all branches of government and society in building common norms values and agreements for action on health as a global public good. This need has already been recognised by the WHO and Global Fund and by many Governments and regional bodies which work with the Global Health Programme of the Graduate Institute Geneva to develop learning networks for health specialists and diplomats. It is therefore proposed that the UK and Canada should consider how to develop their own learning networks in global health diplomacy, drawing together national and international expertise in this field and working with the WHO.

Building on this experience, if evaluation demonstrates the value of this first step, UK and Canada could extend learning networks to Commonwealth and other partner countries. Again following evaluation a similar approach may prove beneficial in respect of other global public goods, such as action on climate and environmental disruption.

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40 Graham Lister, *Building Leadership for Health* 2012. Available at: <http://www.building-leadership-for-health.org.uk/>

## **5. Renewal and extension of global health protection collaboration programmes.**

The UK and Canada separately and together participate in a range of collaborations to improve global health security. These include the twinning of laboratories in Commonwealth Countries—the UK, Canada, Australia, and Singapore—to spread knowledge and build up capacity on Antimicrobial Resistance possibly to be announced at the Commonwealth Heads of Government Meeting in 2014 as a contribution to international effort in this sphere.<sup>41</sup> It was also noted that Canada may be asked to join with Public Health England and the Australian National University in the Healthy Polis: International Consortium for Urban Environmental Health and Sustainability.<sup>42</sup> The longstanding G8 Global Health Security Initiative also engages both Canada and the UK.<sup>43</sup> Support for the continuation and development of these links is called for together with further collaboration for the training and career development of public health laboratory staff. Partnership to support the development of public health capability is proposed to enable countries to fulfil their obligations under the International Health Regulations signed in 2005 but not yet fully applied due to capacity problems.

A Grand Challenges programme is proposed to encourage innovative ways of improving the capture of basic mortality and morbidity

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41 World Health Assembly Side Event, “Antibiotic Resistance—A Threat to Global Health Security and the Case for Action,” 21 May 2013. Available at: [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/200505/WHA\\_Written\\_Contributions\\_Report.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/200505/WHA_Written_Contributions_Report.pdf).

42 Healthy-Polis: International Consortium for Urban Environmental Health & Sustainability, An initiative of the Australian National University, Duke Global Health Institute and Public Health England. 2013 Available at: <https://sites.google.com/site/healthypolis/>.

43 G8 Global Health Security Initiative, Ninth Ministerial Meeting of the Global Health Security Initiative, Brussels, 5 December 2008. Available at: <http://www.g8.utoronto.ca/health/brussels2008.html>.

data. Such an approach should also promote ways of improving basic mortality information, in line with the target proposed to support 100 countries with large populations to develop reliable representative data on causes of death.

## **6. Renewal of support for the Neglected Tropical Diseases (NTDs) programme,**

Proposals for partnership action to support drug delivery and research into Neglected Tropical Diseases (NTDs), addresses five key issues raised by the Colloquium. They are highly prevalent diseases affecting one-sixth of the world's population. They are diseases of poverty where market mechanisms fail to deliver solutions but partnership with pharmaceutical companies who donate drugs can provide very cost effective solutions. They engage civil society organisations who deliver the drugs to patients. They require support from countries such as the UK and Canada with advanced life sciences research capability. And they build on existing joint programmes and partnerships such as the Queen Elizabeth Diamond Jubilee Trust work against trachoma, which is supported by Canada and the UK. Details of the funding of research into NTDs can be found on the Policy Cures web site.<sup>44</sup>

The colloquium now calls for: financial support to close the funding gap, for the delivery of NTD drugs, greater recognition and support for companies providing free drugs and the CSOs that deliver them and support for the ongoing dengue fever vaccines and treatment research programmes.

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44 PolicyCures G Finder, "Investing in R&D for Neglected Diseases: A Public Pull-out Puts Lives at Risk," 2013. Available at: <http://policycures.org/g-finder2013.html>.



## REFLECTION

In her keynote address Ms Una O' Brien developed the theme of the need for a society-wide approach to the determinants of disease, to find policy and social responses to the determinants of health as well as technical responses to diseases. She applied this concept at both national and international levels as both an obligation and an economic and human health and security necessity. This represents a shift from global health governance to the ideal of governance for global health.

We experienced this same Copernican shift; at the outset of our Colloquium, we talked of the contribution of health to foreign policy and the ideas we could teach the world based on our technical knowledge. By the end of our meeting we were thinking of how diplomacy could serve global health as a global public good and how we could learn with partners throughout the world the science of whole society approaches to health. We hope our colloquium has contributed to the development and application of the ideal of governance for global health.

We, the Canada-UK Council, will continue to play our part in encouraging others, the stakeholders in Britain and Canada and the global community, to work together towards public support for and implementation of the actions we propose.

