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Beyond *Fatal Indifference*?

**How the G7/G8 define and discharge
their responsibilities for global health**

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Introduction

The G7/G8 countries (the G8 consists of 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 percent of the world's development assistance spending. Their choices matter for the health of people outside their borders, perhaps even more than for people within them. Over the past several years, multiple reviews and syntheses of the available evidence have concluded that literally millions of lives could be saved per year 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). Other, comparably thorough reviews emphasize interventions that address the multiple vulnerabilities associated with poverty and economic insecurity (3,5,6).

In the years preceding the 2005 Summit at Gleneagles, Scotland, the G8's repeated promises of assistance failed to respond adequately to the health crisis in countries outside the industrialized world (7-9) – a policy position that has been described as *Fatal Indifference* (7). The 2005 Summit attracted more worldwide media attention than ever before, and featured large 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, starting with the question: Were the highly publicized Summit commitments on African debt and development assistance the success many are claiming?

Grudging concessions to the evidence: Debt and development assistance

i. Debt

For almost 20 years, the burden of external debt has been recognized as undermining developing countries' ability to meet basic needs, with destructive health consequences (10,11). The \$15 billion annually that Africa spends on debt servicing is four times what it spends on health and education, "the building blocks of the AIDS response," as UNAIDS executive director Peter Piot recently noted (12). The causes of the developing world's debt crisis are many, originating in the oil price shocks of the 1970s. The effects of the oil price shocks were compounded by high US (and therefore international) interest rates driven by US monetary policy post-1979; by falling prices for the commodities that are the main exports of many developing countries; and by capital flight from those countries, which in turn was facilitated by financial deregulation (13). African countries have borrowed \$540 billion from foreign sources, paid back \$550 billion (in principal and interest), but still owe \$295 billion (14, p. 19). While some economists warn of the "moral hazard" of debt cancellation for least developed countries, implying that cancellation rewards corrupt or inept governments that incur unsustainable debts, the United Nations Commission on Trade And Development argues instead that the severity of the debt overhang, especially in light of African health and developing concerns, renders

failure to cancel the debts the real moral hazard. Thus, the Gleneagles Summit (15) commitment to \$40 billion in multilateral debt cancellation for 18 least developed countries, with a chance for 20 more countries to receive another \$16 billion in debt cancellation, is a welcome and overdue first step, but the conditions under which it is being offered are not.

The commitment applies only to a limited number of countries once they reach their "completion point" in the World Bank/IMF enhanced Heavily Indebted Poor Countries (HIPC) initiative, largely funded by the G7 countries.¹ Although this initiative has freed up funds for public spending on health and education (16), it has also been widely criticized for making debt relief conditional on adopting a variety of market-oriented economic policies that have only a tenuous relation to poverty reduction (11,17) and may worsen health conditions (see Addendum for a case study)². Further, many countries that are not part of HIPC will nevertheless require substantial debt relief if they are to have any chance to reach the Millennium Development Goals (MDGs) endorsed by the United Nations General Assembly in 2000 (19). Although ambitious when viewed against the background of recent progress in development, the MDGs are modest when measured against the scale of global need (20), and pay insufficient attention to intra-national issues of equity (21). In other words, a country could theoretically achieve the MDGs, even while worsening the health and income gap between rich and poor within its borders (21). The 2005 Summit also continued a long-standing refusal to address the question of whether 'odious debts' incurred by highly repressive or larcenous governments (e.g. those of Zaire under Mobutu, Kenya under Moi, South Africa pre-1994 and Nigeria pre-2002) should be regarded as uncollectible under international law (22,23).

