Global Public Goods for Health Workshop
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Welcoming address by
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Good morning to you all. It is a great pleasure, personally and on behalf of IDRC, to welcome you to this timely and important meeting. Let me also express IDRC's gratitude to our collaborators in organizing this workshop—to WHO, to CIDA, and to Health Canada. This is the kind of creative partnership that I believe characterizes the best approaches to the challenges of governance that now confront us all.

As well, I want to salute my friend and frequent colleague, Inge Kaul. As one of the most innovative and productive thinkers in the entire UN system, Inge is making an extraordinary contribution to our understanding of human development, and of global affairs. The volume *Global Public Goods* already stands as something of a classic: essential reading, both for scholars and for policy-makers. We are blessed by her participation with us here today.

There is, after all, no more complete example of a public good—or of a global public good—than the provision of health care. That is obviously not a claim I have to explain to this expert assembly. What is more significant is that the concept of health care as a public good is generally so well understood by non-experts—indeed, by the Canadian public. Canadians for many years have seen health care as a collective undertaking, and not primarily as a private good to be bought and sole in the market.

That is not to say Canada's health care system is free of problems. On the contrary, citizens, politicians, practitioners and scholars in this country are all struggling to understand and respond to the severe demands placed on our whole Medicare system. Demands for new investments. Demands for better governance. Demands for better techniques, and expensive technologies that hold promise for better diagnosis and that can transform surgical intervention.

What is important to recall, however, is that these very arguments and anxieties display a pre-eminently public good in all its attributes. The very fact that we face these issues is evidence that Canadians, by and large, continue to understand health care as a public good, not as a private commodity for private consumption. We have not, as a country, acted on the temptations of the 1980s and 90s to privatize the provision of health care.

Instead, we exert great efforts to maintain and renew Medicare as a collectively provided public good.

In recent weeks I have been powerfully reminded of the distinctive Canadian approach to health care during a trip through South and Central America. In the developing countries of our own hemisphere, the failures of privatized health care—and the injustices—are growing all too apparent. By many measures, access to health care, and standards of public health, are worse in poor countries now than they were a decade ago—after a decade of privatization, private investment, and private profit in health care. And at every stop on my trip, I was asked about the Canadian health care system, about how we manage to provide health care services as a public good. It is true to say that Latin Americans are increasingly intrigued by the Canadian model, not least as an appealing alternative to the U.S. medicine-for-profit design that is more often presented to them.

In the developing countries, privatization of health care has simply not succeeded as a strategy for cost containment or efficiency. Rather, it has tended to exacerbate inefficiencies and inequalities. To generalize, the people of developing countries are discovering the private sector can only make money in health care if it deals with healthy people and not sick people—and with rich people, not poor people. This is not a description of sound health policy (or of popular politics).

The challenge in those countries—not as rich as Canada—is the familiar problem every country shares: the provision problem. This is in part a technical problem, raising issues of technology, organization, and the better application of good science. But as all of you know well, it is also a problem of good governance—deciding who pays and who benefits, and agreeing on procedures for making those decisions openly, fairly, and accountably.

My own organization, I am glad to say, is now investing more resources with others in exactly this direction. We focus especially on public health interventions of highest value to the poorest communities—starting with clean water and safe food—and on building local capacity for good governance. To mention one example: In Tanzania, IDRC is helping health management teams at district level plan their operations by identifying real local needs through local research, rather than by operating according to some program imposed from above.

All of this is to say that I encourage Canadians—as scholars, policy professionals and interested citizens—to overcome our natural modesty and collaborate more actively with those who see value in the Canadian health care model. I think this workshop will make a critical contribution to that end—to developing systems for health care that are accessible, effective, and fair. I look forward to the work, and to the results.

Welcome again, and thank you.