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North American Health Governance: Shocks, Summitry, and Societal Support

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ABSTRACT

Cross-border health challenges have led to innovative governance responses. No longer able to go it alone, actors must coordinate their efforts with their partners. The 2009 outbreak of swine influenza (H1N1), the earlier scare of avian influenza (H5N1), and the spread of severe acute respiratory syndrome (SARS) in 2003 forced the members of the North American Free Trade Agreement to tackle health challenges. Officials, ministers, and leaders collaborated in an effort to achieve a mutually beneficial outcome. These successive shocks, which struck with increasing simultaneity and shared severity, raised trilateral cooperation higher, while North American summitry sustained it.

Key words: global health governance, NAFTA, SARS, H1N1/swine flu, avian influenza, Security and Prosperity Partnership/North American Leaders Summit, Mexico, Canada, United States

RESUMEN

Los retos fronterizos de salud han llevado a los gobiernos a dar respuestas innovadoras. Como los actores ya no pueden actuar solos, deben coordinar sus esfuerzos con sus socios. El brote de influenza (H1N1) de 2009, el temor anterior que provocó la influenza aviar (H5N1) y la propagación del síndrome respiratorio agudo severo (SARS) en 2003 forzaron a los miembros del Tratado de Libre Comercio de América del Norte a abordar tales desafíos. Los funcionarios, los ministros y los líderes colaboraron en un intento de lograr resultados mutuamente beneficiosos. Estos shocks sucesivos, que golpearon con una creciente simultaneidad y severidad compartida, elevaron los niveles de cooperación trilateral, mientras las reuniones cumbres los sustentaron.

Palabras claves: gobernanza en salud global, TLCAN, SARS, H1N1/influenza aviar, sociedad en seguridad y prosperidad/Cumbre de Líderes de América del Norte, México, Canadá, Estados Unidos

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Introduction

How far have Mexico, the United States, and Canada moved toward becoming a single North American community for protecting public health since the North American Free Trade Agreement (NAFTA) formally came into force on January 1, 1994? This question has assumed compelling significance and timeliness with the severe acute respiratory syndrome (SARS) strike on Canada in the spring of 2003 and the outbreak of influenza A(H1N1) –the so-called "swine flu"– in Mexico in April 2009, and its rapid spread to the United States, Canada, and the rest of the world. By the end of January 2010, 209 countries had confirmed cases of H1N1, and at least 14 711 people had died as a result (World Health Organization [WHO], 2010). By January 22, a reported 3 751 people had died in North America: 422 in Canada, 931 in Mexico, and 2 398 in the United States (Pan American Health Organization [PAHO], 2010). Mexico had suffered serious economic costs as its vital tourism industry dwindled and businesses and public facilities closed. Some estimated that for every day of swine flu, Mexico lost approximately US$150 million. Former Mexican Finance Minister Agustín Carstens described the impact of H1N1 as devastating for tourism and costing "close to 0.3percent" of gross domestic product (GDP) or US$2.3 billion (Seegobin, 2009).

As 2010 began, officials in all three North American countries continued to be apprehensive, anticipating that a third wave might come. Their fears were fuelled by the memory of the deadly SARS that had killed 44 Canadians in Toronto in spring 2003 and the avian influenza that migrated around the world in the mid-2000s. Various officials from the World Health Organization (WHO), the Pan American Health Organization, and national health agencies continued to drive the concern in January 2010 with reports and warnings of a possible third wave.

Within North America, the intergovernmental response to these successive health challenges has changed. At the August 9-10, 2009 North American summit in Guadalajara, Mexico, U.S. President Barack Obama, Mexican President Felipe Calderón, and Canadian Prime Minister Stephen Harper gave themselves high marks for their cooperative response to the swine flu threat. They proudly proclaimed in their communiqué that "North America's coordinated response to the initial outbreak of the H1N1 flu virus has proven to be a global example of cooperation" (North American Leaders' Summit, 2009a). They issued a separate statement on H1N1, the first stand-alone statement on health from a North American trilateral summit since its start as an annual event in 2005, or even since North American summitry first arose in 1956 (Swanson, 1975). But was this self-congratulation a symbol of real enduring change, accompanied by an appropriate and adequate response to the

clear compounding health challenge? Did it signal the culmination of an expanding community-building process designed to address a broader array of threats to the health of North Americans?