Perhaps of most immediate concern are the conditions that may be attached to debt cancellation. For example, a separate partial debt cancellation deal for oil-rich Nigeria requires acceptance of "intensive surveillance of its economy by the International Monetary Fund" (24), whose priorities may or may not be related to the country's ability to meet the basic needs of its people. Belgium's IMF representative (with the support of Norway, Switzerland and the Netherlands) is seeking similarly "strict controls" over the economic policies of the 18 countries now eligible for full debt cancellation under the G8 plan (25). The World Bank has expressed concern that the G8 debt cancellation announcement "offered no mechanism for suspending debt relief if a debtor country deviated from economic and social reforms" prescribed by it and the IMF (26) ... and we know from long and bitter experience that the priorities incorporated in those "reforms" have little or nothing to do with improving population health (8,13) Such conditions directly

¹ The completion point refers to eligible countries under the HIPC program completing a multi-year program of macroeconomic policy reforms overseen by the two international financial institutions.

² Debt relief is often also used simply to pay off other creditors. For example, between 2002 and 2005 almost two-thirds of the revenue freed by debt relief for Zambia – our case-country in the Addendum – went to reduce debts owed to other creditors leaving only a third for investing in poverty-reducing programs including health and education (18, Table 2:37).

contradict the 2005 Summit's statement (¶131) that "it is up to developing countries themselves and their governments to take the lead on development. They need to decide, plan and sequence their economic policies to fit with their own development strategies, for which they should be accountable to all their people (15)." ³ Further, the 18 countries in question have already fully complied with the requirements imposed by the IMF and World Bank as part of the HIPC program; the addition of new conditions implies that these institutions are not prepared to release their control over the economic and social policies of poor developing countries, and suggests a broader agenda of forced integration into the global economy on terms dictated by the G8 countries that hold an effective majority in both institutions.

ii. 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 MDGs. At Gleneagles, the G8 committed to increasing development assistance to Africa by \$25 billion by 2010, driven primarily by the pledge of the European Union (EU) to raise its members' aid spending to the long-standing United Nations target of 0.7 percent of each industrialized country's Gross National Income (GNI) (15). Conversely, Canada and the United States were conspicuous by refusing to state timetables for reaching the 0.7 percent 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 years (27) – undermining the claims of Canadian political leaders that the target might be unaffordable. The \$670 million in increased aid in 2005 pledged by the USA amounts to less than one percent of that country's additional annual military spending in Iraq, and 0.5 percent of the value of the US Administration's 2004 corporate tax cuts (28). Moreover, concern is in order about whether the G8 will keep their promises: the 2005 Summit Communiqué implied that the G8 will continue to count debt relief as part of their aid spending -- repudiating the recommendation made at the International Conference on Financing for Development in 2002 that "donor countries ... take steps to ensure that resources provided for debt relief do not detract from ODA resources intended to be available for developing countries" (29, ¶151).

Development assistance is not a panacea for sustainable gains in health and development. Intense pre-Summit debate underscored long-standing issues of "absorptive capacity" (the ability of countries to cope with large infusions of funds and technical expertise), diversion of funds, failure to target aid on meeting such basic needs as those addressed by the MDGs, and lack of coordination among donor agencies, programs and non-governmental organizations (3,30). Development assistance that is tied to "technical cooperation" or purchases from donor country suppliers is a special problem. According to the civil society organization ActionAid,

³ This statement, in turn, is one of the few in the Summit that clearly embodied recommendations from the UK Commission for Africa's Report (4), which were intended to frame the host country's African policy agenda for the Summit.

the G7 donor countries are the worst in this regard: the USA ties 47 percent of its aid to the hiring of its consultants, and 70 percent of the rest to the purchase of its goods (31). A further concern is the ideological nature of some aid disbursements. The US administration, for example, continues to provide much of its aid through 'faith-based' organizations and, under its PEPFAR initiative (the President's Emergency Plan For Aids Relief), at least one-third of the funds must be used to promote abstinence and organizations providing information on abortion services are cut off from funding. Aid recipients must also take a public stand against prostitution, yet women sex workers are often a major target group for AIDS prevention education (32). Although two other G8 members – the UK in its Commission for Africa recommendations, and Canada in its 2005 International Policy Statement – have clearly affirmed the importance of the right to reproductive health, the only G8 comment on the US Administration's violation of this right was, ironically, "to welcome the launch of the President's Emergency Plan for AIDS Relief" (33).