# Annex 1

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## Background Note

This year's Colloquium of the Canada-UK Council (CUKC) focuses on how Britain and Canada can best work together to address "New Realities for Global Health," and as is the tradition the meeting and the follow-up will contribute to the development of foreign and health policy in both countries to identify ways in which our countries can further their joint objectives. This note provides a background to our discussions.

In his introduction, the Canadian prime minister, Stephen Harper, reminds us of the Canada-UK Joint Declaration dedicated to establishing "A Stronger Partnership for the 21<sup>st</sup> Century" and the long relationship between our countries in all spheres. The UK prime minister, David Cameron, notes that the subject of global health is "highly topical" and "poses economic, development and foreign policy challenges and I am myself chairing a UN Commission looking at the Sustainable Development Goals<sup>45</sup> as successors to the Millennium Development Goals, many of which involve global health; so I am aware of the many opportunities for Britain and Canada to make a real impact on the global quality of life."

Global health refers to health issues influenced by factors that extend beyond state borders -preparedness for pandemic influenza, emerging infections, climate change, international development and a global healthcare industry with annual expenditure of US\$6.5 trillion.<sup>46</sup> Global health interacts with all core functions of foreign policy:

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45 United Nations Commission on Sustainable Development, Sustainable Development Knowledge Platform, 2013. Available at: <http://sustainabledevelopment.un.org/csd.html>.

46 World Health Organization: Spending on Health a Global Overview.2012 Available at <http://www.who.int/mediacentre/factsheets/fs319/en/index.html>.

achieving national and global security, creating economic wealth, supporting developments in low-income countries and promoting human dignity through the protection of human rights and the delivery of humanitarian assistance.

## **UK and Canada Address Global Health and Foreign Policy**

The UK was one of the first nations to publish a cross-Government strategy for global health which aimed to set out how Government Departments should work together coherently to improve health in the UK and overseas. Internationally, the strategy is regarded as an example of good practice by several countries and institutions, many of whom have used it to drive their own strategies.

The current Coalition Government starting, with the previous Government's publication *Health is Global: A UK Government Strategy 2008-2013*, has developed an outcomes framework to support the next phase of the strategy, reaffirming a set of guiding principles and underpinned across Government by departments' own delivery plans. The outcomes framework 2011-2015<sup>47</sup> looks to support the Coalition Government's priorities for foreign policy, international aid commitments and improving the UK population health outcomes by focussing on global health security, international development and trade for better health.

The refreshed UK strategy is underpinned by ten guiding principles but noteworthy for the Canada-UK Colloquium are to: "protect the health of the UK proactively by tackling health challenges that begin outside our borders ; work for strong and effective leadership on global health through strengthened and reformed institutions such as

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47 *Health is Global: an outcomes framework for global health 2011-15*. Available at: <https://www.gov.uk/government/publications/health-is-global-an-outcomes-framework-for-global-health-2011-15--2>.

WHO; use health as an agent for good in foreign policy, recognising that improving the health of the world's population can make a strong contribution towards promoting a low-carbon, high-growth global economy.” Canadian Ron Labonté and Michelle Gagnon use the UK strategy as a case study to help understand how and why health is integrated into foreign policy and to help other nations interested in developing whole of government global health strategies and a form of global health diplomacy.<sup>48</sup>

Canada is also committed to contributing to global health. In October 2013, the Canadian Society for International Health held a conference entitled “Global Health in 2013: Are We Having an Impact?”<sup>49</sup> The impact of SARS served to remind Canada of the importance of global health for national health, however, subsequent discourse appears to focus on global health as an aspect of its duty to aid and support low income countries as a health and foreign policy goal. Canada has taken important initiatives to support its interpretation of global health and the role it can play,<sup>50</sup> but has so far chosen not to formalise a national strategy in this sphere.

The process of producing cross-government and whole-of-society engagement with global health, whether in a formal strategy or by other

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48 Michelle L. Gagnon and Ron Labonté, “Understanding How and Why Health is Integrated into Foreign Policy—A Case Study of Health is Global, a UK Government Strategy 2008–2013,” *Globalization and Health* 9:24 (2013). Available at: <http://www.globalizationandhealth.com/content/9/1/24>.

49 Canadian Society for International Health recently held a conference entitled “Global Health in 2013: Are We Having an Impact?.” Available at: <http://www.csih.org/en/>.

50 Ruth M. Campbell, Maja Pleic, and Hillary Connolly, “The Importance of a Common Global Health Definition: How Canada’s Definition Influences Its Strategic Direction in Global Health.” *Journal of Global Health* 2:1 (June 2012). Available at: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3484757/>.

means is complex and time consuming but it can break down silos with the support of a well organised and credible policy community and support from the prime minister and the foreign ministry is essential. The next iteration of the global health policy beyond 2015 will build on such commitments and extend the engagement of the private sector and other agencies such as the BBC World Services, which have an extensive impact both on health and public perceptions. The aim of our colloquium is to inform the content as well as the process of developing such commitments in both countries.