The limited scholarship thus far on this subject offers answers that divide into four distinct schools of thought. The first suggests that emerging health challenges have induced NAFTA countries not to cooperate (Price-Smith, 2009). Particular challenges, such as bovine spongiform encephalopathy (BSE, or mad-cow disease), have provided the NAFTA countries with an incentive to close their borders to their neighbors, for fear that disease in one country could have an affect on their own citizens' health. This was the case in May 2003 when both Mexico and the U.S. banned Canadian cattle and beef after only one case of BSE had been discovered in Alberta. National health has thus trumped efforts to promote more collaborative and coordinated responses.

The second school suggests that the increased cooperation and coordination expected after NAFTA have not occurred due to political, professional, legal, administrative, and cultural barriers that remained among the countries. There has been no desire to overcome these barriers, and in many cases, incentives to keeping them appear to exist (Homedes and Ugalde, 2003). Indeed, any harmonization in health has been hindered by insufficient legal mechanisms to support crossborder collaboration, a lack of mutual respect among health professionals across countries, inadequate information sharing and direction setting on crossborder initiatives, and the absence of any push to break down cultural barriers –including language barriers– across the countries.

The third school argues that although NAFTA did not provide governments with an incentive to cooperate on health, it did open up the opportunity and mobility for convergence and crossover in the health sector (Appleton, 1999). Here, convergence and crossover are highlighted cautiously, however, since the market incentives at the forefront of NAFTA could cause a negative spillover into those systems that are more highly prized at home than in neighboring countries.

The fourth school proposes that over time the North American partners have increasingly collaborated on health due to the escalating frequency and severity of health shocks that have hit the region hard and cannot be contained within the countries' respective borders (Kirton and Guebert, 2010). Diseases that do not respect borders, such as SARS, have highlighted the need for North America to cooperate and coordinate on health prevention to ensure the health of their publics as well as of their integrated economies.

The North American community's attention has once again turned to health. With shocks such as SARS in 2003, the fear of avian influenza in the mid-2000s, and

the H1N1 outbreak in 2009 occurring more regularly and rapidly bringing more deaths and economic harm to North America, innovative and coordinated community-wide responses have increased (Cooper, Kirton, and Schrecker, 2007; Cooper and Kirton, 2009). These shocks have forced the NAFTA countries to overcome their deep desire, legally entrenched in the free trade agreement, to deal with health in an autonomous –indeed autarchic– way. These old desires have been overcome or pushed aside as the new challenges have compelled the countries to act more collaboratively than before. The old reluctance has been trumped by the fears aroused by these new, more frequent shared health shocks. This recent shift in North American health governance could indicate that a broader and more coordinated approach to health –one that does not only include issues that transcend borders– might develop in future years.

Domestic Differences on Public Health

Healthcare systems, structure, quality, and expectations differ a great deal among the three North American countries and their citizens (Ruelas, 2002). The total expenditure on health care as a percentage of GDP for 2007 in each country was as follows: Mexico 5.9 percent, the United States 16.0 percent, and Canada 10.1 percent. The public sector is the main source of health funding for Canada, but not for the U.S. or Mexico (OECD, 2009). The probability of dying under the age of five is 35 per 1000 live births in Mexico, 8 in the U.S., and 6 in Canada (WHO, 2008a, 2008b, and 2008c). Each country has developed its own unique system to deal with health. Each has different health outcomes, satisfaction, and rates of success.

These domestically embedded differences were deliberately legally entrenched in NAFTA. The agreement contained direct legal guarantees that national sovereignty on health issues would remain intact. It signalled that no trilateral cooperation or convergence was needed or desired in this field. Five chapters in the agreement (11, 12, 14, 16, and 27) relate to health. Chapter 11, Article 1 states, "Nothing in this Chapter shall be construed to prevent a Party from providing a service or performing a function such as law enforcement, correctional services, income security or insurance, social security or insurance, social welfare, public education, public training, health, and child care, in a manner that is not inconsistent with this Chapter" (NAFTA, 1994). Indeed, all the references made to health guaranteed complete national autonomy and restricted regional convergence on health, not supporting or encouraging cooperation in any way.

