



“The Best of Times, the Worst of Times?”

The G8 and Prospects for a Global Health Ethic

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Prepared for “Making Sense of a Pluralist World”

Sixth Pan-European Conference on International Relations

University of Turin, Italy September, 2007

Introduction: Why the G8?

In 2001, colleagues and I¹ began the first normative ‘report card’ on the G7/G8² and global health (Labonte et al., 2004; Labonte & Schrecker, 2004). The focus was and remains justified for at least two reasons. First, the G8 countries “account for 48% of the global economy and 49% of global trade, hold four of the United Nations’ five permanent Security Council seats, and boast majority shareholder control over the International Monetary Fund (IMF) and the World Bank” (G8 Research Group, 2005: 5). They provide roughly 75 percent of the world’s development assistance; their deep pockets, organizational resources and

¹ This paper draws on findings from several years of research collaboration with Ronald Labonte and David Sanders, and I am indebted as well to many members of the Globalization Knowledge Network of the WHO Commission on Social Determinants of Health. All views expressed, however, are exclusively my own.

² The Russian Federation achieved partial membership of the Group of 7 industrialized countries, making it the G8, in 1998 and full membership in 2003. However, Russia still does not participate in the periodic meetings of finance ministers that have become an important element of the Group’s activities, achieved partial membership in the group in 1998, and full membership in 2003. Thus, some references in this paper are to the G7, as appropriate in the context.

superior bargaining power provide them with formidable advantages in trade negotiations and dispute resolution proceedings; and firms located within their borders are the primary sources of outward foreign direct investment (FDI). The decisions their governments make, individually and jointly, have unavoidable impacts on literally billions of people outside their own borders, whether or not those impacts are intended. Second, although the G8 came into existence (as the G6) in response to a number of shocks in the international environment and initially had a narrow focus on macroeconomic policy coordination, annual Summits and periodic ministerial meetings – in particular, meetings of finance ministers – have emerged as important in a variety of social and economic policy fields. According to John Kirton, a leading academic observer of the G8, Summits “have value in establishing new principles in normative directions, in creating and highlighting issue areas and agenda items, and in altering the publicly allowable discourse used” (Kirton et al., 2006: 3). Acknowledging both the dominant role of the G8 in the global economy and the function of Summits as “the only forum where heads of the major governments routinely meet” (Collier, 2007: 13), Paul Collier presents his recent and important book *The Bottom Billion* as nothing less than a development policy agenda for the G8.

Health issues have become an established element of the international community’s frame of reference. In 2000, the United Nations General Assembly’s support for the Millennium Development Goals (MDGs) represented unprecedented agreement on a specific development agenda. Three of the MDGs are explicitly health-related, and four other directly address crucial social determinants of (ill) health. The MDGs have numerous shortcomings as policy objectives (Pogge, 2004; Moser et al., 2005; Gwatkin, 2005), yet have the merit of recognizing at least implicitly “that many of the most devastating problems that plague the daily lives of billions of people are problems that emerge from a single, fundamental source: the consequences of poverty and inequality” (Paluzzi & Farmer, 2005: 12). Also in 2000, the G8 took the lead in establishing the Global Fund to Fight AIDS, Tuberculosis and Malaria in recognition of the need for new resources to address those diseases, and for a new way of delivering those resources. Acknowledging that health outcomes are affected by much more than access to health care (Evans & Stoddart, 1990; Marmot, 2006), in 2005 the World Health Organization established a multinational Commission on Social Determinants of Health (http://www.who.int/social_determinants/en). The Commission’s interim statement will have

been released by the time of the Turin conference, although the longer term impact of its activities obviously remains to be seen.

The 'report card' work initially addressed commitments made at the 1999 through 2001 Summits, although subsequent publications updated the analysis to include the 2005 Summit at Gleneagles, which arguably represented a high point in terms of G8 interest in development issues (Labonte & Schrecker, 2005; Labonte et al., 2005; Labonte & Schrecker, 2006; Schrecker et al., 2007; Labonte & Schrecker, 2007a). We first considered the extent to which G8 countries had lived up to their Summit commitments. However, we examined not only commitments that directly referred to health, but also commitments in a variety of other policy fields that affect social determinants of health. These included education and nutrition; development assistance; trade policy and market access; macroeconomic policy and poverty reduction; and debt relief. Furthermore, we examined not only the extent to which the G8 had fulfilled or complied with their commitments, but also the *adequacy* of those commitments when measured against the nature and scale of unmet needs and with the *appropriateness* of commitments, based on what is known about influences on health outcomes. In other words, we were and are concerned not only with whether the G8, individually and collectively, have done what they said they would do but also with whether they committed themselves to doing enough, and what the evidence indicates is necessary.

Globalization, development and health

Like studying social determinants of health in general, describing the health implications of Summit commitments and G8 policies outside the health care field is methodologically demanding (Labonte & Schrecker, 2007b). It requires simultaneously 'working backward' from what is known about the elements of daily life that increase probability of illness or injury, and 'working forward' from different bodies of evidence relevant to how policy choices and dynamics at the national and international level influence those elements. A valuable schematic is provided by Diderichsen et al. (2001: 14), who categorize pathways leading from social context to disparities in health outcomes with reference to "four main mechanisms – social stratification, differential exposure, differential susceptibility, and differential consequences" and draw specific attention to how stratification is a function of

“those central engines in society that generate and distribute power, wealth and risks” (Diderichsen et al., 2001: 16).

One of the strongest “engines” is transnational economic integration (‘globalization’): societies rich and poor alike are becoming part of the global marketplace, in various ways and on various terms. Globalization is a fundamental (perhaps the most fundamental) element of the context for development, and influences social determinants of health through many pathways that are often interconnected (Labonte & Schrecker, 2007c). (In recognition of this fact, globalization was the topic of one of the knowledge networks set up to support the WHO Commission.) Globalization is therefore also an essential element of the context for assessing G8 commitments and policies as they affect health. Perhaps most fundamentally, debate surrounds globalization’s effects economic growth and poverty reduction. Over the long term, and with considerable variation at any given income level, richer societies are healthier (World Bank, 1993; Deaton, 2003). Both for this reason and because of the importance of poverty (however defined) as a contributor to ill health, if globalization could be shown to be reliable and effective in increasing growth rates and reducing poverty, then a strong initial presumption would exist that measures to promote globalization, such as trade liberalization, should be embraced for their health benefits (Feachem, 2001). However, the evidence that globalization contributes either to economic growth or to poverty reduction is at best equivocal, depending *inter alia* on how one assesses the extent to which national economies have been integrated into the global marketplace; how poverty is defined; and how many uncertainties about data quality one is willing to live with or overlook (Satterthwaite, 2003; Reddy & Pogge, 2005; Kawachi & Wamala, 2007). Even globalization’s enthusiasts concede that there may be substantial numbers of losers within national economies. Thus, the only responsible answer is that “the net effects of globalization on the poor can only be judged on the basis of ‘context-specific’ empirical studies” (Nissanke & Thorbecke, 2006: 1340). In other words, it depends.

Despite a long global economic boom, performance in poverty reduction has been modest. The numbers of people living poverty as measured by the either of the World Bank’s

contentious poverty lines (the so-called \$1/day and \$2/day thresholds)³ increased substantially in sub-Saharan Africa (SSA), and increased slightly worldwide when the higher of these two poverty lines is used (Figures 1 and 2). Roughly half the world's people live at or below the \$2/day income level. In some countries with the most impressive records in poverty reduction, such as Vietnam and China, rapid growth has been accompanied by major increases in economic inequality and drastic reductions in access to health care, as more reliance is placed on private (mainly out-of-pocket) financing (Bloom et al., 2002; Sepehri et al., 2003; Akin et al., 2004; Zhang & Kanbur, 2005; Akin et al., 2005; Dummer & Cook, 2007). Recent recalculations of the incidence of poverty in 11 Asian countries found that it increased substantially once out-of-pocket medical expenses were taken into account (van Doorslaer et al., 2006).⁴ In many Latin American countries, high levels of economic inequality mean that even modest redistributive programs would be more effective poverty reducers than many years of solid economic growth (Paes de Barros et al., 2002; Jubany & Meltzer, 2004; de Ferranti et al., 2004); a recent Asian Development Bank report suggests that economic inequality in many countries in that region is rising toward Latin American levels (Development Indicators and Policy Research Division, 2007). Finally, consider the warning of health economist Angus Deaton that “economic growth, by itself, will not be enough to improve population health, at least in any acceptable time. As far as health is concerned, the market, by itself, is not a substitute for collective action (Deaton, 2006).”

Even if the connection between globalization and growth were stronger, then, promoting globalization would not fulfil the commitment made by the G8 in 2001 to “make globalization work for all [their] citizens and especially the world's poor” (G8, 2001: ¶3). Once almost heretical, this perspective has now entered the mainstream of development policy discourse – notably, by way of a number of recent research syntheses and consultative

³ These define poverty with reference to incomes of US \$1 and \$2/day (in 1985 dollars, at purchasing power parity, or roughly \$1.50 and \$3.00 in today's US dollars). They were originally developed based on a number of national poverty lines, rather than on any direct relation to the actual cost of a minimal market basket of goods – one of several grounds on which they are often criticized.