The appropriate response to these problems is not to reject increased aid, as some have. Rather, it is to learn from past experiences and good examples, and to support independent judicial and civil society organizations in recipient countries that can serve as domestic watchdogs on the fairness and effectiveness of aid disbursements. Further, it must be recognized that, even under favourable – and probably unrealistic – economic and political assumptions, many developing countries will require substantial inflows of aid through 2015 and beyond if they are to achieve the MDGs (34). There are no 'set-and-forget-in-2015' solutions to the challenge of achieving health for all.

But still dropping the ball: Health systems, trade, arms and corruption

i. Health systems

Publicity for modest progress on debt and aid diverted attention from areas where the G8 dropped the ball, again. Perhaps the single most conspicuous failure is the lack of new money for the Global Fund to Fight AIDS, Tuberculosis and Malaria, announced by the G8 in 2001 with rhetoric about "a quantum leap in the fight against infectious diseases." The Fund estimates that it will need US \$7.1 billion in 2006 and 2007 to fund new proposals and continuations of existing work (35), against pledges of US \$1.45 billion as of July 2005 (36). The G8 said nothing about this funding 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" (15). Since the proliferation of funds and donor agencies is increasingly criticized for the competing reporting and staffing demands it places on recipient countries (37, 38), the Gleneagles commitment to work towards the UN AIDS goal of 'Three Ones' – one national AIDS implementation agency, one national policy, one monitoring framework – is a positive sign, if honoured. Yet it is substantially less ambitious than the recommendation of the UK Commission for Africa report that a "Fourth One, a single pooled fund, should also be pursued" (3, p. 198) for AIDS funding.

This strategy, if applied more broadly to health development assistance, would begin to decouple aid from the strategic, economic or ideological interests of the donor country and allow disbursements to be allocated more by health need and local health system and development requirements.

ii. Trade

A less visible but equally destructive failure involves trade. The G8 insist that “drawing the poorest countries into the global economy is the surest way to address their fundamental aspirations” (39). 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. Industrialized countries must lower trade barriers to such goods, and in particular must eliminate agricultural subsidies that lower world prices and limit developing country export opportunities (4,7,8)⁴. 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” (15).

The irony is bitter because many developing countries have destroyed domestic industries, such as textiles and clothing in Zambia (40, and as recounted in the Addendum) and poultry in Ghana (41), by lowering trade barriers and accepting the resulting social dislocations as the price of global integration. A recent study applied standard econometric modeling to the counterfactual: What would economic growth have been in sub-Saharan Africa over the past 20 years had its countries not been forced to liberalize their economies by the IFIs and conditions attached to aid (42,43). The study concluded the costs to be roughly \$272 billion – about the same amount these countries received in aid during this time. “Effectively, this aid did no more than compensate African countries for the losses they sustained by meeting the conditions that were attached to the aid they received” (42, p. 2).

Recognition is growing among development policy specialists that developing countries need stronger “special and differential treatment” (44) provisions under trade treaties. Reflecting this recognition, the UK Commission for Africa

⁴ We nonetheless offer three *caveats* to this basic conclusion. First, economic growth through raw commodity export has largely proven a dead-end for many developing countries, as well as a source of internal conflict over control of the resource exports (e.g. oil, gold, diamonds, other minerals). The escalating tariffs many G8 countries retain on manufactured or value-added goods are particularly egregious in keeping such countries underdeveloped within a “primary commodity trap.” This applies to agricultural products as well. Second, national policies must ensure that historic gender, cultural or class biases within developing countries that do increase their exports do not allow the benefits of export-led growth to accumulate in the hands of a few elite groups or companies. Third, some small poor countries are net food importers – largely due to how their boundaries were originally partitioned by European colonizing nations in the early 20th century – and benefit from depressed global food prices. As production and export subsidies (eventually) decline in rich world exporting nations, compensatory payments will need to be made to poor food importers if they are unable to achieve domestic food self-sufficiency.