## NEW REALITIES FOR GLOBAL HEALTH

Much has changed over the past five years; the economic crisis has gone deeper, power and opportunity is shifting with the increasing importance of countries of the East and South. The changing diplomatic environment has been described as a move from “pyramids of power” to “networks of influence.” Cooperation on health issues continues to extend across borders through sub regional and regional groups and engages many diverse agencies including NGOs and civil society groups from local, national, regional and global levels. This brings increasing complexity with the need for skills in what Parag Khanna describes as “mega-diplomacy.”<sup>51</sup> Diplomats must now work with technical health experts to support relationship building and negotiation at many different levels. At the same time the link between health and other foreign policy objectives such as human security, trade and soft power and its importance as a cross cutting determinant of sustainable development is more apparent both in bilateral relations and in global governance.

The programme for the 2013 CUKC reflects these new realities for health, economic development and foreign policy and provides an opportunity for dialogue to develop some policy options for practical actions by the governments of the UK and Canada as well as academic,

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51 Parag Khanna, “Mega-Diplomacy: The New World Order,” January 2011. Available at <http://bigthink.com/videos/mega-diplomacy-the-new-world-order>.

business and civil society communities to act together on the international stage including at the UN, WHO, EU, NAFTA and with Commonwealth partners to achieve greater impact than acting alone.

Global health poses myriad challenges including: communicable and non-communicable diseases, areas in which research has been neglected, problems in achieving the MDG targets including field such as maternal and child health, the migration of health professionals and areas such as mental health which have claimed little attention. Discussions at our colloquium focussed particularly on the interface between global health and foreign policy, exemplified in UN General Assembly Resolution A/RES/65/95.<sup>52</sup> The topics considered include, global health: foreign and security policy-UK and Canada perspectives, global health transitions, support for global health initiatives and strengthening health systems, institutional structures and non-state actors for global health.

### **Global Health: Foreign and Security Policy: UK and Canadian Perspectives**

The aim of this session was to advance health diplomacy and ensure that political, security, development and health objectives are maximised through collaboration in the face of such matters as: the recent use of chemical weapons and the award of the Nobel Peace Prize to the Organisation for the Prohibition of Chemical Weapons for its extensive efforts to eliminate such weapons; the lack of resources in some countries to implement International Health Regulations (IHR); UK and Canadian leadership as part of the G7+ Mexico framework and the surveillance tools for public health events of international concerns in accordance with IHR and UK CMO identification of the “rise of

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52 UN General Assembly Resolution “65/95. Global health and foreign policy” 2011 Available at [http://www.who.int/mental\\_health/policy/resolution\\_global\\_health\\_and\\_foreign\\_policy.pdf](http://www.who.int/mental_health/policy/resolution_global_health_and_foreign_policy.pdf).

antimicrobial resistance as big a risk as terrorism and public health emergencies and pandemics.”

The UK Ministry of Defence recently published a consultation paper on Global Strategic Trends—Out to 2040.<sup>53</sup> This paper surveys future threats to human security and concludes that “no state group or individual can meet these challenges hence the struggle to establish an effective system of global governance.” It argues that “globalisation is likely to continue but widespread economic protectionist measures are possible in response to geopolitical insecurity or macroeconomic insecurity”; “inequality is likely to be a significant source of grievance possibly resulting in increased conflict; “65% of the world’s population will live in urban areas and rapid urbanisation is likely to lead to an increased urban rather than rural insurgency and the worst affected cities may fail with significant humanitarian and security implication”; “counter-proliferation initiative are unlikely to be wholly successful, nuclear weapons are likely to proliferate and terrorist groups are likely to acquire and use chemical, biological radiological or weapons possibly through organised crime groups; there are few convincing reasons to suggest the world will become more peaceful.” Soft power will increasingly be utilised to facilitate the achievement of political goals, (recognising health as part of foreign and security policy); “climate change will amplify existing social, political and resource stresses shifting the tipping point at which conflict ignites”; “perceptions of inequality and associate grievances will result in increased instability and social tension, possibly setting the conditions for conflict.” The report concluded that “Despite strong international trends the state will remain the building block of the international system however, globalisation is likely to have a Darwinian ‘survival of the fittest effect’ on poor governance. Effective governance will be an ever present concern.” The recognition of global health as a strategic concern for human security may lead the colloquium to identify joint actions as NATO members to support peace building through health initiatives.

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53 UK Ministry of Defence, “Strategic Trends Programme: Global Strategic Trends Out to 2040.” Available at: [http://www.da.mod.uk/colleges/jscsc/courses/RND/supporting-documents/gst4\\_update9\\_Feb10.pdf/view](http://www.da.mod.uk/colleges/jscsc/courses/RND/supporting-documents/gst4_update9_Feb10.pdf/view).

And there are also opportunities to take forward the work of the G8 Global Partnership on threats to human security.