⁴ The difference arises from the fact that poverty estimates in Asian countries are generally derived from surveys of household consumption, rather than from income data. Thus, a household that has borrowed or sold essential assets to finance medical care may appear from survey data to have escaped poverty, rather than sunk deeper into it.

processes. The International Labour Organization's World Commission on the Social Dimension of Globalization (2004) organized its recommendations around the idea of "fair globalization" and addressed *inter alia* the need for reform of trade, the international financial system, labour standards, and development financing. In its 2005 report the UN Millennium Project, established as an advisory body to the Secretary-General, mustered a prodigious amount of evidence to support its arguments for organizing development assistance, trade policy, and scientific research around the imperative of achieving the MDGs. Also in 2005 the multinational Commission for Africa, established by the British government as part of the lead-up to the 2005 G8 Summit, argued for similar reforms with specific reference to the development needs of sub-Saharan Africa. The Helsinki Process on Globalization and Democracy (<http://www.helsinkiprocess.fi>), a joint venture of the governments of Finland and Tanzania, has recognized the challenges presented by globalization as a starting point for its work program and generated thoughtful proposals for reform (see e.g. Helsinki Process Secretariat, ed., 2005). The United Nations Development Programme (through its annual Human Development Reports) and the Department of Economic and Social Affairs, although somewhat marginalized within the UN system, nevertheless continue to demonstrate the incomplete and unequally distributed benefits of globalization. In this they are joined by an expanding number of social scientists who concede the "asymmetrical" character not only of the distribution of globalization's benefits, but also of the ability to influence its rules and institutions (Birdsall, 2006a; Birdsall, 2006b).

Globalization is important in another way, as well. As production has been reorganized across multiple national boundaries (Dicken, 2003), genuinely global labour markets have begun to emerge; jurisdictions can be played off against one another based on labour costs and 'flexibility'; and redistributive policies are constrained by the possibility of disinvestment and capital flight. Cerny has captured this dynamic with reference to the competition state, focused on "promotion of economic activities, whether at home or abroad, which will make firms and sectors located within the territory of the state competitive in international markets" (Cerny, 2000: 136). One consequence is far-reaching redefinition of citizenship rights, which even in formal democracies are increasingly held not by individuals as members of a polity but rather by transnational corporations and players in the global financial markets. "These markets can now exercise the accountability functions associated

with citizenship: they can vote governments' economic policies in or out, they can force governments to take certain measures and not others" (Sassen, 2003: 70; see generally Sassen, 1996). A parallel development, albeit structurally related, is the infusion of the logic of the marketplace into domestic economic and social (including health) policy. Individuals and households, like sectors of national economies, are expected to 'earn their keep' in the new global environment and domestic social policy priorities reflect, at least in part, anticipated rates of return on investment. This pattern is clearly evident in Giddens' proposals to replace the welfare state with a "social investment state" (Giddens, 1998; on this trend in Canadian social policy see Jenson & Saint-Martin, 2003) and more generally in the tendency to justify targeted income support and health care policies, such as Mexico's Oportunidades program (Molyneux, 2007), in terms of their contribution to human capital. Questions about the health and future of those unable to meet the challenge of (global) competition are conveniently left aside.

The G8 and health: challenges

The assessment presented here concentrates on official development assistance (ODA), debt relief, trade policy and support for health systems. These are by no means the only areas of G8 policy that are relevant to population health, but taken together they strongly influence both the volume of resources available to meet basic health-related needs such as those related to income, nutrition and education in much of the developing world and the policy environment for meeting those needs, to the point where shortcomings in these areas are unlikely to be offset by initiatives in others.

The most immediate need is for increased resources to support national health systems (Schieber et al., 2007). Despite substantial increases in development assistance for health in recent years, health systems in low- and some middle-income countries remain drastically underfunded relative to the costs of "a rather minimal health system," estimated by the World Health Organization's Commission on Macroeconomics and Health (Commission on Macroeconomics and Health, 2001) as \$34/capita (\$40 in 2007 dollars). By comparison, per capita health spending from all sources, public and private, in countries where 1.1 billion people live is \$14 or less (World Bank Health, 2007). If they are to provide basic health care,

such countries will need to rely on external resources well into the future. The savage arithmetic has been described by Jeffrey Sachs, who chaired the both the Commission and the Millennium Project. Sachs estimates that poor sub-Saharan countries might be capable of generating US \$50 per capita in total annual public revenue. “This tiny sum must be divided among all government functions ... [T]he health sector is lucky to claim \$10 per person per year out of this, but even rudimentary health care requires roughly four times that amount Foreign aid is therefore not a luxury for African health. It is a life-and-death necessity” (Sachs, 2007). His argument is not relevant only to sub-Saharan Africa: think for example of Haiti, the poorest country in the Western Hemisphere, or Vietnam, where public sector spending on health care was just US \$4/capita as recently as 2001 (United Nations Country Team Viet Nam, 2003).

A similar arithmetic is relevant to development assistance more generally. The Commission for Africa and the Millennium Project each argued that approximate doubling of the industrialized world’s development assistance spending *circa* 2005 was needed and justified within a relatively short time frame. Each body acknowledged recurring (and legitimate) concerns about the effectiveness of aid, but emphasized *donor* policies and practices as constraints on aid effectiveness, the Millennium Project noting *inter alia* that “the notion of taking the [Millennium Development] Goals seriously remains highly unorthodox among development practitioners” *because of* a lack of financial support from the industrialized world (UN Millennium Project, 2005: 202; see also 59). If nothing else, these and related findings (see e.g. Collier, 2006a; Collier, 2006b) should have shifted the burden of proof to the aid sceptics: those who claim that improvements in health can be achieved without substantial and predictable increases in aid flows. They do, however, leave open an important (and ultimately ethical) question about the basis for determining aid’s effectiveness, which has not been addressed by the G8. While the Millennium Project emphasized the importance of using aid more effectively in support of the MDGs, the effectiveness of aid is frequently equated with its contribution to economic growth; indeed Killick (2005: 19) argues that *less* attention should be paid to the MDGs and poverty reduction, and more to “promoting the development of directly productive sectors.”

External debt has long been recognized as undermining developing countries’ ability to meet basic needs (Cornia et al., eds., 1987; Cheru, 1999), and one of the most serious

constraints on aid's effectiveness is that "dozens of heavily indebted poor and middle-income countries are forced by creditor governments to spend large parts of their limited tax receipts on debt service, undermining their ability to finance investments in human capital and infrastructure. In a pointless and debilitating churning of resources, the creditors provide development assistance with one hand and then withdraw it in debt servicing with the other" (UN Millennium Project, 2005: 35). With this observation, the Millennium Project was merely repeating numerous earlier critiques by academic researchers and civil society organizations. In every region of the developing world except sub-Saharan Africa, financial outflows in the form of debt service substantially exceed development assistance receipts – and in sub-Saharan Africa, because development assistance accounts for a larger share of many countries' budgets than in other regions, the negative impact of any outflow of funds for debt servicing is especially serious even though ODA receipts now exceed debt service payments. At the same time, debt relief does not automatically bring about increased expenditure on basic needs, although this has happened in some countries following the past decade's multilateral initiatives (Gupta et al., 2002); much else needs to happen, not least because of the relatively modest increase that even complete debt cancellation would provide in the revenues available to most governments (Schieber et al., 2007). Like increased development assistance, easing the debt burden of developing economies is best viewed as a necessary rather than a sufficient condition for improving the meeting of basic needs.

Then there is trade. Policy protagonists who disagree about much else agree that improving market access for developing country exports is indispensable for growth, poverty reduction and associated improvements in social determinants of health. 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 (Watkins & Fowler, 2002; Commission for Africa, 2005), although the actual magnitude and distribution of benefits from agricultural trade liberalization remains uncertain (Wise, 2004; Birdsall et al., 2005; McMillan et al., 2006). Within the industrialized countries agricultural subsidies are often justified in populist terms, yet they mainly benefit the richest agricultural producers and agribusiness firms (Commission for Africa, 2005: 279-284; United Nations Development Programme, 2005: 130). Both within and outside the agricultural sector, a source of special concern is the tendency of industrialized countries to

apply much higher tariffs (tariff peaks) to labour-intensive exports, which are of special importance to many developing countries, than they do to raw or semi-processed commodities (IMF Staff, 2002). The irony is bitter because some developing countries have destroyed domestic industries by opening their markets to imports, accepting the resulting social dislocations as the price of global integration (Jeter, 2002; Atarah, 2005). Curiously, the literature does not appear to include a systematic inventory of such cases – an important area for future research. Commitments either under the General Agreement on Trade in Services (GATS) or in a proliferation of bilateral and regional trade agreements may open up health care as well as services such as water and sewage treatment to private investment in a way that ‘locks in’ privatization and its associated barriers to access to services by the poor and economically insecure. And despite an interpretation of the Agreement on Trade-Related Aspects of Intellectual Property (TRIPs) that apparently preserves flexibility in response to crises such as the AIDS epidemic, it is far from clear that intellectual property rights have been removed as a barrier to ensuring access to essential medicines ‘on the ground’ in developing countries (Haakonsson & Richey, 2007; Kerry & Lee, 2007). In other words, substantial opportunities exist to reshape trade policy in a way that is development-friendly and supportive of improvements in health, but the challenges are formidable.

The G8 and health: the responses

Superficially, the G8 have responded to the need for increased aid, in the form of the Gleneagles commitment to double development assistance to Africa by 2010, a promised annual increase of \$25 billion, driven primarily by the European Union (EU). Although aid spending in 2005 increased, it included major one-off debt cancellations for strategically important and oil-rich Iraq and Nigeria. Some of the committed spending may simply offset substantial losses in tariff revenue from import liberalization by developing countries, for instance as a result of the Economic Partnership Agreements (EPAs) now being negotiated between the EU and African countries (Stevens & Kennan, 2005). The industrialized world’s overall development assistance spending in 2006 fell by 5.1 percent, and “[e]xcluding debt relief for Nigeria, aid to sub-Saharan Africa increased by only 2%,” creating “a challenge to meet the Gleneagles G8 summit commitment” in the measured words of the OECD

Development Assistance Committee (2007). Although the Gleneagles commitment was reiterated in 2007 (G8, 2007b), it remains unclear whether and how it will be met, since no specific mechanisms for mobilizing new money have yet been agreed upon.

