The G8 and Global Health

What now? What next?

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ABSTRACT

The policies of the G8 countries (the G7 industrialized countries plus Russia) matter for population health and the determinants of health worldwide. In the years before the 2005 Summit, relevant G7 commitments were more often broken than kept, representing an inadequate response to the scale of health crises in countries outside the industrialized world. The commitments made in 2005 by some G7 countries to increase development assistance to the longstanding target of 0.7% of Gross National Income, and by the G7 as a whole to additional debt cancellation for some developing countries, were welcome and overdue. However, Canada and the United States did not state timetables for reaching the development assistance target, and new conditionalities attached to debt relief may undermine the benefits for population health. Lack of adequate funding for the Global Fund to Fight AIDS, Tuberculosis and Malaria, even after the September 2005 replenishment meeting, is unconscionable; yet even if those funds were provided, additional resources for developing country health systems would be needed. Similarly, widespread agreement on the need for improving market access for developing country exports was not met with any concrete policy response to the "asymmetrical" nature of recent trade liberalization; neither was the need to control the deadly trade in small arms. To respond adequately to global health needs, the G8 will need to adopt an agenda that more fundamentally alters the distribution of economic and political power, within and among nations.

MeSH terms: Capitalism; socioeconomic factors; developing countries; international agencies; international health problems; international relations

La traduction du résumé se trouve à la fin de l'article.

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The G7/G8 countries (the G8 comprises the G7 industrialized countries plus Russia) account for roughly half the world's economic activity, a near-majority of the votes on World Bank and International Monetary Fund (IMF) decisions, and almost 75% of the world's development assistance spending. Their choices matter for global health. Since Canada hosted the G8 Summit at Kananaskis in 2002, further evidence has accumulated that millions of lives could be saved per year in the developing world – most spectacularly in sub-Saharan Africa – if demonstrably effective medical and public health interventions (such as improved nutrition and access to safe drinking water, primary health care and essential medicines) were scaled up and made widely available.¹⁻⁴ A comparable evidence base shows the need to address the larger set of multiple vulnerabilities associated with poverty and economic insecurity.^{3,5,6}

In the years before the 2005 Summit at Gleneagles, Scotland, the G7's repeated promises of assistance were more often broken than kept, and represented an inadequate response to the scale of health crises in countries outside the industrialized world.⁷⁻⁹ The 2005 Summit attracted unprecedented media attention, and featured extensively publicized pledges of aid and debt relief for poor, primarily African countries. We provide a brief 'report card' on the global health implications of the Summit, with special emphasis on Africa and Canada's performance and responsibilities post-Gleneagles, starting with the question: were the highly publicized Summit commitments on African debt and development assistance the success many are claiming?

Modest progress: Debt and development assistance

Two recent intensive studies^{3,4} concluded that approximate doubling of development assistance to Africa is necessary, although not sufficient, for recipient countries to have a chance of meeting the Millennium Development Goals (MDGs) endorsed by the United Nations General Assembly in 2000 (see Appendix, pg. 31 of this issue) – even though these goals are modest when measured against the scale of global need,¹⁰ and pay insufficient attention to intra-national issues of equity.¹¹ At Gleneagles, the G8 committed to increasing develop-

ment assistance to Africa by US \$25 billion by 2010, driven primarily by the pledge of the European Union (EU) to raise its members' aid spending to the longstanding United Nations target of 0.7% of each industrialized country's Gross National Income (GNI).¹² The commitment was welcome and overdue. Conversely, Canada, Japan and the United States conspicuously did not specify timetables for reaching the 0.7% target. Doing so would now cost the Canadian treasury about \$6 billion a year, a small fraction of the annual value of federal income tax cuts over the past few years¹³ – a clear indication that higher levels of Canadian financial commitment are readily affordable.