Despite this "hard law" prescription for non-cooperation, ongoing concern and debate have centered on how NAFTA's trade, investment, environmental, and labor

provisions could positively or negatively affect human health (EPA, 2009). At the outset, some thought that NAFTA could bring opportunities in health (Poole, 1996). Administrators and policy makers hoped that the new relationship might encourage reforms in Mexico and the U.S. –that the two southern neighbours would learn and see the benefits of the successful public healthcare system in Canada.

In Canada, however, some worried about the threats that NAFTA posed to their highly valued public healthcare system (Gray, 1996). They were concerned that the new relationship would allow or encourage the U.S. privatized approaches to spill over the northern border. Canada's healthcare system could be challenged under the rules of NAFTA (Canadian Union of Public Employees, 2000). With provincial governments tolerating and even funding private, for-profit medicine, such a challenge would likely arise. Similar concerns arose in Mexico, where there was fear that U.S. firms might open clinics that would contract physicians' services. Some observed that Mexican medical associations became more active after NAFTA due to physicians' concern that U.S. health insurance firms and private hospitals that entered Mexico would exploit them (Homedes and Ugalde, 2003).

In the U.S., environmental groups were adamant that the new NAFTA must uphold the existing domestic health laws and regulations. The protection of the environment and human health, particularly in the areas of industry and agriculture, were of great concern (VanderMeer, 1993). Americans feared that the much less rigorous policies and enforcement in place across the southern border, particularly in the areas of health and the environment, might drag down the United States' high standards and adversely affect Americans' health.

Under NAFTA's legal and institutional architecture, national autonomy in health thus largely prevailed for many years. In each of the three countries –each concerned that the agreement would harm, not help, their distinct and cherished national health systems– national autonomy and autarky were more entrenched than regional cooperation in the NAFTA regime. The only exceptions were where health was integrally linked to environmental and labor issues. In these two fields, NAFTA's regime created, from nowhere, the potential for cooperation and community in the form of two new regional organizations: the Commission for Economic Cooperation (CEC) and the Commission for Labor Cooperation (CLC) (Kirton, 2006).

The NAFTA Era Evolution

From the outset, any trilateral intergovernmental action that did take place on health was largely related to the environment and labor, areas where the NAFTA regime had

created new legal mandates and institutions to identify and act on the links. In both the North American Agreement on Environmental Cooperation (NAAEC) and the North American Agreement on Labor Cooperation (NAALC), health was included. In the NAAEC, under Article 45, environmental law is defined as "any statute or regulation of a Party, or provision thereof, the primary purpose of which is the protection of the environment, or the prevention of a danger to human life or health" (NAAEC, 1993). The language clearly states that human health is an integral part of the environment. The importance of occupational safety and health is also stipulated throughout the NAALC.

Health continued to be identified within these frameworks as the new North American institutions got down to work. In the NAFTA environmental provisions, the countries stated that they would "conditionally protect a party's stricter environmental, health, and safety standards for products and produce (provided that, among other things, such measures are scientifically based)" (Tiemann, 2000). Similarly, the bilateral U.S.-Mexico Border XXI Program, based on the La Paz Agreement, sought "to achieve a clean environment, protect public health and natural resources, and encourage sustainable development" in the border region (EPA, 1996). Under the program, health and environmental agencies in the U.S. and Mexico worked to improve both health and the environment.

In 1996, the U.S. and Mexico took a further step together. They established a bilateral working group on health to deal with immunization, women's health, aging, epidemiological surveillance, migrant health, and addictions. The group continued to work on these issues in different forums through the years. Similar groups arose in Canada and the United States. They were largely bilateral, not trilateral, however. On other issues, such as intellectual property rights, they were global, not continental (Clarkson, 2007).

The CEC provided a nest for trilateral health cooperation and convergence. In October 1996, the North American Working Group on the Sound Management of Chemicals held hearings in Mexico to discuss the elimination of mercury, polychlorinated biphenyls (PCBs), dichlorodiphenyltrichloroethane (DDT), and chlordane from the North American environment. DDT, which was widely used in Mexico to control malaria and exported from there to Colombia, Panama, and Guatemala, was harming both the environment and the health of citizens in other parts of North America (Wiehoff, 1996).