Support for health systems represents an especially egregious policy failure given the G8's claim at the 2001 Summit that the Global Fund to Fight AIDS, Tuberculosis and Malaria would "make a quantum leap in the fight against infectious diseases and to break the vicious cycle between disease and poverty" (G8, 2001: ¶15). However the Fund is seriously underfinanced: it had only \$2.6 billion in pledges and contributions in hand for 2007 as of August of that year (Global Fund, 2007) – far below estimated resource needs of \$5.9 billion in 2007 based on the MDGs and other internationally agreed targets, with further escalation in the demand for Fund resources anticipated in future years (Banati et al., 2006). Former UN Special Envoy Stephen Lewis warns that "what is happening, in a very insidious way, is that African governments are being discouraged from asking for what they really need from the Global Fund. The word is out, and it's often reinforced by Western diplomats at country level -- don't ask for too much, because the Global Fund just doesn't have the resources." Consequently, "governments are reluctant to ask for what they really need, lest their whole proposal be turned down. They undershoot the level, in order to accommodate the G8 refusal to fund the Global Fund at the levels required" (quoted in Cook, 2006). The underfinancing problem is linked to the Fund's lack of a stable, long-term financing mechanism; it relies instead on periodic replenishment meetings where it essentially passes a hat among donors. Over the last three Summits (2005-2007), the G8 have failed to make firm commitments to changing this situation; the 2007 promise to "provide predictable, long-term additional funding in the ongoing replenishment round" (G8, 2007a) was unaccompanied by details about either amounts or mechanisms. A monitoring report promised for September 2007 may or may not address this issue.

The G8 record on debt relief is one of gradual and grudging, but consequential, response. Starting in the 1999 the G8 led the industrialized world in partially cancelling the debts of up to 40 countries, 32 of them in Africa, under the enhanced Heavily Indebted Poor Countries (HIPC) initiative. "[T]he amount of debt relief ... was determined by eligibility thresholds which (according to public statements by [International Monetary] Fund and [World] Bank officials) were based on initial analysis... and then modified to suit political

compromises amongst G7 creditors, balancing the need to include strategic G7 allies and their desire to keep costs down” (Martin, 2004: 17). Eligibility thresholds are based on a ratio of anticipated export earnings to debt service obligations; partly because of undue optimism about export performance, HIPC’s progress toward meeting basic needs and reducing debt burdens has been inadequate (United Nations Secretary-General, 2006). Many saw only modest decreases in their debt service obligations; three – Mali, Mozambique and Bolivia – actually experienced *increases* in these obligations as of 2005 (United Nations Department of Economic and Social Affairs, 2005: 148); and eligibility for debt cancellation was accompanied by the requirement that macroeconomic policies be approved by the World Bank and International Monetary Fund, creating what some observers view as a destructive reprise of earlier conditionalities aimed at integrating national economies into the global marketplace (Cheru, 2000; Cheru, 2001; Gaynor, 2005).

At Gleneagles, the G8 agreed to cancel an additional \$40 - \$56 billion of debts owed by HIPC’s to the World Bank, IMF and the concessional arm of the African Development Bank once they have reached their “completion point” under the earlier initiative. This Multilateral Debt Relief Initiative (MDRI) was welcome and overdue, yet it is incomplete and compromised. Development assistance to recipient countries will be reduced by some or all of the amount of additional debt relief provided under MDRI (Joint World Bank/IMF Development Committee, 2005; Tomitova, 2005). The shell game may enter a new round if donor countries, mainly the G8, do not fully fund the requisite levels of debt relief through the World Bank, thus reducing the budget of the International Development Association (IDA), the branch of the Bank that offers grants and below-market loans (Hurley, 2007). No mechanism exists to ensure the participation of private sector creditors in multilateral debt relief initiatives. In addition, debt relief will not be extended to many countries that are not statistically desperate enough to qualify, despite high levels of poverty (only a minority of the world’s poor live in HIPC’s; see Labonte & Schrecker, 2004: 1665-1666) and high external debt burdens (Hanlon, 2000; Pearce et al., 2005).

Two fundamental questions have consistently been ignored by the G8. First, how should sustainability of external debt be defined for purposes of determining eligibility for debt relief? The current criterion, based on a country’s ability to service its debts from export earnings, prioritizes the interests of creditors. An alternative definition of sustainability

prioritizes public expenditure for meeting basic needs or achieve the MDGs, then works backward to determine how much of the public budget should be devoted to debt repayment. Calculations using this approach indicate a need for far more extensive debt cancellation, for a much larger number of countries, than available under MDRI (UN Millennium Project, 2005; United Nations, 2005; Mandel, 2006). Second, should “odious debts” incurred by repressive or corrupt governments without the consent of their subjects be regarded as collectable under international law (Khalfan et al., 2003)? The Commission for Africa cited an estimate “that stolen African assets equivalent to more than half of the continent’s external debt are held in foreign bank accounts” (Commission for Africa, 2005: 150); the recent leak of a report completed for the Kenyan government in 2004, documenting the theft of more than £1 billion by former President Moi and his associates (Kroll Associates UK Ltd., 2004), merely underscores the urgency of addressing this problem.

In 2005, the G8 did commit themselves to “[w]ork vigorously for early ratification of the UN Convention Against Corruption and start discussions on mechanisms to ensure its effective implementation” (G8, 2005), although only three G8 countries (France, the UK and the United States) have so far ratified it. The Convention is potentially valuable because it binds parties to implement mechanisms to seize and repatriate illegally appropriated assets. The effectiveness of these provisions will depend on the enthusiasm of governments whose countries have been victimized, which is by no means assured (Rice et al., 2007). However, even if ratified by all members of the G8 the Convention cannot substitute for a systematic initiative to define odious debts, to develop multilateral mechanisms to preclude their collection (by either public- or private-sector creditors), and to ensure that cancelling debts run up by dictatorial regimes in Haiti, Iraq, Liberia, Nigeria and many other countries could not be counted as development assistance.

The G8 claimed in 2002 that: “The launch of multilateral trade negotiations by World Trade Organization (WTO) members in Doha ... placed the needs and interests of developing countries at the heart of the negotiations” (G8, 2002). Similar rhetoric in following years culminated in the 2006 Summit’s call “for a concerted effort to conclude the negotiations of the WTO’s Doha Development Agenda (DDA) and to fulfill the development objective of the Round” (G8, 2006b: ¶1). Only days later, negotiations reached an impasse over the issue of agricultural subsidies. Expectations for the Doha round may always have been too high

(Ricupeiro, 2006), yet this must count as a serious failure of leadership. The failure is perhaps not surprising: the costs of eliminating subsidies and other protectionist measures will be borne by a limited number of well defined producer groups, while the domestic benefits (if any) will be more widely distributed and less visible. More generally, the introduction of development goals into trade policy would mean a fundamental shift in the self-interested character of negotiations as they now exist (Stiglitz & Charlton, 2005), yet if anything this strengthens the case for G8 leadership – assuming, that is, that the rhetoric of commitment to integrating development objectives into trade policy is to be taken seriously. On other trade issues, the 2006 Summit statement on infectious diseases acknowledged problems with access to essential medicines and implied that intellectual property protection might be part of the problem, but made no proposals or commitments for solving it (G8, 2006a: ¶ 32) ... and silence has reigned with respect to the potentially destructive consequences for health of GATS negotiations, and to the health implications of proliferating bilateral and regional trade agreements. The fact that the United States has sought stronger, ‘TRIPs-plus’ intellectual property protection in such agreements (Fink & Reichenmuller, 2006) is not reassuring.

Why care?

Many international relations scholars are sceptical about applying ethical criteria to the actions of national governments, viewing as unrealistic the expectation that they will be driven by considerations other than national interest. On this view, the G8 can be expected to adopt measures favourable to the health of those outside the industrialized world (either intentionally or incidentally) only when these can be expected to generate politically salient payoffs or enhance the competitive advantage of national economies and firms within their borders. Conversely, a long tradition of rigorous, engaged scholarship by such authors as Richard Falk supports the application of ethical standards to international relations. The associated language of obligations that cross national borders is gaining prominence, as exemplified by the recent statement that: “Global actors and institutions, whether they act bilaterally (especially direct overseas development assistance, trade agreements) or multilaterally (through e.g., the United Nations system, World Bank or International Monetary Fund), are obligated to remedy global inequalities that exist in affluence, power,

and social, economic and political opportunities” (Ruger, 2006). (The author, now an academic, was previously a speechwriter for the president of the World Bank.) To oversimplify greatly, at least two sources for such an obligation can be identified.

First, the persistence of unmet basic needs in a world of unprecedented abundance, where the resources available to a rich global minority for discretionary consumption sometimes appear limitless, may be regarded as sufficient in itself to create an obligation to reallocate resources and redesign policies in order to give priority to meeting basic needs. Henry Shue (1996: 10) captured this argument succinctly with the observation that: “One person’s desire for an additional jar of caviar is not equal in urgency to another person’s need for an additional bowl of black beans.” As an illustration of its policy-relevance, one estimate is that spending \$5.1 billion annually to make a core set of 23 treatment and prevention interventions universally available in countries where 90 percent of child deaths occur, along with making the additional investments needed to provide or rebuild the necessary health system infrastructure (which were not costed), could prevent the deaths of six million children under five each year (Bryce et al., 2005). Even if such estimates carry no ethical force in isolation, they may acquire that force by comparison with (for example) the \$9.4 billion that the top-performing 26 hedge fund managers in the US earned in 2005 (Taub, 2006); the estimated \$200 billion annual cost of the US military adventure in Iraq (Leonhardt, 2007); or global military spending that now approaches \$1 trillion a year.

Second, globalization is characterized by an increasingly dense web of trade and investment flows and policy choices that connect the destinies of rich and poor within and across national borders. The operation of those flows and choices is a logical starting point for identifying past and current causal responsibility: who makes what happen, how, and to whom? At the core of this argument is the proposition that causal responsibility implies moral responsibility. This position is exemplified by Thomas Pogge’s view of moral responsibility for the global persistence of poverty in an interconnected world order (Pogge, 2001; Pogge, 2002a; Pogge, 2002b; Pogge et al., 2005). “Our failure to make a serious effort toward poverty reduction,” he concludes, “may constitute not merely a lack of beneficence, but our active impoverishing, starving, and killing millions of innocent people by economic means” (Pogge, 2001: 15). The G7 collectively, and some G7 governments individually, have promoted a particular form of globalization, reflecting their own domestic economic interests,

so that “[f]or the first time in history, capitalism is being adopted as an application of a doctrine, rather than evolving as a historical process of trial and error” (Przeworski et al., 1995: viii). These governments, and by implication the polities to which they respond, must bear moral responsibility for the consequences.