Development assistance is not a panacea. Pre-Summit debate underscored the importance of such longstanding issues as “absorptive capacity,” diversion of funds, failure to target aid on meeting basic needs, and lack of coordination among donor agencies, programs and non-governmental organizations.^{3,14} The appropriate response is not, however, to reject increased aid but to learn from past experiences and good examples while recognizing that, even under favourable economic and political assumptions, most sub-Saharan countries (for instance) will require substantial inflows of aid through 2015 and beyond if they are to achieve the MDGs.¹⁵

Perhaps the most serious constraint on aid's effectiveness is that in most regions of the world, the value of annual debt service payments consistently exceeds the amount developing countries receive in development assistance – a problem that has been recognized for almost 20 years as undermining developing countries' ability to meet basic needs, with destructive health consequences.^{16,17} Between 1970 and 2002, African countries borrowed \$540 billion, paid back \$550 billion and still owe \$295 billion¹⁸ – creating a situation in which Africa spends 2–4 times as much each year on debt servicing as on health and education, which UNAIDS executive director Peter Piot calls “the building blocks of the AIDS response.”¹⁹

The Gleneagles commitment to US \$40 billion in multilateral debt cancellation for 18 poor countries, with a chance for 20 more countries to receive another US \$16 billion in debt cancellation,¹² is therefore welcome. At the same time, the commit-

ment applies only to a limited number of countries once they reach their “completion point” in the World Bank/IMF Heavily Indebted Poor Countries (HIPC) initiative. That initiative has freed up funds for public spending on health and education,²⁰ but has been criticized for making debt relief conditional on adopting a variety of market-oriented economic policies that have only a tenuous relation to poverty reduction.^{17,21}

Disturbingly, new conditionalities appear to be in the offing. A new, separate partial debt cancellation deal for oil-rich Nigeria required acceptance of “intensive surveillance of its economy by the International Monetary Fund”.²² IMF representatives of several European countries are reportedly seeking “strict controls” over the economic policies of the 18 countries now eligible for full debt cancellation under the G8 plan,²³ and the World Bank has expressed concern that the plan “offered no mechanism for suspending debt relief if a debtor country deviated from economic and social reforms” prescribed by it and the IMF.²⁴ Further, many countries that are not part of HIPC will nevertheless require substantial debt relief if they are to attain the MDGs.²⁵ Finally, the 2005 Summit continued a longstanding refusal to address the question of whether ‘odious debts’ incurred by highly repressive or corrupt governments (e.g., those of Zaire under Mobutu, Kenya under Moi, South Africa pre-1994 and Nigeria pre-2002) should be regarded as uncollectable under international law.

But still dropping the ball: Health systems and trade

Publicity for modest progress on debt and aid diverted attention from areas where the G8 was less successful, most conspicuously in the continuing inadequacy of their financing for the Global Fund to Fight AIDS, Tuberculosis and Malaria. The Fund, hailed by the G8 in 2001 as “a quantum leap in the fight against infectious diseases,” estimates that it will need US \$7.1 billion in 2006 and 2007 to fund new proposals and continuations of existing work,²⁶ but at the time of the Summit had received pledges of just US \$1.45 billion.²⁷ The G8 said nothing about this gap beyond a vague promise to “work to meet the financing needs for HIV/AIDS,

including through the replenishment this year of the Global Fund,”²⁸ and the subsequent September 2005 replenishment meeting only increased the Fund's budget for 2006–2007 to US \$3.7 billion – just over half the amount needed.²⁸ The G7's unwillingness to provide the modest resources needed for the Fund's programs is remarkable in view of the literally millions of preventable deaths that occur each year from HIV/AIDS, tuberculosis and malaria.^{5,6} Yet even if those funds were provided, more and different resources would be needed. ‘Vertical,’ disease-specific programs are no substitute for multi-year commitments to provide budget support for health systems that are essential to delivering such programs and offering primary health care. Thus, new funding is needed in amounts several times the current amount of development assistance for health, of which support for the Global Fund is and should be only a part.²⁹