A practical proposal for strengthening health protection is currently under consideration which includes twinning of laboratories in Commonwealth Countries—the UK, Canada, Australia, and Singapore—possibly with DFID funds to spread knowledge and build up capacity on antimicrobial resistance possibly to be announced at Commonwealth Heads of Government Meeting . The plan would entail twinning of laboratories to better understand resistance in one or two organisms as a start of a multiyear collaboration through training, external QA, and in some cases provision of reagents. Better national awareness could be developed and lead to better national engagement to the problem based on evidence and lead to more collaborative global action.

Health security is also addressed by measures to strengthen capacity for monitoring cross-border health threats, as required by the International Health Regulations. While the United States is investing considerable resources in providing training and development and laboratory support services in this field, for political reasons these are not always acceptable. The Colloquium could identify opportunities for Canada and the UK, possibly with the European Centre for Disease Control as well as with other Commonwealth countries to offer alternative sources for capacity building and reference laboratory services. Our meeting will also consider options for improving global governance, including steps to support the reform agenda of the WHO and to develop capacity in diplomacy for global public goods.<sup>54</sup> (Also see below.)

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54 Graham Lister and David Gleicher, Global Health Europe, “Glossary: Global Public Goods,” 2014. Available at: <http://globalhealth-europe.org/index.php/glossary-71/institution/81-global-public-goods>.



## Global Health Transitions

The recently published WHO report on the global burden of disease for 2000-2011 (and projections for 2015 and 2030<sup>55</sup>) reveals three major shifts in health trends since the first report in 1990: populations are growing considerably older; more people are dying from non-communicable diseases (NCDs) such as heart disease, cancer, diabetes and other chronic disorders and disease burden is now defined by disability instead of premature death.

Whilst recognising these changes in the global burden of disease, we must take note of the CDC Director's warning in September 2013 of complacency on global health issues that public health is more needed than ever and has more potential than ever "including neglected diseases and maternal and child health." In addressing new priorities it is important to recognise that the MDGs have still not been met in many countries and there are many outstanding issues to address.

One issue that serves as a reminder of the need for further action is the need to improve maternal and child health, while progress has been made over the past five years, for example in increasing the number of trained birth attendants, there is still a long way to go to ensure that such services are sufficiently well led and resourced. As Canada played a leading role in raising the priority of this issue (with UK support) it is now appropriate to consider the next steps that are now required.

Thus while NCDs are an increasing focus of attention, it must be remembered that in many countries these represent a double burden of disease, as basic health needs are not yet met. Action on NCDs could include steps to engage the business community (particularly major international employers and food, drink and communications sectors) as well as civil society groups in actions to address issues such as: mental stress, obesity, smoking, alcohol and drug consumption as well as other social determinants of health including poverty and the role of women.

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55 World Health Organization, "Global Burden of Disease."  
Available at: [http://www.who.int/topics/global\\_burden\\_of\\_disease/en/](http://www.who.int/topics/global_burden_of_disease/en/).

The WHO recognises the need to engage businesses/NGOs and civil society in actions for global health but faces many difficulties in addressing the potential conflicts of interest this raises. The colloquium will consider action to engage Canadian and UK based businesses/NGOs/CSOs in addressing global health issues both at home and internationally, through partnerships that recognise such contributions in specific programmes without implying endorsement of all aspects of their business. This could build on the UN Global Compact<sup>56</sup> with partners engaged in this field such as Oxfam’s “Behind the Brands Campaign.”<sup>57</sup>

### **Support for Global Health Initiatives**

The recent report of the High-Level Panel on the Post 2015 Agenda<sup>58</sup> and the outcome of the discussions at the UN General Assembly make the case for a “new global partnership to eradicate poverty and transform economies through sustainable development.” The Panel identified five transformative shifts: leave no-one behind; put sustainable development at the core; transform economies for jobs and inclusive growth; build peace and effective open and accountable institutions for all; and forge a new global partnership. In other words this is no longer solely an agenda for developing countries; it places new demands on everyone to mobilise social, economic and environmental action to ensure healthy lives. Thus it could be that health and wellbeing at

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56 United Nations Global Compact, 2005. Available at: <http://www.unglobalcompact.org/>.

57 Oxfam, “Behind the Brand,” 2013. Available at: <http://www.behindthebrands.org/>.

58 High Level Panel on the Post 2015 Development Agenda Available at: <http://www.post2015hlp.org/>.

home and international contributions to this goal will be the lens by which to gauge progress for all countries.

It has been pointed out that there appears to be an assumption that health will continue to be prioritised. The CUKC challenge is to examine whether health is a priority in the post-2015 agenda it is therefore important to explore the call for Universal Health Coverage, the evolving development context and the extent to which this supports the continued high-level focus improving global health and strengthening national health systems and UK and Canadian thinking about future development financing. This will set out the arguments for health investments in terms of governance, the golden thread of development and the continued focus on improving equity.