The concept of health as a human right (in ethics and in international law) arguably connects these positions, drawing on each of them. The basis in international law can be found in a series of texts starting with the 1948 Universal Declaration of Human Rights (UDHR), which specifies that “[e]veryone has the right to “a standard of living adequate for the health and well-being of himself and his [*sic*] family” (Article 25). The 1966 International Covenant on Economic, Social and Cultural Rights (ICESCR), never ratified by the United States, is explicit about “the right of everyone to the enjoyment of the highest available standard of physical and mental health” (Article 12),⁵ and a variety of other instruments also address health issues. Much recent literature on health as a human right emphasizes the obligations of nation-states towards people within their own borders, where state obligations are limited to “progressive realization” in the context of their “available resources” (ICESCR, Article 2). However, Pogge argues that Article 28 of the UDHR, which states that “[e]veryone is entitled to a social and international order in which the rights and freedoms set forth in this Declaration can be fully realized,” creates claims on the institutional order at an international level as well as within national borders (Pogge, 2002a). Apart from the content of legal texts, if what human rights scholar Audrey Chapman describes as the “intrinsic value and worth of all human beings” (Chapman, 1993: 21) is to have much meaning, then it cannot be contingent on accidents of birth that mean some people are born in Sierra Leone, where they can expect to live 39 years, and others in suburbia where they can expect to live twice as long. In other words, the right to health must be interpreted to imply some form of ethical obligation to redistribute resources *across* national borders. Just as importantly, the right to health constitutes a direct challenge to the values of the global marketplace. Human rights of any kind lose meaning when their realization must be vindicated with reference to an external

⁵ For further explication of the right to health, specifically the Article 12 right, see (Committee on Economic, Social and Cultural Rights, 2000; Chapman, 2002; Nygren-Krug, 2002; Hunt, 2003).

criterion such as the right-holder's future income earning potential (human capital), or the contribution that improving her health might make to a regional or national economy.

The ethical positions stated here are not elaborated with the detail that would satisfy philosophers, nor was that intended. The information provided here suffices to identify ethical bases for health-related obligations that cross the borders between rich and poor countries, and to demonstrate the existence of a body of international law incorporating those obligations in a way that is not *a priori* implausible. Human rights in the international frame of reference, as a rule, are unaccompanied either by enforcement mechanisms analogous to those available in national contexts, where the right to health as incorporated in national constitutions has at least occasionally been used to enforce access to treatment (Hogerzeil et al., 2006), or by mechanisms based on mutual agreement like the dispute resolution procedures available through the WTO and many bilateral and regional trade agreements. Possible outlines of such mechanisms are suggested by two examples. First, the United Nations' Special Rapporteur on the Article 12 right to health, appointed in 2002, has identified potential tensions between the right to health and provisions of trade agreements in recommending "that urgent attention be given to the development of a methodology for right to health impact assessments in the context of trade" (Hunt, 2004: ¶74). Second, Hammonds & Ooms (2004) argue that public expenditure ceilings (that affect health care among other areas) agreed to by many African governments as the price of World Bank and IMF approvals that are a precondition for grants, concessional loans and debt relief mean that recipient countries have, in effect, been pressured by Bank shareholders into violating their obligations with respect to the right to health. This argument could apply with even greater force to recent revelations that in 29 sub-Saharan countries the IMF has often insisted on public sector wage ceilings based on excessively cautious projections of future development assistance receipts, and on average permitted just 27 cents of every incremental dollar in development assistance to be spent on new programs, with the balance used for paying down domestic debt and accumulating foreign exchange reserves (Independent Evaluation Office, 2007; Working Group, 2007).

Conclusion: Issues for the future

From the preceding discussion and an expanding research literature, several issues emerge that comprise both an agenda for research on the G8 and global health and a set of strategic and tactical challenges for advocacy. The most immediate problem is “the current behaviour of the United States as an irresponsible and crassly self-seeking hegemon” (Evans, 2005: 195). It remains to be seen whether this phenomenon will persist beyond the current presidency, reflecting a longer term shift in the country’s strategic orientation. If so, then the US position will continue to limit progress at annual Summits, although not necessarily the policies of other G8 countries individually and jointly.

Recent G8 initiatives, and indeed much recent research and advocacy, embody what might be called African exceptionalism: belief that the problems of SSA are somehow qualitatively different from those of the rest of the developing world, meriting special attention as well as distinctive policy responses. The focus on SSA is plausible since (for instance) the region is the epicenter of the HIV epidemic, and as noted earlier the increase in poverty contrasts with trends in other regions. On the other hand, the majority of the world’s poor (as measured by either of the World Bank poverty lines) do not live in SSA, and the incidence of HIV infection is rising rapidly in a number of other areas. The presumption underlying African exceptionalism appears to be that other developing countries, with a few exceptions like Haiti, are on an upward economic trajectory that contrasts with SSA’s current prospects, again with a few exceptions, and implies brighter futures for their residents.

This presumption is the most serious weakness of Collier’s recent book. In rich and poor countries alike, existing divisions within societies, economies and cities are widening based on how individuals, households and firms are incorporated into the global marketplace. In the industrialized world, manufacturing employment is disappearing or becoming informalized, while a large proportion of service sector jobs even in ‘global cities’ characterized by a concentration of producer services are low-paid and insecure (Sassen, 2006: ch. 6): they involve cleaning buildings and homes, delivering goods, working in restaurants, or providing personal services as nannies and maids. People doing this work are caught up in “global circuits” (Sassen, 2000), but not in a way that offers them much of a future. Divisions between winners and losers are even clearer in much of the developing

world. The World Bank concedes that globalization of labour markets will increase economic inequality in most developing countries, leaving the “unskilled poor” even farther behind (World Bank, 2007: 67-100). Concern should be muted, in its view, because a new global middle class will emerge and “[a]s average incomes rise, the number of poor will shrink and the tax base will grow, making effective assistance easier to provide and social safety nets a viable remedy for increasing inequality” (World Bank, 2007: 69).

Even if it emerges as predicted, will the new middle class want to share? Little evidence supports this conjecture, and much calls it into question. Recent experience suggests that even the governments of formally democratic countries may be willing to leave a substantial proportion of their population behind as the price of development. India, for example, has shown at least as much interest in clearing literal and metaphorical space for commercial development in its large cities as it has in meeting basic needs – leading the United Nations Development Programme (2005: 30-31) to observe that “[w]ere India to show the same level of dynamism and innovation in tackling basic health inequalities as it has displayed in global technology markets, it could rapidly get on track for achieving the MDG targets.” The South African government’s notorious recalcitrance in providing antiretroviral therapy may be attributable both to the low value of the poor and ‘unskilled’ in the global economy (Bond, 2001:179-182) and to resistance by domestic elites to the taxes that would be needed to fund comprehensive treatment (Nattrass, 2004: 88). More generally, few African governments have lived up to their commitment (in the Abuja declaration of 2001) to increase public spending on health to 15 percent of general government expenditures (Working Group, 2007: 20). The tendency toward urban segregation by income in cities of the developing world, often literally cast in concrete by transportation planning decisions that favour roads for a car-owning minority (Leaf, 1996; Alcantara de Vasconcellos, 1997; Pucher et al., 2005), provides yet another reason for scepticism.

As for the G8 themselves, how far can and will G8 leaders advocate and pursue policies that promote global health? Can the necessary politically decisive pluralities be mobilized in support? It is tactically attractive to appeal to enlightened self interest, notably by linking health with security. Claiming that “better health for anyone, anywhere on earth, benefits everyone else” (Global Forum for Health Research, 2002: 35) is vacuous. More specific claims emphasize such factors as the increase in opportunities for disease

transmission associated with rapid, low-cost air travel. However, actual danger to most people in high-income countries is limited to a small range of diseases, such as SARS and influenza, which can be easily transmitted through casual contact before symptoms develop. (Not surprisingly, much of the 2006 Summit statement on infectious diseases addressed planning for an influenza epidemic in the industrialized world.) Only the occasional intrepid adventure traveler or tropical disease researcher is likely to be exposed to malaria; most G8 residents have absolutely nothing to lose from the HIV epidemic in developing countries, from the social conditions that contribute to vulnerability to infection (Bates et al., 2004; De Vogli & Birbeck, 2005), or from the rapid increase in non-communicable diseases once mistakenly thought to be diseases of affluence (Adeyi et al., 2007).

Distribution of health risks, in other words, parallels (and partly responds to) the economic bifurcations that are characteristic of contemporary globalization; appeals to self-interest are unlikely to be credible either to leaders or to electorates. The extent to which leadership on global health issues can be expected from the G8 thus is likely to depend on incorporation into their policies of some form or other of global health ethic. One approximation to the policy stance that would be needed is Norway's current foreign policy, which (for instance) involves opposing development conditionalities that promote privatization, supporting only trade policies that will not prevent poorer countries from developing into "welfare societies" similar to Norway's own, and taking a leadership role in seeking "new global financing sources that can contribute to a redistribution of global wealth and the strengthening of the UN institutions" (Government of Norway, 2006). However, in the Anglo-American context from which I write, the prevailing political discourse has become relentlessly hostile to even modestly redistributive policies. For instance, "solidarity" is routinely invoked even by governments of the centre-right in discussing access to health services in continental Europe, while a recent content analysis did not even find the term in Canadian health policy reform documents (Flood et al., 2002; Giacomini et al., 2004).