A less conspicuous but equally destructive policy failure involves trade. The G8 insist that “drawing the poorest countries into the global economy is the surest way to address their fundamental aspirations.”³⁰ Development policy protagonists who disagree about much else agree that improved market access for developing country exports is crucial for poverty reduction and its associated health benefits. The research literature and many developing country governments attach special importance to eliminating agricultural subsidies that lower world prices and limit developing country export opportunities.^{4,7,8} Two years have elapsed since industrialized country intransigence on this point led to the collapse of trade talks at Cancún, yet the G8 had nothing specific to offer beyond a vague promise to reduce or eliminate such subsidies “by a credible end date.”¹² Although some analysts question the importance of agricultural subsidies,³¹ it is widely acknowledged that the process of trade liberalization has been highly “asymmetrical” in its impacts and benefits for industrialized and developing countries.^{32,33} Indeed, many developing countries have destroyed domestic industries, such as textiles and clothing in Zambia³⁴ and poultry in Ghana,³⁵ by lowering trade barriers and accepting the resulting social dislocations as the price of global integration.

The G8 claimed at Gleneagles that “it is up to developing countries themselves and their governments ... to decide, plan and sequence their economic policies to fit with their own development strategies.”¹² One specific mechanism that could facilitate this process involves strengthening provisions for special and differential treatment (SDT) of developing economies in international trade agreements.³⁶ Although SDT received strong support from the UK Commission for Africa,⁴ it was not specifically addressed at the Summit, and G8 members are reportedly reluctant to support strengthening such provisions in World Trade Organization negotiations.³⁷

The arms trade demands special policy attention. Recent research suggests that the consequences of the trade in small arms are even more deadly than was previously thought.³⁸ In 1999 and 2000, the G8 made vague comments about the need to “exercise restraint” in conventional weapons trade even as two of its members – the US and Russia – saw their small arms exports to developing countries surge dramatically.³⁹ Although these exports and the overall value of the arms trade with developing countries have since declined,³⁹ the UK Commission for Africa⁴ noted that “many of the largest manufacturers, exporters and brokers of arms to Africa are to be found in the G8 and EU countries” and urged “as a matter of priority... negotiations on an international Arms Trade Treaty” including “more effective and legally-binding agreements on arms brokering.” At Gleneagles, the G8 committed financial and technical assistance to African peacekeeping efforts in conflict zones, and devoted six pages of commitments to nuclear and biological weapons, yet all they could muster for small arms control was recognizing “the need for further work to build a consensus for action.”¹²

What to expect from the G8?

Can the G8 play a leadership role in global health? The institution originated in an attempt to restore the profitability of private investment after a series of economic crises in the 1970s,⁴⁰ and like any club that operates on a *de facto* unanimity rule, at least at Summits the G8 is limited by its most recalcitrant member – currently the United States. But we should not let the G8 or its member countries off so easily.

The single most disturbing statement from Gleneagles is: “Further progress in Africa depends above all on its own leaders and its own people.”¹² This can be read as a welcome retreat from paternalism, including the paternalism embodied in the celebrity-backed “Make Poverty History” campaign leading up to the Summit. It can also be read as an abdication of responsibility for the damaging legacy of colonialism^{3,4} and for subsequent obstacles to improving population health in the developing world created by market-oriented economic policies and retreats from social provision. The context for those policies was created both by conditions attached to loans from the World Bank and IMF, and by the ‘softer’ conditionality of creating an investor-friendly environment in an era of hypermobile capital.^{7-9,17} Consequently, the choices available to African political leaders – even those with good intentions and genuine popular support – often have been limited by constraints entirely outside their control.

Gleneagles may set a precedent in terms of the G8’s debt and aid promises, which demand critical evaluation and careful monitoring. Caution is in order, however, about the benefits that can be anticipated from incremental change, so long as the G8’s policy priorities continue to reflect the economic and political interests of the world’s rich minority. Taking global health seriously means replacing the G8 agenda with one that more fundamentally alters the present distribution of economic and political power, within and among nations.