There may also be opportunities for Canadian collaboration with Public Health England and the Australian National University in the Healthy-Polis: International Consortium for Urban Environmental Health and Sustainability<sup>59</sup> as the global organisation aiming to build research and training capacity in health protection covering a wide range of environmental determinants of health and sustainability. This would also contribute to the Martin Commissions proposals of Creative Coalitions such as “Fit Cities: a city based network to fight the rise of NCDs and advance the interest of future generations by promoting resilience, inclusiveness and sustainability.”

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59 Healthy-Polis. Available at: <https://sites.google.com/site/healthypolis/>.

## Strengthening Health Systems

Universal health coverage is the umbrella goal for health proposed by WHO in the post-2015 agenda.<sup>60</sup> Margaret Chan, the director general of the WHO, notes that “systems research on health systems has been badly neglected and underfunded, it is not widely recognised that health systems research is essential for strengthening health systems, getting cost effective treatments to those that need them and achieving better health status locally and around the world.”

Nigel Crisp, in his recent book *24 Hours to save the NHS*, also states that “systems thinking and leadership holds the key to many improvements we can make in health and healthcare but there is little research on managing systems and relatively little is taught about it in our universities and institutions.” Jim Yong Kim and his colleagues claim that “the biggest obstacle facing global health is a failure of delivery. The gritty business in developing countries has not attracted much academic interest, even though improving capacity to deliver care in these settings will save lives, leverage and increase returns on existing and new investments in both discovery and development of new resources.”<sup>61</sup> They propose healthcare delivery value chains that apply a systems approach to the complex processes and interventions that must occur across a healthcare system with shared delivery infrastructure so that personnel and facilities are used wisely and economies of scale reaped. Experience of health service delivery in the UK and Canada have many of these attributes, and, together with NHS Overseas, there could well be opportunities for bilateral working towards a “science of delivery by harnessing research and training to understand and improve care

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60 David B. Evans, Justine Hsu, and Ties Boerma, “Universal Health Coverage and Universal Access,” *Bulletin of the World Health Organization* 2013;91:546-546A. Available at: <http://www.who.int/bulletin/volumes/91/8/13-125450/en/index.html>.

61 Paul Farmer, Arthur Kleinman, Jim Kim, and Matthew Basilio, eds., *Reimagining Global Health: An Introduction* (Berkeley: University of California Press, 2013).

delivery.” The authors “believe that this new specialty of global health delivery will lead to innovations that could improve care delivery and outcomes in developed countries including our own [the United States].”

This approach must recognise that leaders help to shape healthcare as learning systems that respond to conditions, resources and their social and cultural environment. Thus for example there will be very different systems requirements for urban and rural environments. What is required is a practical approach to help those responsible for health systems development to build their understanding of the potential for health systems improvement in their circumstances. Action to support this might include research and learning networks for Ministry of Health staff promoted in partnership with the WHO Global Health Observatory and UN University and guides for practitioners as to how to design, manage and lead healthcare systems. There are therefore good health reasons to focus on health systems and leadership but this is also an essential ingredient of public diplomacy to influence communities and their leaders.

Health systems development in low income cities is a priority identified by the Oxford Martin Commission,<sup>62</sup> and is a priority identified in the MoD Future Trends report. The colloquium may wish to consider whether the leadership and development of healthcare systems and healthy communities in large urban conurbations is a specific issue for research collaboration in view of the potential impact on human health and security (see previous section).

The development of health leadership qualifications coupled with steps to improve the recognition, career structure and pay of nurses and midwives holds a key to expanding health system capacity, particularly in rural areas (currently serving 70 per cent of the population in Africa) where there are no doctors (but Medical Assistants trained in basic dispensing) and nurses lead and manage local services including

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62 Oxford Martin Commission for Future Generations, “Securing the Long Term in National and Global Decision Making,” University of Oxford, Oxford Martin School, 2013. Available at: <http://www.oxfordmartin.ox.ac.uk/commission/>.

midwifery and child health. While many nurses are attracted to other countries with higher pay, better conditions and opportunities for professional development, an examination of the supply of nurses also showed that a great number of nurses in East Africa leave the profession either because there are no posts available or because they can find better pay and conditions in other jobs. The colloquium may be able to identify the opportunity for education and research centres in the UK and Canada to partner with nursing education centres in low income countries and professional nursing associations such as the International Council of Nurses and the Commonwealth Nursing Federation to address these needs.

