



'Towards a global health science policy'

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Earlier today I made a few remarks about the increasing globalisation of science from the perspective of arguably the most remote of the smaller advanced economies. There, I was trying to point out the need in addressing global science challenges to have a global view of the issues and to avoid science becoming a new tool of trans-national paternalism. I was also pointing out the risks and problems that could emerge if we do not work out mechanisms for addressing global science challenges collectively and to common standards. A number of issues stand in the way, not the least being in my personal view the lack of an effective international science coordinating system. I want to build on those earlier comments in what I say now and I emphasise that I am speaking in my personal not official capacity.

I am going to focus on an area of my own research, namely non-communicable diseases (NCDs) and in particular obesity and type 2 diabetes. My own interests have come from a life course approach thinking about the interplay of genetic, developmental, epigenetic and lifestyle factors, and thus about the conundrum of what is the appropriate balance between primary and secondary prevention, recognising the many public policy issues surrounding them.

In using this example I want to focus on silos – both disciplinary and jurisdictional. In highlighting these issues it identifies some of the challenges in moving towards global science policy from dimension of scale.

Firstly primary intervention, that is stopping people ever becoming obese, has been a much less addressed issue than dealing with people who are already obese. Secondly small countries have as much commitment and interest in these issues as big ones, and their perspective may be much more important than is readily apparent. So let me expand on these two silos.

First, the problem of disciplinary silos. In the past few years, the area of obesity has been dominated by the arguments of adult physicians and public health experts in the western world that we should focus on adult lifestyle and if necessary use the power of the State to address these. Indeed, this is highlighted in the recent *Lancet* issues and dominated in the thinking of the WHO in its report leading up to the UN High level meeting in 2011. But the reality is that there is both biological and public health evidence of the limitations of this approach, which may be even more problematic in the developing world where issues of food security dominate. But there are other and highly validated bodies of scientific

knowledge which have been largely excluded from the discourse, and there is firm evidence for a broader range of primary prevention approaches based on the biology of the life course. There is also the need for a wider research agenda to find means of secondary prevention in adult life that are effective across cultures and contexts. We all know that long-term changes in lifestyle are hard to induce. There is thus a need to find new forums and approaches that get beyond narrow perspectives and allow the integration and proper evaluation of what we know and what we do not know. These are not trivial matters, as they play into the policy perspective as to whether obesity and NCDs are seen as primarily a matter of personal responsibility or not, which in turn leads to different political positioning. There appears to have been premature closure in the minds of key sectors as to what approaches may be effective, what is the role of different players, and in particular how to manage the complex interaction between the food industry and public health, given the centrality of the food industry to the practical aspects of food supply in both the developed and developing world. There are enormous complexities and the conversation has already become very polarized. Primary and secondary prevention have been put in scientific and policy conflict with each other when they should be seen as synergistic.

Secondly, I want to address the growing challenge of research in these areas which have global implications. Clearly such research has both local and global perspectives, and given its multidimensionality and the complexities of the research needed, multinational research is important and to be encouraged. The challenge is how can and should that be coordinated? In particular, where expertise lies beyond the borders of the major research funding jurisdictions, how might that expertise be incorporated better into addressing global challenges? All said and done the highest prevalences of diabetes are in countries such as the Pacific Islands, and there is compelling evidence for different biologies across populations. This is obviously of particular interest to a country like New Zealand, which has a strong research tradition but represents a minute fraction of the global health research budget. New models may be needed to allow the more rapid incorporation of ideas from multiple sources across the globe into the major research agendas, particularly perspectives from the developing world where the challenges are greatest. Examples are appearing of new approaches and it will be important to learn from them and to find ways to expand upon them.

I applaud the EU for this initiative but I hope this example highlights some of the issues we need to address if we are to move to a more global approach to health research.

Thank you.

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