REFERENCES

- Jha P, Mills A, Hanson K, Kumaranayake L, Conteh L, Kurowski C, et al. Improving the health of the global poor. *Science* 2002;295:2036-39.
- Wagstaff A, Claeson M, [AUTHOR - provide up to 6 names, plus «et al.» for any more than 6 - Ed.] et al. *The Millennium Development Goals for Health: Rising to the Challenges*. Washington, DC: World Bank, 2003. Available online at: http://www1.worldbank.org/hnp/MDG/MDGE_SW.pdf (Accessed on February 18, 2005).
- UN Millennium Project. *Investing in Development: A Practical Plan to Achieve the Millennium Development Goals*. London, UK: Earthscan, 2005. Available online at: http://unmp.forumone.com/eng_full_report/TF1mainreportComplete-highres.pdf (Accessed on February 1, 2005).
- Our Common Interest: Report of the Commission for Africa*. London: Commission for Africa, March 2005. Available online at: http://www.commissionforafrica.org/english/report/thereport/english/11-03-05_cr_report.pdf (Accessed on July 14, 2005).
- Bates I, Fenton C, Gruber J, Lalloo D, Medina Lara A, Squire SB, et al. Vulnerability to malaria, tuberculosis, and HIV/AIDS infection and disease. Part I: Determinants operating at individual and household level. *Lancet Infect Dis* 2004;4:267-77.
- Bates I, Fenton C, Gruber J, Lalloo D, Medina Lara A, Squire SB, et al. Vulnerability to malaria, tuberculosis, and HIV/AIDS infection and disease. Part II: Determinants operating at environmental and institutional level. *Lancet Infect Dis* 2004;4:368-75.
- Labonte R, Schrecker T, Sanders D, Meeus W. *Fatal Indifference: The G8, Africa and Global Health*. Cape Town, South Africa: University of Cape Town Press/IDRC Books, 2004.
- Labonte R, Schrecker T. Committed to health for all? How the G7/G8 rate. *Soc Sci Med* 2004;59:1661-76.
- Labonte R, Schrecker T. *The G8, Africa and Global Health: A Platform for Global Health Equity for the 2005 Summit*. London: Nuffield Trust, 2005. Available online at: <http://www.nuffieldtrust.org.uk/ecomm/files/G8%20Book.pdf> (Accessed on July 14, 2005).
- Pogge T. The First United Nations Millennium Development Goal: A cause for celebration? *J Hum Develop* 2004;5:377-97.
- Gwatkin D. *Who would gain most from efforts to reach the Millennium Development Goals for health? Health, Nutrition and Population (HNP) Discussion Paper*. Washington: World Bank, 2002.
- Official statements and communiqués from Gleneagles (and all previous Summits) are available on the web site of the University of Toronto G8 Research Group, <http://www.g7.utoronto.ca>.
- Canada Department of Finance. *The Budget Plan 2003* [Table A1.9]. Ottawa, ON: Department of Finance, 2003. Available online at: <http://www.fin.gc.ca/budget03/pdf/bp2003e.pdf> (Accessed on July 14, 2005).
- deRenzio P. *Scaling up versus absorptive capacity: Challenges and opportunities in reaching the MDGs in Africa*, ODI Briefing Paper. London: Overseas Development Institute, May 2005. Available online at: http://www.odi.org.uk/publications/briefing/bp_may05_absorptive_capacity.pdf (Accessed on June 27, 2005).
- Sachs JD, McArthur JW, Schmidt-Traub G, Kruk M, Bahadur C, Faye M, et al. Ending Africa’s poverty trap. *Brookings Papers on Economic Activity* 2004;117-240.
- Cornia GA, Jolly R, Stewart F (Eds.). *Adjustment with a Human Face*, vol. 1: *Protecting the Vulnerable and Promoting Growth*. Oxford: Clarendon Press, 1987.
- Cheru F. *Economic, Social and Cultural Rights: Effects of structural adjustment policies on the full enjoyment of human rights*, E/CN.4/1999/50. Geneva, Switzerland: Office of the United Nations High Commissioner for Human Rights, February 24, 1999. Available online at: <http://www.unhcr.ch/Huridocda/Huridoca.nsf/TestFrame/f991c6c62457a285802675100348ae?Opendocument> (Accessed on February 18, 2005).
- United Nations Conference on Trade and Development. *Economic Development in Africa — Debt Sustainability: Oasis or Mirage?* New York and Geneva: United Nations, 2004.
- Piot P. Plenary Address for Closing Ceremony, XV International AIDS Conference: Getting Ahead of the Epidemic. Geneva: UNAIDS, July 16, 2004. Available online at: <http://www.unaids.org> (Accessed on February 18, 2005).
- Gupta S, Clements B, Guin-Siu MT, Leruth L. Debt relief and public health spending in heavily indebted poor countries. *Bulletin of the World Health Organization* 2002;80:151-57.