There are many ways to improve the situation, for example, while there are online resources available on many aspects of healthcare training few nurses have the skills or opportunities to use these in their work situation and while there are books and courses on nurse leadership and other aspects of advanced practice including midwifery leadership and training for community leadership for health, they tend to be very expensive. Access to such courses and the quality and recognition of course could be improved in partnership with the Global Health Workforce Alliance.<sup>63</sup>

### **Institutional Structures and Non-State Actors for Global Health: From Health Governance to Governance for Health**

The report of the High-Level Panel of Eminent Persons on the Post-2015 development agenda illustrate their universal goals and national targets with one on ensuring good governance and effective institutions. This theme of governance is echoed in the Report of the Oxford Martin Commission for Future Generations published in October 2013 of how can businesses, institutions and governments contribute to more

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63 WHO, Global Health Workforce Alliance, 2013. Available at: <http://www.who.int/workforcealliance/about/en/>.

inclusive and sustainable growth. The Commission and its three part report calls for action on “Possible Futures” including reducing NCDs by remedying deficiencies in public health systems, implementing agreed best practice and partnering creatively with industry; “Responsible Futures” by transformative change and campaigns such as reducing tobacco use and “Practical Futures” by creating coalitions, innovative, open and reinvigorated institutions, revaluing the future to rebalance and reduce bias against future generations, investing in younger generations attacking poverty at source and finally establishing a common platform of understanding, recognising that our current response to global challenges is undermined by the absence of a collective vision for society and the need for renewed dialogue on an updated set of shared global values around which a unified and enduring pathway for society can be built.

It can be seen that global health is not only a domestic and foreign policy concern it is also a common interest for future generations. Diplomacy must reflect both national interests and global concerns and the global public goods that protect our collective future. This will require action by governments, NGOs, CSOs and business partners supported by diplomacy, combining technical knowledge in these fields with understanding of international relationship building and negotiation.

This need has been recognised by the WHO, which has been building capability for global health diplomacy as part of its reforms programme. The colloquium can discuss how the UK and Canadian diplomatic and health specialists can develop capability in global health diplomacy and how they might build on the skills developed by WHO Heads of Country Offices in global health diplomacy to extend learning networks for Ministry of Health and Ministry of Foreign Affairs staff in MICs and LICs. This would both address the increasingly complex problems of coordinating national health planning and action (see the Paris/Accra/Bussan Agreements on aid effectiveness<sup>64</sup>) and improve

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64 OECD, “Better Policies for Better Lives,” 2012. Available at: <http://www.oecd.org/dac/effectiveness/parisdeclarationandaccraagendaforaction.htm>.

the capacity of countries to participate in global health governance. In this field there are opportunities to work with WHO and its training partner in this field, the Graduate Institute, Geneva and with the UN University who also have an interest in global governance.

The United States has reassessed its position on global health initiatives elevating structurally the role of diplomacy with a new office for global health diplomacy in the State Department and strengthening leadership for global health from *within* to *by* the US Government. The colloquium can consider ways in which UK and Canada could develop their own capacity for developing learning networks to share common understanding of diplomatic and health priorities. Aid effectiveness and transparency is a field in which Canada and the UK could share research and practical experience to improve the effectiveness of Official Development Assistance and NGO managed aid, it has been noted that this requires effective management of relationships, i.e. health diplomacy.

This capability could be expanded to build networks of diplomats and technical experts for other global public goods expressed in SDGs, such as measures to control: climate change, ocean conditions, water and other natural resources, measures to support poverty reduction and partnership actions in these regards. A further step would be to support the development of such learning networks for other countries and regions thus contributing to building shared global values, or at least a pathway towards this aim.

Professor Graham Lister, Colloquium Rapporteur

Professor John Wyn Owen, CB, FRSPH, FLSW, RSPH, Colloquium Chair



# PROGRAMME

## THURSDAY, 21 NOVEMBER

### **Briefing Day for the Canadian delegation**

- 10.00am **Arrive House of Commons;** met by Mr Andrew Percy MP, Secretary of the British-Canadian All Party Parliamentary Group and Member of the Health Select Committee
- The Rt. Hon Andy Burnham MP, Shadow Secretary of State for Health
- The Baroness Jolly, Liberal Democrat Peer
- 12.30pm **Lunch** hosted by PricewaterhouseCoopers LLP, 1 Embankment Place, Villiers Street, London WC2N 6RH
- 1.15pm **PwC introductions and briefing** on Britain as an economy in the world; threats and opportunities raised by health.
- 2.15pm **International health perspectives and discussion:** Professor Reddy (India) and Dr Alex Ezech APHRC, Kenya
- 3.00pm **Global Health: Younger People's Perspective** - Dr Fiona Adshead moderating
- 6.00pm **Reception** hosted by Mr & Mrs Galen Weston at Fort Belvedere

### **Opening**

- Welcome:** Chair of the British Committee Mr Philip Peacock and Canadian Coordinator Professor Kim Nossal
- 7.30pm **Dinner and Key Note Address**
- Lord Nigel Crisp KCB: The Search for Global Health in the 21<sup>st</sup> Century: Turning the World Upside Down