Why does this matter? The British author of an especially thoughtful critique of the politics behind the 2005 Gleneagles Summit characterized as "astonishing" the US \$121 billion in additional aid spending that would be needed to bring the development assistance commitments made there up to the 0.7 percent of gross national income that has been a non-binding United Nations target since 1970 (Payne, 2006: 926). Assuming of course that the aid

were appropriately used, if the G8 were to meet this target the available financing would correspond to the high end of the range of estimated annual costs to meet the MDGs throughout the developing world. Norway, Denmark and Sweden, incidentally, have met or exceeded the 0.7 percent target for two decades. “Astonishing,” then, clearly depends on the beholder and his own political culture. The amounts in question are large, yet they pale beside the G8’s annual military spending. Taking another approach, in earlier work I broke down the amounts needed to bring each G7 country’s development assistance spending to the 0.7 percent target in terms of Big Macs per person per year, using *The Economist’s* annual price comparison of that all-but-universal gastrocommodity (Figure 3, which will be updated using most recent data for the conference). The resulting amounts were not very astonishing at all.

Granted, development assistance is not a panacea, and spending levels represent a highly imperfect proxy for a country’s overall commitment to development. Granted, as well, it would clearly be preferable from an equity perspective to fund increases through strongly progressive taxation, rather than through the per capita contribution hypothesized in the calculation. The value of the calculation lies, rather, in how utterly foreign it is to the political climate in any jurisdiction with whose politics I am even slightly familiar. Our politicians, regardless of their professed position on the left-right spectrum, simply do not talk or think that way. More typical is a post-Gleneagles comment on African development by Michael Ignatieff, an academic-turned-politician who may yet become Canada’s foreign minister: “I’m not one for handing out lots of bilateral assistance government to government. I think it’s basically a mistake. What you want to do is create international economic regimes that say ‘this is tough love time.’ If you’ve got a product we want, we’ll create a fair international regime; and if you can get your beans to our market, terrific. What we need to do is say, ‘This is a competitive world -- if you have something we want, we’ll play fair.’ End of story” (Ignatieff, 2005). The divisive dynamic that is created by the global marketplace could not be better stated.

I do not mean to suggest in all this that it is realistic to ask why the G8 can’t be more like the Nordic countries. It isn’t, for a number of reasons (oil wealth in Norway’s case, social democratic traditions, proportional representation and the absence of federalism, to name just four). Nevertheless, we cannot abandon the field. Those of us working in global

health policy who are convinced that direct challenges to the priorities of the global marketplace are imperative must first of all find a way of changing the language of our domestic politics, and the underlying thought processes. We must somehow maintain optimism as advocates and humanists, while undertaking a certain willing suspension of disbelief as social scientists.

DRAFT

Figure 1

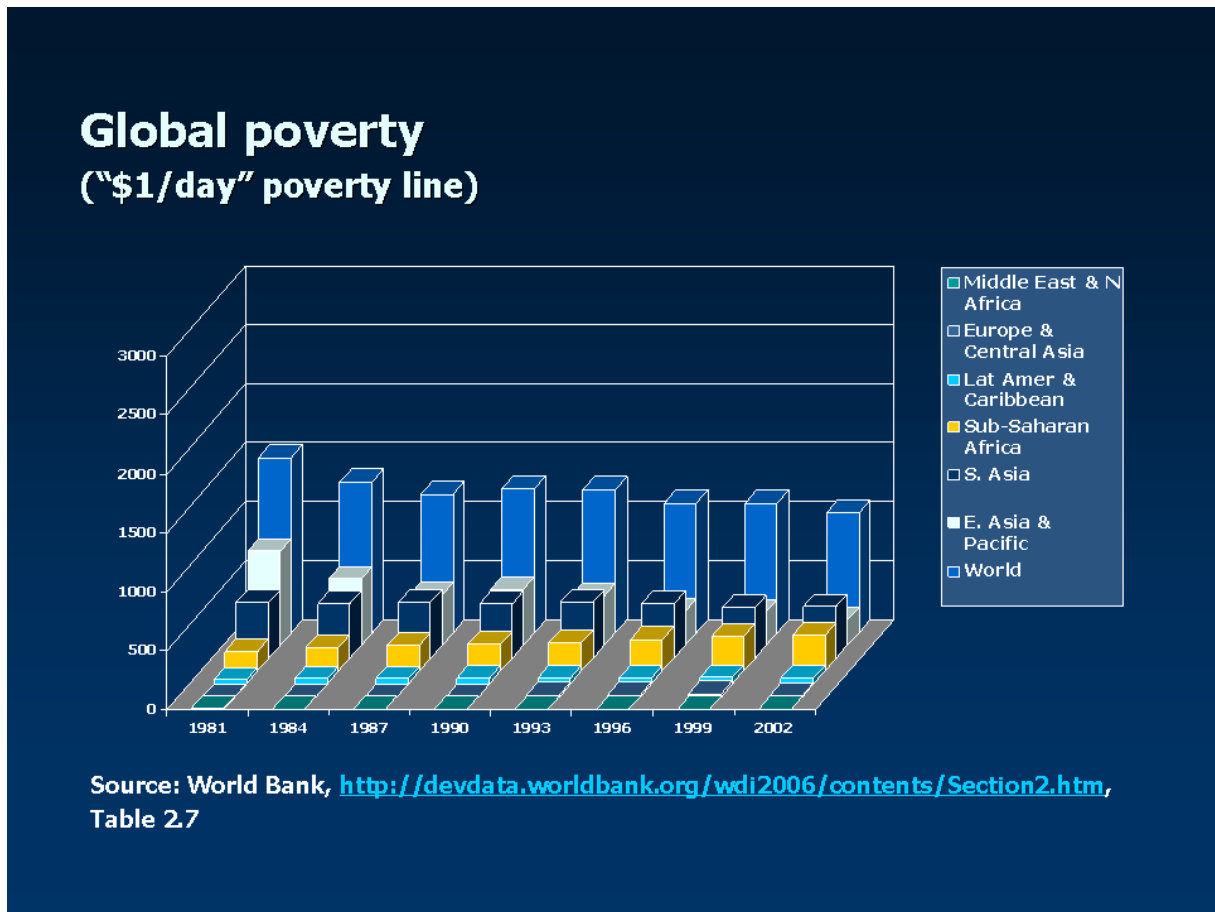
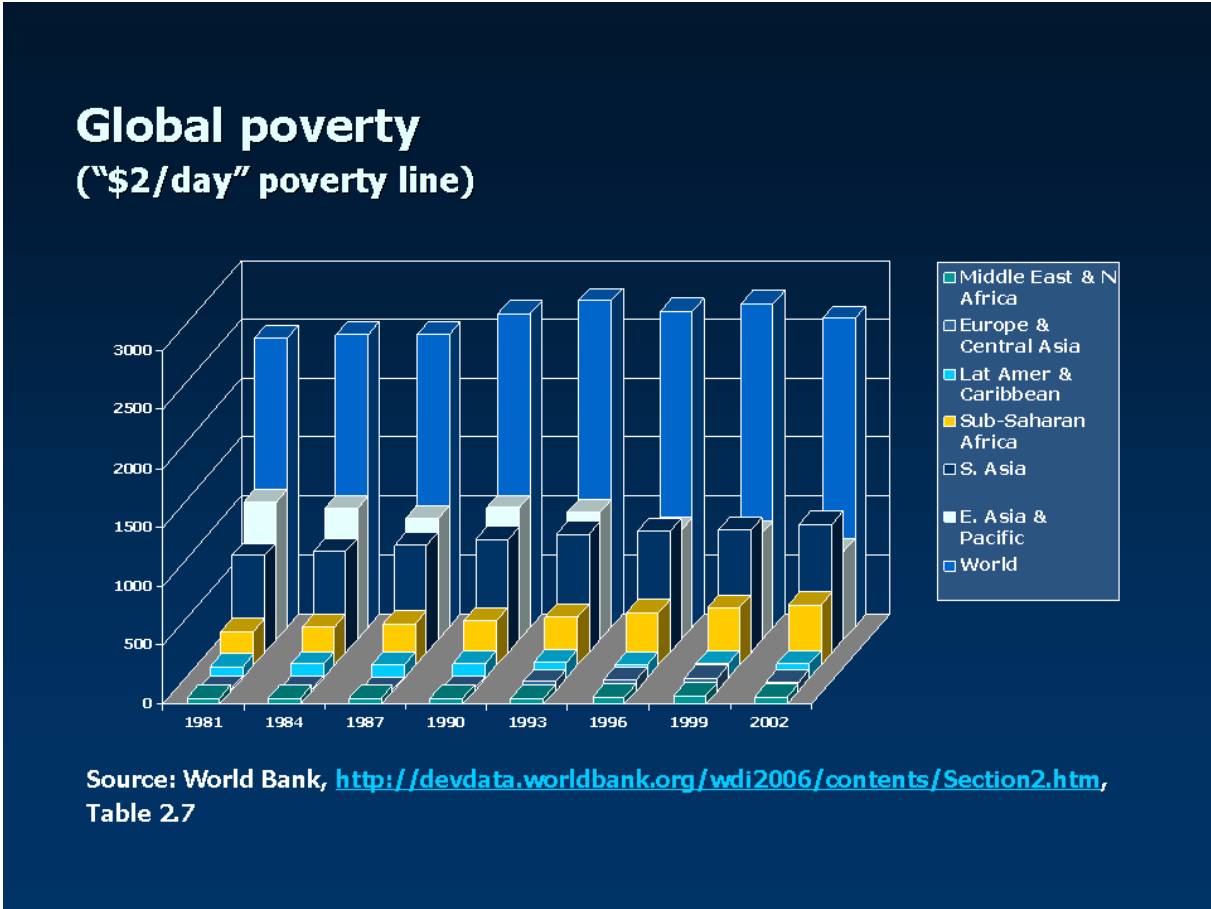
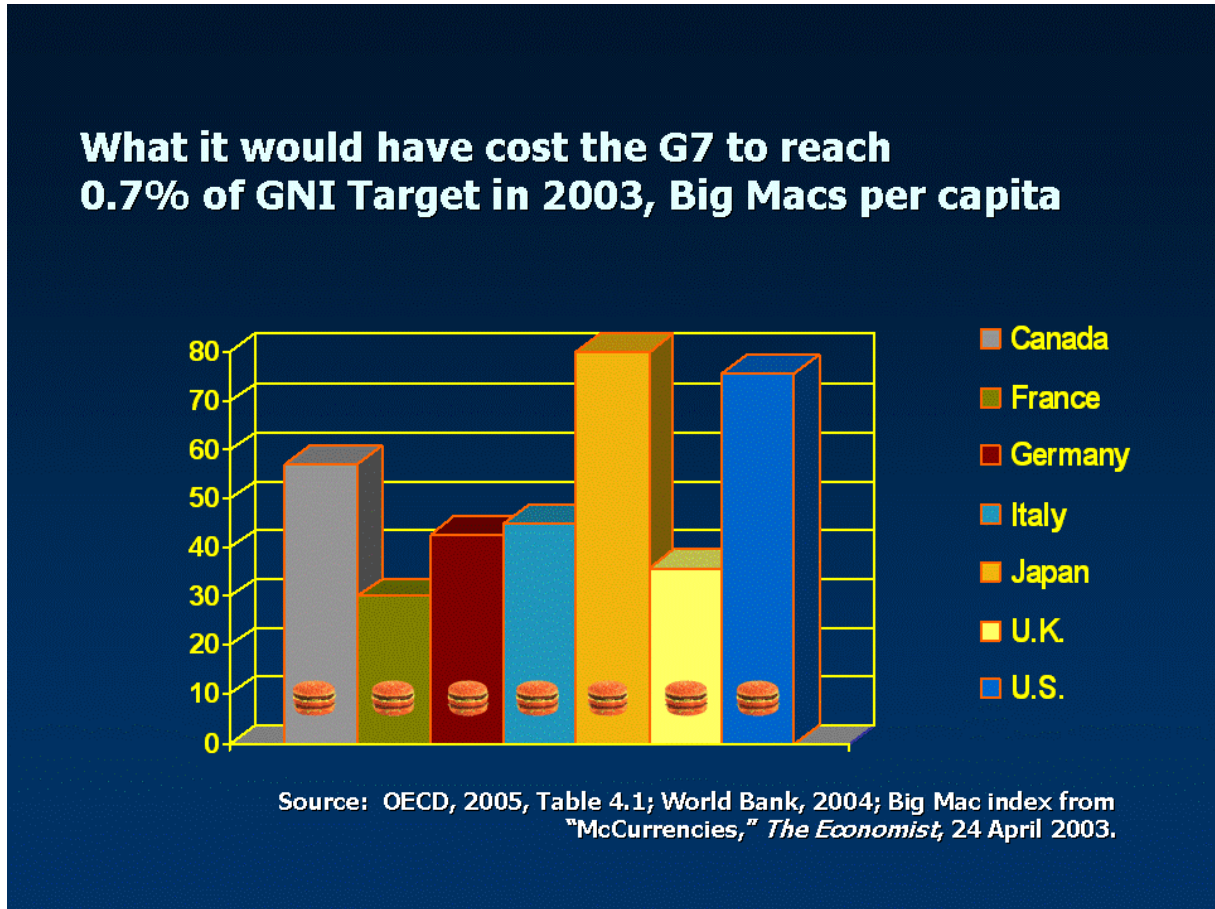