21. Brock K, McGee R. *Mapping Trade Policy: Understanding the Challenges of Civil Society Participation*, IDS working paper 225. Brighton, Sussex: Institute for Development Studies, 2004. Available online at: <http://www.ids.ac.uk/ids/bookshop/wp/wp225.pdf> (Accessed on February 18, 2005).
22. Elliott L, Wintour P. Biggest debt rescue lifts Nigeria's \$31bn burden. *Guardian Weekly*, July 8-14, 2005:11.
23. Europe tries to dilute G8 debt relief deal. *Mail & Guardian On-Line*, July 16, 2005. Available online at: http://www.mg.co.za/articlePage.aspx?articleid=245576&area=/breaking_news/breakingnewsafrika/ (Accessed on August 2, 2005).
24. World Bank Report Calls for Changes to G8 Debt Plan. *New York Times*, August 3, 2005 (online).
25. Pearce C, Greenhill R, Glennie J. *In the Balance: Why Debts Must be Cancelled Now to Meet the Millennium Development Goals*. London: Jubilee Debt Campaign, May 2005. Available online at: <http://www.makepovertyhistory.org/docs/inthebalance.pdf> (Accessed on July 13, 2005).
26. Benn C, Schwartlander B. *The Resource Needs of the Global Fund 2005-2007*. Geneva: Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria, February 2005. Available online at: http://www.theglobalfund.org/en/files/about/replenishment/resources_report_en.pdf (Accessed on July 14, 2005).
27. Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria. *Pledges and Contributions to the Global Fund*. Available online at: <http://www.theglobalfund.org/en/files/pledges&contributions.xls> (Accessed on July 14, 2005).
28. Global Fund Receives Pledges of US \$3.7 Billion for 2006-2007 [press release]. Geneva: Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria, September 6, 2005. Available online at: http://www.theglobalfund.org/en/media_center/press/pr_050906.asp (Accessed on October 2, 2005).
29. Commission on Macroeconomics and Health. *Macroeconomics and Health: Investing in Health for Economic Development*. Geneva: World Health Organization, 2001. Available online at: <http://www.cid.harvard.edu/cidcmh/CMHReport.pdf> (Accessed on October 2, 2005).
30. G8 Communiqué, Genoa, Italy, July 22, 2001. Available online at: <http://www.g8.utoronto.ca/submit/2001genoa/finalcommuniqué.html> (Accessed on February 18, 2005).
31. Birdsall N, Rodrik D, Subramanian A. How to help poor countries. *Foreign Affairs* 2005;84(4):136-52.
32. Birdsall N. A stormy day on an open field: Asymmetry and convergence in the global economy. In: Gruen D, O'Brien T, Lawson J (Eds.), *Globalisation, Living Standards and Inequality: Recent Progress and Continuing Challenges*. Proceedings of a Conference held in Sydney, 27-28 May 2002. Canberra, Australia: Reserve Bank of Australia, 2002;37-65. Available online at: <http://www.rba.gov.au/PublicationsAndResearch/Conferences/2002/> (Accessed on July 14, 2005).
33. Chang H-J. *Kicking Away the Ladder: Development Strategy in Historical Perspective*. London: Anthem Press, 2002.
34. Jeter J. The dumping ground: As Zambia courts western markets, used goods arrive at a heavy price. *Washington Post*, April 22, 2002:A1.
35. Atarah L. *Playing Chicken: Ghana vs. the IMF*. Oakland, CA: Corporate Watch, June 14, 2005. Available online at: <http://www.corpwatch.org/article.php?id=12394> (Accessed on July 14, 2005).
36. Garcia FJ. Beyond Special and Differential Treatment. *Boston College International and Comparative Law Review* 2004;27:291-317.
37. S&D proposals need redrafting, clarification, [WTO] members say. *Bridges Weekly Trade News Digest* 2005;9(22), June 22. Available online at: <http://www.ictsd.org/weekly/05-06-22/story2.htm> (Accessed on July 14, 2005).
38. Graduate Institute of International Studies, Geneva. *Small Arms Survey 2005: Weapons at War*. Oxford: Oxford University Press, 2005. Excerpts available online at: http://www.small-armssurvey.org/publications/yb_2005.htm (Accessed on July 14, 2005).
39. Grimmer RF. *Conventional Arms Transfers to Developing Countries, 1996-2003*. Washington, DC: Congressional Research Service, Library of Congress, August 26, 2004. Available online at: <http://www.fas.org/man/crs/RL32547.pdf> (Accessed on July 14, 2005).
40. Webb M. The Group of Seven and political management of the global economy. In: Stubbs R, Underhill G (Eds.). *Political Economy and the Changing Global Order*, 2nd ed. Don Mills, ON: Oxford University Press Canada, 2000;141-51.