The legally weaker CLC served as a less prominent nest, especially in the face of domestic resistance to cooperation. In Canada, concerns existed that free trade would reduce standards and working conditions in order to compete with the lower wages in the southern United States, where there were fewer unions (Wiehoff, 1996). In 1995,

after the Canadian government slashed transfer payments to the province of Ontario, workers protested because welfare programs were cut, hospitals were closed, and healthcare workers were laid off.

In 2002, eight years after NAFTA and the NAALC entered into force, the NAFTA Tri-National Occupational Safety and Health Working Group was established to improve working conditions and living standards of workers by, *inter alia,* promoting safety and health. It is difficult to determine if the creation of this group was in any way a direct response to the 2001 anthrax threats (see below), or even a response to the countries' desire to work together more closely after their experience with the Global Health Security Initiative (GHSI). But it nonetheless gave them another –now trilateral– venue to work on health.

Outside the two NAFTA-related nests, trilateral cooperation came more slowly. It first emerged in 1998, four years after NAFTA took legal effect. The catalyst was the infectious disease of HIV/AIDS. On the sidelines of the 1996 International AIDS Conference, the health ministers from the three countries signed a joint declaration to help people living with HIV (Daniels et al., 1998). Over time, the three countries met to address health more frequently, often on the margins of other events. But it was not until the 2000s, after the first of successive health shocks, that their cooperative partnership emerged in any sustained way.

The Response to the Anthrax Shock

Shortly after the September 11, 2001 terrorist attacks, the U.S. came under another assault, this time of a biological kind. Letters laced with a substance later identified as anthrax harmed and killed American civilians. This incident was eventually labelled "the worst biological attacks in U.S. history" (FBI, 2008). More of a terrorist shock than a health one, it engendered several responses that had a significant impact on how health would be governed in the region.

Although relatively few individuals were infected by the anthrax attacks –only five Americans died and an additional 17 fell ill– the resulting fears and security concerns were substantial, given that the attacks came so close in time and space to the September 11 assault (Garrett, 2005). The shock signalled the need for a new type of health governance, this time in the frame of political security (Price-Smith and Huang, 2009). Soon after the attacks, U.S. Secretary of Health and Human Services Tommy Thompson recommended that countries fighting bioterrorism share information and coordinate efforts to improve global health security (GHSI, 2010a). In response, the GHSI was launched in November 2001, bringing together the mem-

bers of the Group of Seven (G7) and Mexico, to serve as an "informal, international partnership among like-minded countries to strengthen health preparedness and response globally to threats of chemical, biological, radio-nuclear terrorism (CBRN) and pandemic influenza" (GHSI, 2010b). The United States' northern neighbor, Canada, agreed to host the first meeting, at which there was a strong emphasis on bioterrorism. Mexico hosted the third GHSI meeting in December 2002. Here, the agenda focused not only on bioterrorism, but also on pandemic preparedness (GHSI, 2001 and 2002). The three countries' health ministers or their representatives, such as the deputy ministers, began to meet more and more frequently at a number of such broader gatherings. They did so most notably at the GHSI, which continues to meet at least once a year.

The SARS Shock and Response, 2003

In February 2003, the second shock hit North America when the first case of SARS was reported in Canada. Over the next several months, more than 400 cases were reported in Canada, fewer than the 30 in the U.S., and none in Mexico. Only in Canada did people die as a result. On the whole, Canada bore the brunt of the economic side effects of SARS among the NAFTA countries (Price-Smith and Huang, 2009; Price-Smith, 2009).

However, as is often the case with such acute outbreak events in global health, it was the fear and apprehension aroused by SARS that brought coordination and cooperation to North America and across the globe (Kirton, 2009). That panic, both within infected areas and in uninfected populations, quickly resulted in economic damage (Price-Smith and Huang, 2009). "Preparedness" and "coordination" were also required for an effective response, something that had been lacking until then. The countries hit with SARS largely felt that their domestic systems were inadequate (Bennett, 2009). They thus needed and wanted one another's help, realizing it was no longer desirable, acceptable, or doable on their own. When Paul Martin was appointed Canada's prime minister in late 2003, he declared that he was "determined that Canada would never again be caught unprepared in [such] a crisis" (Martin, 2008).