## Friday, 22 November

- 9.00am **Chairman's Opening Remarks**  
Professor John Wyn Owen CB, RSPH Professorial Fellow
- 9.10am **Session 1: Global Health: Foreign and Security Policy: UK-Canada Perspectives**
- UK** Ms Kate Smith, Director Americas, Foreign & Commonwealth Office
- Canada** Mr Morris Rosenberg, Former Deputy Minister, Department of Foreign Affairs, Trade and Development Canada
- Discussant** Professor David Heymann CBE, Chairman Public Health England
- 10.30am **Break for tea and coffee**
- 10.45am **Session 2: Rapid Global Health Transitions**
- UK** Professor Sir Andy Haines, London School of Hygiene and Tropical Medicine
- Canada** Professor Prabhat Jha; Director, Centre for Global Health Research, University of Toronto
- Discussant** Hon. Dr Keith Martin MD, Executive Director, Consortium of Universities for Global Health
- 12.15pm **Lunch**
- 1.30pm **Session 3: Supporting Global Health Initiatives**
- UK** Dr Neil Squires, Head of Profession for Health, DFID
- Canada** Dr Stanley Zlotkin, Chief, Global Child Health, the Hospital for Sick Children, University of Toronto
- Discussant** Ms Margaret Biggs, Skelton-Clark Fellow, Queen's University, Former President, Canadian International Development Agency (CIDA)

3.00pm **Session 4: Strengthening Health Systems**

**UK** Sir Tom Hughes-Hallett, Executive Chair & Adjunct Professor, Institute of Global Health Innovation

**Canada** Prof. Carolyn Hughes Tuohy; Prof. Emeritus of Political Science and Senior Fellow, School of Public Policy and Governance, University of Toronto.

**Discussant** Professor Rifan Atun, Imperial College

4.00pm **Tea**

4.30pm **Working Groups**

**Group 1: NCDs in Middle Income Countries**

**Co-Chair UK** Dr Nick Banatvala, World Health Organization

**Co-Chair Canada** Dr Catherine Hankins, Deputy Director, Science, Amsterdam Institute for Global Health and Development

**Group 2: MCH (Maternal and Child Health) in Low and Middle Income Countries**

**Co-Chair UK** Professor Joy Lawn, Director, Maternal Reproduction and Child Health, London School of Hygiene & Tropical Medicine

**Co-Chair Canada** Professor John Frank, The Scottish Collaboration for Public Health Research and Policy (SCPRP)

**Group 3: Health Protection: Global**

**Co-Chair UK** Dr Brian McCloskey CBE, Director Global Health, Public Health England

**Co-Chair Canada** Dr Aleks Leligdowicz, Department of Medicine, University of Toronto

**Group 4: Neglected Diseases**

**Co-Chair UK** Professor Alan Fenwick, Imperial College

**Co-Chair Canada** Professor David Zakus, Director, Global Health and Professor of Preventative Medicine, University of Alberta.

7.45pm **Dinner and Keynote Address**

Ms Una O'Brien CB, Permanent Secretary,  
Department of Health

**Saturday, 23 November**

9.00am **Session 5: Reporting back by Groups 1, 2, 3 and 4**

10.15am **Break for tea and coffee**

10.30am **Session 6: Institutional Structures and Non State Actors for Global Health: From Health Governance to Governance for Health**

**UK** Professor Graham Lister, Global Health Programme,  
Graduate Institute Geneva

Dr Obijiofor Aginam, UN University

**Canada** Dr Peter Singer; Chief Executive Officer, Grand Challenges Canada

12.15pm **Lunch**

2.00pm **Session 7: Plenary discussion, summary, way forward, action and next steps**

**Rapporteur;** Professor Graham Lister, Global Health Programme, Graduate Institute Geneva

3.00pm **Chairman's closing remarks**

4.00pm **Organisers' Meeting**

## LIST OF PARTICIPANTS

### **CHAIRMAN AND UK ADVISER TO THE 2013 COLLOQUIUM**

**Professor John Wyn Owen CB**

RSPH Professorial Fellow

### **RAPPORTEUR**

**Professor Graham Lister**

Global Health Programme, Graduate Institute Geneva

### **CANADIAN ADVISER TO THE 2013 COLLOQUIUM**

**Dr Alan Bernstein**

President and CEO, Canadian Institute for Advanced Research

### **SPEAKER: OPENING DINNER 21 NOVEMBER**

**Lord Nigel Crisp KCB**

Independent Member of the House of Lords

### **SPEAKER: COLLOQUIUM DINNER 22 NOVEMBER**

**Ms Una O'Brien CB**

Permanent Secretary, Department of Health

### **BRITISH SPEAKERS (in order of presentation)**

**Ms Kate Smith**

Director Americas, Foreign & Commonwealth Office

**Professor Sir Andy Haines**

London School of Hygiene and Tropical Medicine

**Dr Neil Squires,**

Head of Profession for Health, DFID

**Sir Thomas Hughes-Hallett**

Executive Chair and Adjunct Professor, Institute of Global Health Innovation

## **OTHER BRITISH PARTICIPANTS**

### **Dr Fiona Adshead**

Visiting Professor, University College, London

### **Professor Rifat Atun**

Head, Health Management Group, Imperial College Business School  
Professor of Global Health Systems, Harvard School of Public Health