Figure 2



DATA

Figure 3



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References

- Adeyi, O., Smith, O., & Robles, S. (2007). *Public policy & the challenge of chronic noncommunicable diseases*. Washington, DC: World Bank.
- Akin, J. S., Dow, W. H., Lance, P. M., & Loh, C. P. (2005). Changes in access to health care in China, 1989-1997. *Health Policy and Planning, 20*, 80-89.
- Akin, J. S., Dow, W. H., & Lance, P. M. (2004). Did the distribution of health insurance in China continue to grow less equitable in the nineties? Results from a longitudinal survey. *Social Science & Medicine, 58*, 293-304.
- Alcantara de Vasconcellos, E. (1997). The making of the middle-class city: transportation policy in São Paulo. *Environment and Planning A, 29*, 293-310.
- Atarah, L. (2005). *Playing Chicken: Ghana vs. the IMF* Oakland, CA: Corporate Watch. Available: <http://www.corpwatch.org/article.php?id=12394>.
- Banati, P., Greene, B., & Ferazzi, S. (2006). *Funding the Global Fight Against HIV/AIDS, Tuberculosis and Malaria: Resource Needs for the Global Fund, 2006-2007 and 2008-2010*. Geneva: Global Fund to Fight AIDS, Tuberculosis and Malaria.
- Bates, I., Fenton, C., Gruber, J., Laloo, D., Medina Lara, A., Squire, S. B. et al. (2004). Vulnerability to malaria, tuberculosis, and HIV/AIDS infection and disease. Part II: determinants operating at environmental and institutional level. *Lancet Infectious Diseases, 4*, 368-375.
- Birdsall, N., Rodrik, D., & Subramanian, A. (2005). How to help poor countries. *Foreign Affairs, 84*, no. 4, 136-152.
- Birdsall, N. (2006a). *Stormy Days on an Open Field: Asymmetries in the Global Economy* (Research Paper 2006/31). Helsinki: World Institute for Development Economics Research.
- Birdsall, N. (2006b). *The World is not Flat: Inequality and Injustice in our Global Economy*, WIDER Annual Lecture 2005. Helsinki: World Institute for Development Economics Research.
- Bloom, G., Lu, Y., & Chen, J. (2002). *Financing health care in China's cities: balancing needs and entitlements during rapid change* (IDS Working Paper 176). Brighton, Sussex: Institute of Development Studies.
- Bond, P. (2001). *Against Global Apartheid: South Africa Meets the World Bank, IMF and International Finance*. Cape Town: University of Cape Town Press.
- Bryce, J., Black, R. E., Walker, N., Bhutta, Z. A., Lawn, J. E., & Steketee, R. W. (2005). Can the world afford to save the lives of 6 million children each year? *The Lancet, 365*, 2193-2200.

- Cerny, P. G. (2000). Restructuring the Political Arena: Globalization and the Paradoxes of the Competition State. In R. D. Germain (ed.), *Globalization and its Critics: Perspectives from Political Economy* (pp. 117-138). Houndmills: Macmillan.
- Chapman, A. R. (1993). *Exploring a Human Rights Approach to Health Care Reform*. Washington, DC: Science and Human Rights Program, American Association for the Advancement of Science.
- Chapman, A. R. (2002). Core Obligations Related to the Right to Health. In A. Chapman & S. Russell (eds.), *Core Obligations: Building a Framework for Economic, Social and Cultural Rights* (pp. 185-215). Antwerp: Intersentia.
- Cheru, F. (1999). *Economic, Social and Cultural Rights: Effects of structural adjustment policies on the full enjoyment of human rights*, E/CN.4/1999/50. Geneva, United Nations Economic and Social Council.
- Cheru, F. (2000). Debt Relief and Social Investment: Linking the HIPC Initiative to the HIV/AIDS Epidemic in Africa: The Case of Zambia. *Review of African Political Economy*, 86, 519-535.
- Cheru, F. (2001). *Economic, Social and Cultural Rights: The Highly Indebted Poor Countries (HIPC) Initiative: a human rights assessment of the Poverty Reduction Strategy Papers (PRSP)*, E/CN.4/2001/56. Geneva: United Nations Economic and Social Council.
- Collier, P. (2006a). African Growth: Why a 'Big Push'? *Journal of African Economies*, 15, 188-211.
- Collier, P. (2006b). Editorial: Rethinking Assistance for Africa. *Economic Affairs*, December, 2-4.
- Collier, P. (2007). *The Bottom Billion: Why the Poorest Countries are Failing and What Can Be Done About It*. Oxford: Oxford University Press.
- Commission for Africa (2005). *Our Common Interest: Report of the Commission for Africa*. London: Commission for Africa.
- Commission on Macroeconomics and Health (2001). *Macroeconomics and Health: Investing in Health for Economic Development*. Geneva: World Health Organization.
- Committee on Economic, Social and Cultural Rights (2000). *General Comment 14: The right to the highest attainable standard of health*, E/C.23/200/4. United Nations High Commission for Human Rights [On-line]. Available: [http://www.unhcr.ch/tbs/doc.nsf/\(symbol\)/E.C.12.2000.4.En?OpenDocument](http://www.unhcr.ch/tbs/doc.nsf/(symbol)/E.C.12.2000.4.En?OpenDocument).
- Cook, Daniel (2006, October). Ways to fight the AIDS pandemic [interview with Stephen Lewis, UN Special Envoy for AIDS]. *Africa Report*, 109-111.

- Cornia, G. A., Jolly, R. & Stewart, F. (eds.) (1987). *Adjustment with a Human Face*, vol. 1: *Protecting the Vulnerable and Promoting Growth*. Oxford: Clarendon Press.
- de Ferranti, D., Perry, G., Ferreira, F. H., & Walton, M. (2004). *Inequality in Latin America & the Caribbean: Breaking with History?* Washington, DC: World Bank.
- De Vogli, R. & Birbeck, G. L. (2005). Potential Impact of Adjustment Policies on Vulnerability of Women and Children to HIV/AIDS in Sub-Saharan Africa. *Journal of Health Population and Nutrition*, 23, 105-120.
- Deaton, A. (2003). Health, Inequality, and Economic Development. *Journal of Economic Literature*, 41, 113-158.
- Deaton, Angus (2006). Global Patterns of Income and Health. *WIDER Angle*, 2006, no. 2, 1-3.
- Development Indicators and Policy Research Division, Asian Development Bank (2007). *Key Indicators 2007: Inequality in Asia* (vol. 38). Manila: Asian Development Bank.
- Dicken, P. (2003). *Global Shift: Reshaping the Global Economic Map in the 21st Century*. (4th ed.) New York: Guilford Press.
- Diderichsen, F., Evans, T., & Whitehead, M. (2001). The Social Basis of Disparities in Health. In M. Whitehead, T. Evans, F. Diderichsen, A. Bhuiya, & M. Wirth (eds.), *Challenging Inequities in Health: From Ethics to Action* (pp. 13-23). New York: Oxford University Press.
- Dummer, T. J. B. & Cook, I. G. (2007). Exploring China's rural health crisis: Processes and policy implications. *Health Policy*, 83, 1-16.
- Evans, P. (2005). Neoliberalism as a Political Opportunity: Constraint and Innovation in Contemporary Development Strategy. In K. Gallagher (ed.), *Putting Development First: The Importance of Policy Space in the WTO and IFIs* (pp. 195-215). London: Zed Books.
- Evans, R. G. & Stoddart, G. L. (1990). Producing Health, Consuming Health Care. *Social Science & Medicine*, 31, 1347-1363.
- Feachem, R. G. A. (2001). Globalisation is good for your health, mostly. *British Medical Journal*, 323, 504-506.
- Fink, C. & Reichenmuller, P. (2006). Tightening TRIPS: Intellectual Property Provisions of US Free Trade Agreements. In R. Newfarmer (ed.), *Trade, Doha, and Development: A Window Into the Issues* (pp. 285-300). Washington, DC: World Bank.
- Flood, C. M., Stabile, M., & Tuohy, C. (2002). The borders of solidarity: How countries determine the public/private mix in spending and the impact on health care. *Health Matrix*, 12, 297-356.