RÉSUMÉ

Les politiques des pays du G8 (les pays industrialisés du G7 plus la Russie) importent pour la santé de la population et les déterminants de la santé dans le monde entier. Au cours des années qui ont précédé le Sommet de 2005, les engagements pertinents du G7, plus souvent brisés que tenus, ont constitué une réponse insuffisante face à l'ampleur des crises sanitaires qui sévissent dans les pays hors du monde industrialisé. Certains pays du G7 se sont engagés en 2005 à accroître leur aide au développement pour qu'elle atteigne enfin la cible de 0,7 % du revenu national brut, et l'ensemble du G7 a résolu d'annuler une portion supplémentaire de la dette de certains pays en développement. Ces engagements ont été bien accueillis, et on les attendait depuis longtemps. Toutefois, ni le Canada, ni les États-Unis n'ont publié d'échéancier à l'égard de leur objectif d'aide au développement, et les nouvelles conditions qui se rattachent à l'allègement de la dette pourraient en réduire les avantages pour la santé de la population. Le financement insuffisant du Fonds mondial de lutte contre le sida, la tuberculose et la malaria, même après la réunion de réapprovisionnement de septembre 2005, choque la morale; pourtant, même si les fonds étaient octroyés, les systèmes de santé des pays en développement auraient besoin de ressources supplémentaires. De même, bien que l'on se soit entendu sur la nécessité d'améliorer l'accès des pays en développement aux marchés pour leurs exportations, cela ne s'est accompagné d'aucune politique concrète pour remédier au caractère asymétrique de la libéralisation récente des échanges. On n'a pas non plus jugé nécessaire de limiter le commerce mortel des armes de petit calibre. Pour répondre adéquatement aux besoins mondiaux en matière de santé, le G8 devra adopter un plan d'action qui modifie fondamentalement la répartition des pouvoirs économiques et politiques à l'intérieur des pays et entre eux.