### **Dr Nick Banatvala**

World Health Organization

### **Ms Isobel Braithwaite**

University College London

### **Mr Anthony Cary CMG**

Hon. President CUKC, Commonwealth Scholarship Commissioner and  
former British High Commissioner to Canada

### **Mr Peter Chenery**

Hon. Treasurer, CUKC

### **Professor David Cope**

Clare Hall, University of Cambridge, CUKC Council Member and  
Commonwealth Scholarship Commissioner

### **The Baroness Cox**

Chief Executive Officer, HART (Humanitarian Aid Relief Trust)

### **Ms Anjou Dargar**

Thomson Reuters

### **Mr George Edmonds-Brown**

Executive Secretary, CUKC

### **Professor Alan Fenwick**

SCI, Imperial College

### **Baroness Fookes DBE, DL**

Council Member, CUKC

### **Professor David Heymann CBE**

Chairman, Public Health England

### **Mr Andrew Jack**

*Financial Times*

**Ms Lucy Joyce OBE**

Head, North America Department, Foreign & Commonwealth Office

**Ms Hollie Kluczewski**

Newcastle University

**Professor Joy Lawn**

Director, Maternal Reproduction and Child Health, London School of Hygiene & Tropical Medicine

**Mr Nicolas Maclean CMG**

Council Member, CUKC

**Dr Brian McCloskey CBE**

Director of Global Health, Public Health England

**Ms Modi Mwatsama**

Director, Global Health, UK Health Forum

**Mr Philip Peacock**

Chairman, Canada-UK Council

**Mrs Corin Robertson**

Deputy British High Commissioner to Canada

**Professor Itesh Sachdev**

Council Member, CUKC

**Dr Val Snewin**

International Activities Manager, The Wellcome Trust

**Ms C. Alexandra Stewart**

The W. Garfield Weston Foundation

**Mr Cameron Stocks**

National Director of Medsin-UK

**CANADIAN SPEAKERS (in order of presentation)**

**Mr Morris Rosenberg**

Former Deputy Minister, Department of Foreign Affairs, Trade and Development Canada

**Professor Prabhat Jha**

Founding Director, Centre for Global Health Research, University of Toronto

**Professor Stanley Zlotkin**

Chief, Global Child Health, the Hospital for Sick Children, University of Toronto

**Professor Carolyn Hughes Tuohy**

Professor Emeritus of Political Science and Senior Fellow, School of Public Policy and Governance, University of Toronto

**Dr Peter Singer**

Chief Executive Officer, Grand Challenges Canada

**OTHER CANADIAN PARTICIPANTS**

**Thomas Balint**

Deputy Director, EU/European Bilateral and Institutional Relations Division, Foreign Affairs, Trade and Development Canada

**Ms Maureen Bartram**

Centre for International and Defence Policy, School of Policy Studies, Queen's University

**The Hon. Dr. Carolyn Bennett MP**

**Ms Margaret Biggs**

Skelton-Clark Fellow, Queen's University, Former President, Canadian International Development Agency (CIDA)

**HE Mr Gordon Campbell**

High Commissioner of Canada to the United Kingdom

**Dr Mel Cappe**

University of Toronto and Chair, Canadian Committee, Canada-UK Council



**Dr John Dirks**

President and Scientific Director, Gairdner Foundation, Toronto

**Professor John Frank**

The Scottish Collaboration for Public Health Research and Policy (SCPHRP)

**Dr Catherine Hankins**

Deputy Director, Science, Amsterdam Institute for Global Health and Development

**Mme Hélène Laverdière MP**

**Dr Aleks Leligdowicz**

Department of Medicine, University of Toronto

**Hon. Dr Keith Martin MD, PC**

Executive Director, Consortium of Universities for Global Health

**Dr. Caroline Martin**

Manager, Science & Innovation Program, Canadian High Commission

**Professor Kim Richard Nossal**

Director, School of Policy Studies, Queen's University, and Canadian Coordinator, Canada-UK Council

**Mr Scott Proudfoot**

Minister Counsellor Political Affairs & Public Diplomacy, Canadian High Commission

**Professor David Zakus**

Director, Global Health, and Professor Preventative Medicine, University of Alberta,

**GUEST PARTICIPANTS**

**Professor Srinath Reddy**

Public Health Foundation of India

**Dr Alex Ezeh**

African Population and Health Research Center, Kenya

**Professor Obijiofor Aginam**

Senior Academic Officer, United Nations University—Institute of Sustainability and Peace; Adjunct Research Professor of Law, Carleton University, Ottawa

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