SARS brought some immediate changes. In August 2003, Canada hosted an international technical workshop on regulatory issues associated with developing vaccines and immunotherapy products for SARS (Gorman, 2004). In November, at the fourth GHSI ministerial, members shared their lessons from SARS (GHSI, 2003). In February 2004, once Martin had taken office in Canada, trilateral efforts came. The

more general, multi-subject Trilateral Cooperation Charter was concluded to "protect and promote public health" and to "increase communication, collaboration, and the exchange of information among the three countries in the areas of drugs, biologics, medical devices, food safety, and nutrition to protect and promote human health" (Health Canada, 2005). This trilateral cooperation made noteworthy efforts in several fields, including the fight against fraudulent weight-loss products in 2005 and fraudulent diabetes cures in October 2006.

More importantly, SARS catalyzed a shift in health collaboration at the global, regional, and domestic levels. It provided a clear case of the future challenges countries needed to be prepared for. Following the outbreak, the demand for more cooperative and coordinated efforts led to the development of a global pandemic preparedness plan. Such cooperation began at the fifth GHSI meeting in Paris in 2004 and continued in 2005 at an international conference of health ministers from 30 countries that Canada, the U.S., and Mexico participated in (Bennett, 2009).

Avian Influenza and the Advent Of North American Summitry, 2005

Also at the December 2004 GHSI ministerial, those present recognized recent concerns about a possible avian influenza pandemic. They announced their commitment to work with the WHO on pandemic influenza preparedness and acknowledged the importance of enhancing surveillance and outbreak response activities (GHSI, 2004).

The following year, in 2005, North American summitry began on a stand-alone basis in the form of the Security and Prosperity Partnership of North America (SPP) (Ackleson and Kastner, 2006; Clarkson, 2006 and 2008; Rozental 2006). The SPP was created because the leaders of the three countries wanted something that went above and beyond the partial, silo system of the NAFTA institutional architecture (Martin, 2008; CEC, 1997; McKinney, 2000; Anderson and Sands, 2007). The summit provided an opportunity to discuss numerous issues, including ones that were a core part of the NAFTA framework from the beginning, such as trade. But it has also been used to address issues, such as health, where there was not only no dedicated institutional nest but also a great reluctance to engage in trilateral cooperation in virtually any form.

The advent of SPP summitry in 2005 marked a major change. In Waco, Texas, at their first meeting, the three leaders made two commitments on health: to "improve productivity through regulatory cooperation to generate growth, while maintaining high standards for health and safety," and to "enhance the stewardship of our environment, create a safer and more reliable food supply while facilitating agri-

cultural trade, and protect our people from disease" (SPP, 2005). The first promise placed health directly in the context of regulatory cooperation. The second mandated the direct protection of human health as a common value along with environmental enhancement and food safety.

At the second summit in Cancún, Mexico, in March 2006, held just after the ecological shock of a major hurricane had struck the resort, attention to health grew and became the object of regulatory cooperation in its own right. The leaders declared,

> The SPP provides a framework for us to advance collaboration in areas as diverse as security, transportation, the environment, and public health.…We are convinced that regulatory cooperation advances the productivity and competitiveness of our nations and helps to protect our health, safety, and environment. (SPP, 2006)

The leaders further moved proactively and preventively, mandating a major program of cooperation on avian and human influenza. A section of their joint statement, titled "Avian and Human Pandemic Influenza," declared,

> Given the highly integrated nature of our economies, an outbreak of pathogenic avian flu or human pandemic influenza in any one of our countries would affect us all.…We have endorsed a set of shared principles to underpin cooperative activities by our Governments in all stages of avian influenza and human pandemic influenza management: prevention; preparedness; response; and recovery. Pursuant to these principles, officials will develop, as an immediate priority, incident management protocols to ensure that we are well prepared in advance of an outbreak in North America. (SPP, 2006)

This move on pandemic preparedness was not surprising. Following the first SPP summit, at the September 2005 United Nations General Assembly there was a renewed commitment to collaborate on preventing an influenza pandemic. U.S. President George W. Bush announced the establishment of the International Partnership on Avian and Pandemic Influenza. Also, after returning from a November 2005 Asia-Pacific Economic Cooperation (APEC) meeting in Korea, Canadian Prime Minister Paul Martin, with the experience of SARS still fresh in his mind, was alarmed to hear how Asian countries were dealing with the issue of avian influenza –by simply doing nothing and allowing infected poultry to be sold. He requested that Canada convene a ministerial meeting to "ensure that the concerns of the world's leaders were conveyed to the World Health Organization" (Martin, 2008). In 2006 the health ministers of the Group of Eight (G8) met for the first time ever and invited Mexico to join them, thus creating another opportunity to discuss this issue.