- G8 (2001). *Communiqué*. Genoa. Available: <http://www.g8.utoronto.ca/summit/2001genoa/finalcommuniqué.html>.
- G8 (2002). *G8 Africa Action Plan*. Kananaskis and Ottawa. Available: <http://www.g8.utoronto.ca/summit/2002kananaskis/afraction-e.pdf>.
- G8 (2005). *Africa*. Gleneagles, Scotland. Available: <http://www.g8.utoronto.ca/summit/2005gleneagles/africa.pdf>.
- G8 (2006a). *Fight Against Infectious Disease*. St. Petersburg. Available: <http://www.g8.utoronto.ca/summit/2006stpetersburg/infdis.html>.
- G8 (2006b). *Trade*. St. Petersburg. Available: <http://www.g8.utoronto.ca/summit/2006stpetersburg/trade.html>.
- G8 (2007a). *Chair's Summary*. Heiligendamm, Germany. Available: <http://www.g8.utoronto.ca/summit/2007heilgendamm/g8-2007-summary.pdf>.
- G8 (2007b). *Growth and Responsibility in Africa: Summit Declaration*. Heiligendamm, Germany. Available: <http://www.g8.utoronto.ca/summit/2007heilgendamm/g8-2007-africa.pdf>.
- G8 Research Group. (2005). *The G8 and Africa Final Report: An Overview of the G8's Ongoing Relationship with African Development from the 2001 Genoa Summit to the 2005 Gleneagles Summit*. Toronto, Civil Society and Expanded Dialogue Unit, G8 Research Group, University of Toronto.
- Gaynor, C. (2005). Structural Injustice and the MDGs: A Critical Analysis of the Zambian Experience. *Trocaire Development Review*, 2005, 57-84.
- Giacomini, M., Hurley, J., Gold, I., Smith, P., & Abelson, J. (2004). The policy analysis of 'values talk': lessons from Canadian health reform. *Health Policy*, 67, 15-24.
- Giddens, A. (1998). *The Third Way: The Renewal of Social Democracy*. Cambridge: Polity Press.
- Global Forum for Health Research (2002). *The 10/90 Report on Health Research 2001-2002*. Geneva: World Health Organization.
- Global Fund to Fight AIDS, Tuberculosis and Malaria (2007). Pledges and Contributions [On-line]. Available: <http://www.theglobalfund.org/en/files/pledges&contributions.xls>
- Government of Norway (2006). The Soria Moria Declaration on International Policy, Chapter 2: International Policy. Information from the Government and the Ministries of Norway [On-line]. Available: <http://odin.dep.no/smk/english/government/government/001001-990363/dok-bn.html>

- Gupta, S., Clements, B., Guin-Siu, M. T., & Leruth, L. (2002). Debt relief and public health spending in heavily indebted poor countries. *Bulletin of the World Health Organization*, 80, 151-157.
- Gwatkin, D. R. (2005). How much would poor people gain from faster progress towards the Millennium Development Goals for health? *The Lancet*, 365, 813-817.
- Haakonsson, S. J. & Richey, L. A. (2007). TRIPs and public health: the Doha Declaration in Africa. *Development Policy Review*, 25, 71-90.
- Hammonds, R. & Ooms, G. (2004). World Bank Policies and the Obligation of its Members to Respect, Protect and Fulfill the Right to Health. *Health and Human Rights*, 8, 27-60.
- Hanlon, J. (2000). How much debt must be cancelled? *Journal of International Development*, 12, 877-901.
- Helsinki Process Secretariat (ed.) (2005). *Helsinki Process Papers on Global Economic Agenda*. (2005). Helsinki: Foreign Ministry of Finland.
- Hogerzeil, H. V., Samson, M., Casanovas, J. V., & Rahmani-Ocora, L. (2006). Is access to essential medicines as part of the fulfilment of the right to health enforceable through the courts? *The Lancet*, 368, 305-311.
- Hunt, P. (2003). *Economic, Social and Cultural Rights: The right of everyone to the enjoyment of the highest attainable standard of physical and mental health*, E/CN.4/2003/58. Geneva: United Nations Economic and Social Council.
- Hunt, P. (2004). *Economic, Social and Cultural Rights: The right of everyone to the enjoyment of the highest attainable standard of physical and mental health -- Addendum: Mission to the World Trade Organization*, E/CN.4/2004/49/Add.1. Geneva: United Nations Economic and Social Council.
- Hurley, G. (2007). *Multilateral Debt: One Step Forward, How Many Back?* Brussels: European Network on Debt & Development (EURODAD).
- Ignatieff, M. (2005). Exclusive Interview: The next federal cabinet minister? *McGill Tribune* (online edition) [On-line]. Available: <http://www.mcgilltribune.com/media/paper234/news/2005/10/04/News/Exclusive.InterviewThe.Next.Federal.Cabinet.Minister-1008769.shtml>
- IMF Staff (2002). *Improving Market Access: Toward Greater Coherence Between Aid and Trade*. Washington, DC: International Monetary Fund.
- Independent Evaluation Office, International Monetary Fund (2007). *The IMF and Aid to Sub-Saharan Africa*. Washington, DC: IMF.

- Jenson, J. & Saint-Martin, D. (2003). New Routes to Social Cohesion? Citizenship and the Social Investment State. *Canadian Journal of Sociology*, 28, 77-99.
- Jeter, J (2002). The dumping ground: As Zambia courts western markets, used goods arrive at a heavy price. *Washington Post*, April 22.
- Joint World Bank/IMF Development Committee (2005). *Note on the G8 Debt Relief Proposal: Assessment of Costs, Implementation Issues and Financing Options*. Washington, DC: IMF/World Bank.
- Jubany, F. & Meltzer, J. (2004). *The Achilles' Heel of Latin America. The State of the Debate on Inequality* (Report FPP-04-5). Ottawa: Canadian Foundation for the Americas (FOCAL).
- Kawachi, I. & Wamala, S. (2007). Poverty and Inequality in a Globalizing World. In I. Kawachi & S. Wamala (eds.), *Globalisation and Health* (pp. 122-137). Oxford: Oxford University Press.
- Kerry, V. B. & Lee, K. (2007). TRIPS, the Doha declaration and paragraph 6 decision: what are the remaining steps for protecting access to medicines? *Globalization and Health*, 3, no. 3. Available: <http://www.globalizationandhealth.com/content/3/1/3>.
- Khalfan, A., King, J., & Thomas, B. (2003). *Advancing the Odious Debt Doctrine*. Montreal, Quebec: Centre for International Sustainable Development Law.
- Killick, T. (2005). Don't Throw Money at Africa. *IDS Bulletin*, 36, no. 3, 14-19.
- Kirton, J., Kokotsis, E., Corlazzoli, V., Varey, M., Rath, A., & Sunderland, L. (2006). *Gleneagles Final Compliance Report, July 8, 2005, to June 1, 2006*. Toronto: G8 Research Group, University of Toronto.
- Kroll Associates UK Ltd. (2004). *Project KTM: Consolidated Report*. London. Available: https://secure.wikileaks.org/leak/KTM_report.pdf.
- Labonte, R. & Schrecker, T. (2005). *The G8, Africa and Global Health: A Platform for Global Health Equity for the 2005 Summit*. London: Nuffield Trust. Available: <http://www.nuffieldtrust.org.uk/ecomm/files/G8%20Book.pdf>
- Labonte, R. & Schrecker, T. (2004). Committed to Health for All? How the G7/G8 Rate. *Social Science & Medicine*, 59, 1661-1676.
- Labonte, R. & Schrecker, T. (2006). The G8 and Global Health: What now? What next? *Canadian Journal of Public Health*, 97, 35-38.
- Labonte, R. & Schrecker, T. (2007a). Foreign policy matters: a normative view of the G8 and population health. *Bulletin of the World Health Organization*, 85, 185-191.