recommended a “development test” whereby a dispute over a developing country’s arrogation of its trade treaty commitments should be screened to determine if it was required to meet its domestic development goals (4, p. 281)⁵. The G8 itself, as we noted earlier, claimed at Gleneagles that developing countries must “decide, plan and sequence their economic policies to fit with their own development strategies,” for which purpose easing trade treaty obligations and increasing their domestic policy flexibilities are essential. Yet no reference was made to this need in the documents emerging from the Summit apart from a rather bland and arguably contradictory acknowledgement in the *G8 Communiqué on Trade* that there must be “appropriate flexibility” for least developed countries to “sequence their overall economic reforms in line with their country-led development programmes *and their international obligations*” (15). G8 members are also reportedly reluctant to support strengthening special and differential treatment provisions in World Trade Organization negotiations (45).

iii. Arms control

Recent research suggests that the consequences of the trade in small arms are even more deadly than was previously thought (46). 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 (47). Although these exports and the overall value of the arms trade with developing countries have since declined (47), the UK Commission for Africa (4) 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.” The Gleneagles Summit committed financial and technical assistance to African peace-keeping efforts in conflict zones and devoted six pages of commitments to nuclear and biological weapons, but all it could muster for small arms control was recognizing “the need for further work to build a consensus for action” (15).

iv. Corruption

Corruption and capital flight undermine opportunities to improve population health. When political leaders loot their countries’ treasuries for personal gain or wealthy elites shift their assets abroad, the effect is to reduce governments’ ability to support basic needs like health care and education, as the tax base shrinks and governments borrow rather than financing their activities from domestic revenues (4,7,48). A further pernicious consequence is ‘donor fatigue’ and political backlash against aid spending that is seen, sometimes with good reason, as further enriching a corrupt

⁵ “This test would focus on the likely net effects of not implementing WTO rules in favour of more development orientated trade policy, and on negative spillovers, and would allow greater discussion of development concerns, rather than merely the implementation of the rule of law” (4, p. 280).

minority. It is good news, then, that the G8 will “[w]ork vigorously for early ratification of the UN Convention Against Corruption and start discussions on mechanisms to ensure its effective implementation” (15). The Convention, which no G8 country has yet ratified, is especially valuable because it binds parties to implement mechanisms to seize and repatriate illegally appropriated assets (4, 49). However, the G8 did not set the timetable for their own ratification of the Convention that a pre-Summit press report (50) suggested was in the works. What happened?

A thorough policy on corruption would also have to extend to the role played by multinational corporations in participating in bribery for special favours – with corporations based in G8 countries, notably Russia, Italy, the USA, Japan and France, amongst the worst global offenders, according to Transparency International’s 2002 Bribe Payers Index (51). While all G8 members have adopted the OECD Convention on Bribery, the Summit’s pledge (15) in the *Statement on Africa* to “rigorously enforce[e]” existing laws under this Convention merely reiterates past promises that have not been kept. Transparency International is calling on the G8 to issue a clear timetable for how it will pursue prosecution and public discrediting of corporate offenders under this Convention, as well as closing safe tax havens under G8 jurisdiction, notably that of the UK and the USA, where the proceeds of corruption are often banked (52).

What to expect from the G8?

Can, or should, 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 (53) – what political scientist Stephen Gill calls “part of an attempt to institutionalize a new form of transnational capitalist hegemony, and to reinforce the power of certain social forces within an emergent transnational civil society” (54, p. 131). This is the international political economy perspective. From an institutional perspective, even if one is more sanguine about the motivations of its member countries, the G8 is like any club that operates on a *de facto* unanimity rule in that every member has a veto for purposes of joint declarations of purpose like those that emerge from annual Summits. Currently, that veto is most often exercised by the United States when policies that would reduce global inequalities in the distribution of opportunities to be healthy are at stake.