The North American leaders (all members of APEC) thus moved from a reactive discussion to a proactive approach to a third shock that was rising in Asia and had not –but could– strike North America. They developed regional governance in public health, through trilateral institutionalization from the top. They were supported by other, more global bodies.

The three countries largely complied with their SPP public health commitments from 2006. In August 2007 the North American pandemic plan was released (SPP, 2007b). It outlined how Canada, Mexico, and the U.S. would work together to combat an outbreak of avian influenza or an influenza pandemic in North America. The plan complemented national emergency management plans. It built upon the core principles of the International Partnership on Avian and Pandemic Influenza, the standards and guidelines of the World Organization for Animal Health and the WHO guidelines, including the revised International Health Regulations and the rules and provisions of NAFTA and the World Trade Organization. While it thus reinforced broader efforts, the plan made clear that regional cooperation and convergence in health were required, since multilateralism was not enough to protect vulnerable North Americans from the particular threats they faced from abroad.

At the 2007 SPP summit in Montebello, Quebec, the leaders' attention to and action on health increased again. The summit agenda broadened substantially, with the old subject of health in general, and avian and pandemic influenza in particular, now joined by many newcomers: chemicals, automotive emissions, energy use, intellectual property, border screening, and indigenous health issues (including suicide prevention, fetal alcohol spectrum disorder, diabetes, and indigenous health systems). Health became a pervasive, crosscutting value and concern. It had grown from a general topic, through a specific concern with high-profile diseases, to embrace several specific industrial sectors and instruments, security, chronic diseases, and health systems as a whole.

Montebello also marked a major normative advance. Health was no longer framed only within a biomedical model (disease protection) or as an economic determinant (the connection between health and trade, agriculture, or food). Montebello added the securitization of health in the form of border screening. Although it did not suggest health was a human right, it moved tentatively into the domain of redistribution and equity by emphasizing the need to protect the health of particularly vulnerable and dispossessed groups (for example, indigenous health).

The leaders again called for regulatory cooperation on health, now due to the competitive pressures on North America from abroad. The section titled "Enhancing the Global Competitiveness of North America" stated that "in this highly competitive environment, compatible regulations and standards enable us to protect health,

safety, and the environment, as well as to facilitate trade in goods and services across our borders" (SPP, 2007a). A new principle of regional regulatory health cooperation for global competitiveness was thus produced.

In the realm of commitments, the leaders noted that their three countries had completed a North American Plan for Avian and Pandemic Influenza, a Regulatory Cooperation Framework, and an Intellectual Property Action Strategy. The latter sought to avoid negative impacts on health while developing collaborative measures to improve the detection and deterrence of counterfeiting and piracy, expanding public awareness of the importance of intellectual property to the three economies and for consumer health and safety, and measuring the scope and magnitude of counterfeiting and piracy in North America more effectively, as well as developing best practices for enforcement and sharing information and intelligence on border enforcement techniques.

In the section titled "Protecting Our Environment, Health and Quality of Life," the leaders reported that in order to "raise the health status of indigenous people" their countries had exchanged information and research on various health issues, "including suicide prevention, Fetal Alcohol Spectrum Disorder, diabetes, and indigenous health systems" (SPP, 2007a). The joint statement also declared that Mexico had started a program to increase the supply of low-sulphur fuels in the country to "protect the environment, enhance health of people and promote the competitiveness of the automotive industry." The proactive desire to improve human health thus led to trilateral regulatory convergence in the automotive, energy, and environmental areas. It also extended to border issues: the section on "Smart and Secure Borders" stated a desire to develop "mutually acceptable approaches to screening people during a pandemic."