- Labonte, R. & Schrecker, T. (2007b). Globalization and social determinants of health: Introduction and methodological background (part 1 of 3). *Globalization and Health*, 3, no. 5. Available: <http://www.globalizationandhealth.com/content/3/1/5>.
- Labonte, R. & Schrecker, T. (2007c). Globalization and social determinants of health: The role of the global marketplace (part 2 of 3). *Globalization and Health*, 3, no. 6. Available: <http://www.globalizationandhealth.com/content/3/1/6>.
- Labonte, R., Schrecker, T., & Gupta, A. S. (2005). A global health equity agenda for the G8 summit. *British Medical Journal*, 350, 533-536.
- Labonte, R., Schrecker, T., Sanders, D., & Meeus, W. (2004). *Fatal Indifference: The G8, Africa and Global Health*. Cape Town: University of Cape Town Press.
- Leaf, M. (1996). Building the road for the BMW: Culture, vision, and the extended metropolitan region of Jakarta. *Environment and Planning A*, 28, 1617-1635.
- Leonhardt, David (2007). What \$1.2 Trillion Can Buy. *New York Times*, January 12.
- Mandel, S. (2006). *Debt Relief as if People Mattered: A rights-based approach to debt sustainability*. London: New Economics Foundation.
- Marmot, M. (2006). Health in an unequal world. *The Lancet*, 368, 2081-2094.
- Martin, M. (2004). Assessing the HIPC Initiative: The Key Policy Debates. In J. Teunissen & A. Akkerman (eds.), *HIPC Debt Relief: Myths and Realities* (pp. 11-47). The Hague: Forum on Debt and Development (FONDAD).
- McMillan, M., Zwane, A. P., & Ashraf, N. (2006). My Policies or Yours: Does OECD Support for Agriculture Increase Poverty in Developing Countries? In A. Harrison (ed.), *Globalization and Poverty*. Chicago: University of Chicago Press for National Bureau of Economic Research.
- Molyneux, M. (2007). *Change and Continuity in Social Protection in Latin America: Mothers at the Service of the State?*. Geneva: United Nations Research Institute for Social Development.
- Moser, K. A., Leon, D. A., & Gwatkin, D. R. (2005). How does progress towards the child mortality millennium development goal affect inequalities between the poorest and least poor? Analysis of Demographic and Health Survey data. *British Medical Journal*, 331, 1180-1182.
- Nattrass, N. (2004). Unemployment and AIDS: the social-democratic challenge for South Africa. *Development Southern Africa*, 21, 87-108.
- Nissanke, M. & Thorbecke, E. (2006). Channels and policy debate in the globalization-inequality-poverty nexus. *World Development*, 34, 1338-1360.

- Nygren-Krug, H. (2002). *25 Questions and Answers about Health and Human Rights*. Geneva: World Health Organization.
- OECD Development Assistance Committee (2007). Development aid from OECD countries fell 5.1% in 2006. Organization for Economic Cooperation and Development [Online]. Available: http://www.oecd.org/document/17/0,2340,en_2649_201185_38341265_1_1_1_1,00.html
- Paes de Barros, R., Contreras, D., Feres, J. C., Ferreira, F. H. G., Ganuza, E., Hansen, E. et al. (2002). *Meeting the Millennium Poverty Reduction Targets in Latin America and the Caribbean*. Santiago: United Nations Economic Commission for Latin America and the Caribbean.
- Paluzzi, J. E. & Farmer, P. E. (2005). The Wrong Question. *Development*, 48, no. 1, 12-18.
- Payne, A. (2006). Blair, Brown and the Gleneagles agenda: making poverty history, or confronting the global politics of unequal development? *International Affairs*, 82, 917-935.
- Pearce, C., Greenhill, R., & Glennie, J. (2005). *In the Balance: Why Debts Must be Cancelled Now to Meet the Millennium Development Goals*. London: Jubilee Debt Campaign.
- Pogge, T. (2001). Priorities of Global Justice. *Metaphilosophy*, 32, 6-24.
- Pogge, T. (2002a). Human Rights and Human Responsibilities. In P. De Greiff & C. Cronin (eds.), *Global Justice & Transnational Politics* (pp. 151-195). Cambridge, MA: MIT Press.
- Pogge, T. (2002b). *World Poverty and Human Rights*. Cambridge: Polity.
- Pogge, T. (2004). The First United Nations Millennium Development Goal: a cause for celebration? *Journal of Human Development*, 5, 377-397.
- Pogge, T., Risse, M., Patten, A., Cruft, R., Anwander, N., & Satz, D. (2005). Symposium: World Poverty and Human Rights. *Ethics & International Affairs*, 19, 1-83.
- Przeworski, A., Bardhan, P., Bresser Pereira, L. C., Bruszt, L., Choi, J. J., Comisso, E. T. et al. (1995). *Sustainable Democracy*. Cambridge: Cambridge University Press.
- Pucher, J., Korattyswaropam, N., Mittal, N., & Ittyerah, N. (2005). Urban transport crisis in India. *Transport Policy*, 12, 185-198.
- Reddy, S. G. & Pogge, T. W. (2005). *How Not to Count the Poor, version 6.2*. New York: Columbia University.
- Rice, Xan, Campbell, Duncan, and White, Michael (2007). UK attacks Kenya over role in search for missing £1bn. *The Guardian*, September 1.

- Ricupeiro, R. (2006). The Paradoxes and Contradictions of World Trade. *Bridges Monthly Review*, 10, 17-20.
- Ruger, J. P. (2006). Ethics and governance of global health inequalities. *Journal of Epidemiology and Community Health*, 60, 998-1002.
- Sachs, J. D. (2007). Beware False Tradeoffs. Foreign Affairs [On-line]. Available: http://www.foreignaffairs.org/special/global_health/sachs
- Sassen, S. (1996). *Losing Control? Sovereignty in an Age of Globalization*. New York: Columbia University Press.
- Sassen, S. (2000). Women's Burden: Counter-geographies of Globalization and the Feminization of Survival. *Journal of International Affairs*, 53, 503-524.
- Sassen, S. (2003). Economic Globalization and the Redrawing of Citizenship. In J. Friedman (ed.), *Globalization, the State, and Violence* (pp. 67-86). Walnut Creek, CA: AltaMira Press.
- Sassen, S. (2006). *Cities in a World Economy*. (3rd ed.) Thousand Oaks, CA: Pine Forge Press.
- Satterthwaite, D. (2003). The Millennium Development Goals and urban poverty reduction: great expectations and nonsense statistics. *Environment & Urbanization*, 15, 181-190.
- Schieber, G. J., Gottret, P., Fleisher, L. K., & Leive, A. A. (2007). Financing Global Health: Mission Unaccomplished. *Health Affairs*, 26, 921-934.
- Schrecker, T., Labonte, R., & Sanders, D. (2007). Breaking Faith with Africa: The G8 and population health post-Gleneagles. In A.F.Cooper, J. J. Kirton, & T. Schrecker (eds.), *Governing Global Health: Challenge, Response, Innovation* (pp. 181-205). Aldershot: Ashgate.
- Sepethri, A., Chernomas, R., & Akram-Lodhi, A. (2003). If they get sick, they are in trouble: health care restructuring, user charges, and equity in Vietnam. *International Journal of Health Services*, 33, 137-161.
- Shue, H. (1996). Environmental Change and the Varieties of Justice. In F. Hampson & J. Reppy (eds.), *Earthly Goods: Environmental Change and Social Justice* (pp. 9-29). Ithaca: Cornell University Press.
- Stevens, C. & Kennan, J. (2005). *EU-ACP Economic Partnership Agreements: The Effects of Reciprocity*. Brighton, Sussex: Institute of Development Studies. Available: <http://www.dfid.gov.uk/aboutdfid/organisation/epas-effects-reciprocity.pdf>.
- Stiglitz, J. & Charlton, A. (2005). A Development Round of Trade Negotiations? In F.Bourguignon, B. Pleskovic, & A. Sapir (eds.), *Annual World Bank Conference on*

Development Economics--Europe 2005: Are We on Track to Achieve the Millennium Development Goals? (pp. 31-60). New York: Oxford University Press.

- Taub, Stephen (2006, May). Really Big Bucks. *Alpha* [on-line]. Available: <http://www.dailyii.com/article.asp?PositionID=&ArticleID=1040590&p=1>.
- Tomitova, L. (2005). Is the G8 Dealing Justly with Debt? Carnegie Council on Ethics and International Affairs [On-line]. Available: http://www.cceia.org/resources/articles_papers_reports/5185.html/:pf_printable?
- UN Millennium Project (2005). *Investing in Development: A Practical Plan to Achieve the Millennium Development Goals*. London: Earthscan.
- United Nations (2005). *In larger freedom: towards development, security and human rights for all: Report of the Secretary-General*, A/59/2005. New York: United Nations.
- United Nations Country Team Viet Nam (2003). *Health Care Financing for Viet Nam* (Discussion Paper No.2). Ha Noi: United Nations Viet Nam.
- United Nations Department of Economic and Social Affairs (2005). *World Economic and Social Survey 2005: Financing for Development*, E/2005/51/Rev.1, ST/ESA/298. New York: United Nations.
- United Nations Development Programme (2005). *Human Development Report 2005 -- International cooperation at a crossroads: Aid, trade and security in an unequal world*. New York: Oxford University Press for the United Nations Development Programme.
- United Nations Secretary-General (2006). *Recent developments in external debt*, A/61/152 New York: United Nations.
- van Doorslaer, E., O'Donnell, O., Rannan-Eliya, R. P., Somanathan, A., Adhikari, S. R., Garg, C. C. et al. (2006). Effect of payments for health care on poverty estimates in 11 countries in Asia: an analysis of household survey data. *The Lancet*, 368, 1357-1364.
- Watkins, K. & Fowler, P. (2002). *Rigged Rules and Double Standards*. Washington, D.C.: Oxfam International.
- Wise, T. A. (2004). *The Paradox of Agricultural Subsidies: Measurement Issues, Agricultural Dumping, and Policy Reform* (GDEI Working Paper 04-02). Medford, MA: Global Development and Environment Institute, Tufts University.
- Working Group on IMF Programs and Health Spending (2007). *Does the IMF Constrain Health Spending in Poor Countries? Evidence and an Agenda for Action*. Washington, DC: Center for Global Development.
- World Bank (1993). *World Development Report 1993: Investing in Health*. New York: Oxford University Press.

World Bank (2007). *Global Economic Prospects 2007: Managing the Next Wave of Globalization*. Washington, DC: World Bank.

World Bank Health, Nutrition and Population Program (2007). HNPStats. World Bank [Online]. Available: <http://devdata.worldbank.org/hnpstats>

World Commission on the Social Dimension of Globalization (2004). *A Fair Globalization: Creating Opportunities for All* Geneva: International Labor Organization.

Zhang, X. B. & Kanbur, R. (2005). Spatial inequality in education and health care in China. *China Economic Review*, 16, 189-204.

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