At the same time, the requirement for unanimity is an explanation, not an excuse. The single most disturbing statement from Gleneagles was: “Further progress in Africa depends above all on its own leaders and its own people” (15). 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. However, the Gleneagles statement about the prerequisites for “further progress” must 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 promoted by the G8.

Those policies were backed up 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 (7-9,11,55). All too often, the choices available to developing country leaders, even those with good intentions and popular support, 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 (56). The G8 policy agenda, however, continues to reflect the economic and political interests of the world's rich minority. Taking global health seriously means replacing that agenda with one that more fundamentally alters the present distribution of power, within and among nations.

Addendum: From Structural Adjustment to the HIV Pandemic?

The causal pathways that link structural adjustment conditionalities with the illness of particular individuals are not linear or straightforward. But it is plausible to link HIV infections to the rise of free markets in Zambia, a policy shift actively promoted by international financial institutions. In 1992, as part of a structural adjustment program attached to loans from the IMF, Zambia opened its borders to many foreign goods, including textiles. Its domestic, state-run clothing manufacturers, inefficient by wealthier nation standards, could not compete. Within eight years, 132 of 140 clothing and textile mills closed and 30,000 jobs disappeared, which the World Bank later acknowledged as "unintended and regrettable consequences" of the adjustment process (40).

For conventional economists, this is a textbook example of how and why trade liberalization works: Consumers get better and cheaper goods (at least for a time) and inefficient producers are driven out of business. But many Zambians paid a heavy price for that presumed inefficiency, one that cascaded throughout other sectors of Zambia's limited manufacturing base. Large numbers of previously employed Zambian workers came to rely on the informal, ill-paid and untaxed underground economy. Poverty rates rose, particularly in rural areas (57). Privatization of state enterprises – another plank of the adjustment program – eliminated a revenue stream that might have been used to support social programs, such as education and health care. Instead, and again at the request of the international financial institutions, Zambia imposed user fees, cut health staff and reduced the salaries of those who remained – just when the AIDS pandemic was surging out of control. The UK Commission for Africa concluded: "Evidence shows that IMF and World Bank economic policy in the 1980s and early 1990s took little account of how these policies would potentially impact poor people in Africa. Many health and education systems began to break down. And all of this came just as AIDS began to take its deadly toll" (4, p. 23; see also (58) for a review of evidence linking structural adjustment conditionalities – currency devaluation, removal of food subsidies, privatization, trade liberalization and user-fees – with increased HIV/AIDS risk for African women and children.)

The Zambian government is now seeking to undo several of these policies, eliminating user fees for education, reducing charges for public health care and reintroducing agricultural subsidies. But it continues to be hampered by World Bank and IMF conditionalities. For example, the IMF, under its requirements for a medium term expenditure framework (59) requires Zambia to restrict its government payroll bill to 8 percent of GDP. To prevent professionals from leaving the country, and to retain desperately needed teachers and health workers, wage packets and supports caused Zambia's public sector payroll to climb to 8.4 percent of GDP in 2003 (18). As a result, it was temporarily suspended from debt relief in 2003, requiring it to pay \$377 million in debt servicing costs, \$247 million of which actually went back to the IMF (57, p. 73). Zambia's eligibility for debt relief under HIPC was restored in 2004 when a combination of fiscal austerity and rising export earnings dropped the wage ratio to 7.8 percent of GDP – but not before the Dutch government donated \$10 million to pay for more teachers in order to keep the wage ratio within IMF prescribed guidelines (57,60). To reach its HIPC completion point, and so become eligible for the G8's debt cancellation package, Zambia must continue with plans to commercialize its energy utility, introduce policies to support private sector competition and privatize its national bank (18) – all of which face strong domestic opposition (57).

These points do not absolve Zambian rulers from responsibility for their country's declining health and rather ruinous economic performance over the past two decades. But they do point to serious flaws in the priorities that G7 countries, through the international financial institutions, continue to assert with respect to economic and social policies in many of the world's poorest countries, often creating conditions that undermine the effectiveness of their commitments to increased funding for health.

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