The summit's top-down development of regional health governance now reached into the ministerial domain. The statement noted, "Our ministers of industry and commerce, foreign affairs, security, environment, energy, health, transportation, and trade have also met in recent months, reflecting our deepening dialogue within North America" (SPP, 2007a). The health shock from Asia, in the form of tainted toothpaste and food from China, probably propelled these moves.

In 2008, when the leaders met at another site still recovering from the devastation of a recent hurricane –New Orleans– they again dealt with health, if less so than in the two previous years. This suggested that Mexico and Canada as hosts, more than George W. Bush's United States, were driving summit action on health. The joint statement declared an intention "to implement compatible fuel efficiency regimes and high safety standards to protect human health and the environment, and to reduce the costs of producing cars and trucks for the North American mar-

ket". It added, "To improve our citizens' access to safe food, and health and consumer products in North America, we are increasing cooperation and information sharing on the safety of food and products" (SPP, 2008). With the fear of avian influenza waning, autos, energy, and food were the three health subjects of concern.

The countries were now using high standards and improved access for health ambitiously through compatible regimes on auto and fuels, and less far-reaching cooperation and information sharing on food and product safety. This new agenda and its principles were likely driven by three shocks hitting a more equally vulnerable North America from overseas. The first was lead poisoning in toys (as well as questionable milk products) from China. The second was rising food prices around the world. The third was the historically high price of North American oil and gas in the summer of 2008.

The Swine Flu Shock, 2009

Influenza A(H1N1) broke out in April 2009. From the outset, it was clearly seen as a major North American problem. On April 24, the U.S. and Mexico simultaneously reported cases. That same day, the WHO commended the U.S. and Mexico for their proactive reporting and for their collaboration on the matter. The WHO declared that it would work with the health authorities in the NAFTA countries in order to better understand the risks of H1N1 (WHO, 2009a). A mere three days later, the outbreak had spread to the third NAFTA member: on April 27, all three NAFTA partners reported cases of H1N1, with 40 cases confirmed in the U.S., 6 in Canada and 26 in Mexico, where 7 people had already died as a result (WHO, 2009b). By May 1, H1N1 had gone global, with 13 countries reporting cases. But it was still North America that was the cause for most concern. Of the 367 reported cases, 90 percent were in North America. All 10 deaths that had resulted had occurred in Mexico and the United States (WHO, 2009c).

North American citizens paid close attention to H1N1. In a poll conducted in the United States on April 29, 2009, 73 percent of respondents said they were following swine flu news closely or somewhat closely; 44 percent said they were concerned that they or someone in their immediate family would contract the influenza within the year; 25 percent said that they had avoided places where large numbers of people gather; 59 percent said they were washing their hands or using hand sanitizer more often (Harvard School of Public Health, 2009).

By early July, the shock had escalated immensely. The number of H1N1 cases reported in North America reached 52 147 (more than half the total number of cases worldwide) (WHO, 2009d). There were 7 983 cases in Canada, 10 262 in Mexico, and

33 902 in the United States. The total number of H1N1 deaths in North America was 314 (almost three-quarters of the total worldwide): 25 in Canada, 119 in Mexico and 170 in the United States. In response to the escalating pandemic, Mexico hosted an international meeting on H1N1 at the beginning of July. All three North America ministers of health attended, along with Margaret Chan, the director general of the WHO. Once again, the WHO commended Canada, Mexico, and the United States on their coordination and leadership. Chan stated that the "WHO and the international community have much to thank these three countries for setting a precedent that, up to now, nearly every country has followed" (2009).

A poll at the end of July indicated that Canadians and Americans were still paying close attention to news related to swine flu (70 percent in Canada and 75 percent in the United States) (Angus Reid Strategies, 2009). It found that 42 percent of Canadians and 52 percent of Americans (slightly more than in April) were worried about personally contracting swine flu. Fifty-five percent of Canadian respondents and 59 percent of American respondents were worried about a friend or family member being infected. Both groups, however, were satisfied with the way their respective governments were responding to the H1N1 pandemic: 71 percent of Canadians said they were very or moderately satisfied, and 68 percent of Americans agreed that their government was taking the necessary approach. In contrast, in the United Kingdom, only 52 percent of respondents were very or moderately satisfied with their government's response. Within North America, the immediate intense trilateral cooperation had thus secured strong societal support.

On August 6, the WHO (2009f) reported that there were 102 905 (out of a total 177 457) confirmed cases in the Americas and that 1 274 of the 1 462 deaths had occurred in the region.[1] It was an obvious cause for concern and discussion when NAFTA leaders met in Guadalajara three days later for their now renamed North American Leaders' Summit (NALS).

Health was indeed one of the major themes discussed at this summit. By mid-July, U.S. Secretary of State Hillary Clinton had announced that the leaders would discuss it as well as security, economic, and trade policy and regional challenges at their meet (Kellerhale, 2009). But it was health and the environment that dominated their agenda at Guadalajara, with separate declarations on each (NALS, 2009b and 2009c). At the end of the summit, Obama underscored the three countries' willingness and need to cooperate on the matter: "In response to the H1N1 pandemic, our three governments have worked closely, collaboratively, and responsibly. With sci-

[1] By the end of July, the WHO had stopped reporting the breakdown of H1N1 by country and moved to regional updates (2009d, 2009f, and 2010).

ence as our guide, we resolved to continue taking all necessary preparations and precautions to prepare for the upcoming flu season and protect the health of our people. And this challenge transcends borders, and so must our response" (White House, 2009).

The declaration on H1N1 affirmed the strong trilateral connection among the three countries. And in concluding, the three leaders identified the benefit and importance of working together: "We know that cooperation and communication between nations, governments, citizens, and domestic and international organizations are the most effective ways to ensure that we are all protected. The strong collaboration between our countries allowed us to have a more secure North America region" (NALS, 2009c).

Cooperation and convergence on health were thus highlighted at Obama's first North American summit. The three countries have engaged in self-congratulation, but their efforts have also been commended by the global community. Health received a huge amount of attention, with all three countries acknowledging the need to collaborate in the face of H1N1. All three were hit hard by the pandemic and, with no clear end in sight, the leaders correctly identified that, by working together, they would be much better off than if they were to forge ahead alone.

This collaboration continued after the August 2009 summit. The GHSI held a special ministerial meeting on H1N1 September 10 and 11, before gathering again to discuss the issue at their annual meet in December. As with the previous North American health shocks, the GHSI once again brought together individuals from the North American community and beyond to deliberate and coordinate on this health crisis (GHSI, 2009). Moreover, the new process for implementing the leaders' agreements at their trilateral summits meant that North America's health ministers would engage trilaterally in a regular, leader-guided way, at least in the near future. By November, 63 percent of Americans were still concerned that they or someone they knew would be infected, and 65 percent thought the Obama administration was doing everything it could to address the issue (Ipsos News Centre, 2009). Societal support for the trilateral response thus remained strong.

Conclusions

The shocks that highlighted the vulnerabilities of the three North American countries, reinforced by economic and security concerns, and the establishment of North American summitry played a role in moving North American cooperation on health forward (Kirton, 2007; Boin et al., 2005). Thus, the countries seem both able and willing

to cooperate on crisis health issues. However, the impact of these same factors on health challenges that do not transcend borders or that do not arise in a "shocking" fashion is less clear. For example, it is unclear whether recent trends toward regional cooperation have led to more cooperation on other issues such as U.S. healthcare reform, as might have been expected. Despite the desire by many Americans to have a healthcare system more closely resembling Canada's and Obama's recent push to reform the healthcare system, resistance remains (Blendon and Taylor, 1989; Blendon et al., 1990; Donelan et al., 1999; PollingReport, 2009). On areas such as food safety and indigenous health, the degree to which the three countries work together also remains limited. Challenges, such as food products that could be harmful to human health, like tomatoes carrying salmonella from Mexico or cattle with BSE from Alberta, could continue to result in less North American cooperation, not more. Summitry without shocks and the societal support they bring can only do so much.

However, recent health shocks like SARS and swine flu have led Canada, Mexico, and the United States to collaborate and coordinate increasingly on health. The three countries have worked together successfully to tackle the challenges. The North American governments have responded to these challenges and in doing so have recognized that going it alone on certain issues is no longer desirable. By working together first on areas where collaboration has been necessary, the North American partners may still be able to break down some of the negative perceptions that have plagued the issue of health from NAFTA's outset. Thus, even though action by the three countries on health governance has not broadened as much as their agenda has, they will be able to cooperate more easily when the right opportunity comes.

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