

Chapter 12

Breaking Faith with Africa: The G8 and Population Health after Gleneagles

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The G8 summit at Gleneagles was preceded by unprecedented popular culture rhetoric (the Live 8 concerts and the Make Poverty History wristband campaign) and also by the release of two major research syntheses on the topic. The United Nations Millennium Project was established in 2002 as an advisory body to the UN secretary general, under the directorship of economist Jeffrey Sachs, to explore policy options for achieving the Millennium Development Goals (MDGs) (Sachs and McArthur 2005; UN Millennium Project 2005). The Commission for Africa was established and chaired by Britain's prime minister Tony Blair in support of an African development focus for the summit (see Commission for Africa 2005).¹ Nevertheless, the author of the August/September 2005 cover story in *African Business* wondered: 'So, after the sound and fury of Gleneagles, what are we left with? Have there been any decisive policy changes that will ultimately lead most of Africa out of poverty?' (Versi 2005). The conclusion: 'One must say, reluctantly given the well-meaning intentions, that there were not.'

If one accepts this view of the Gleneagles outcome, as reflected in the content of summit commitments themselves and in subsequent policy developments, including the 2006 G8 St. Petersburg Summit, then it can be viewed as continuing a recent pattern of commitments and policies affecting health in the region: some commitments are fulfilled, others are compromised by uncoordinated initiatives or inadequate resources, and still others incorporate policy prescriptions that are actually destructive of health and human well-being (Labonté and Schrecker 2004; Labonté *et al.* 2004; Labonté and Schrecker 2005, 2006). Despite several genuinely positive outcomes from Gleneagles, the departure from a past pattern of 'fatal indifference' (Labonté *et al.* 2004) must be viewed as incremental rather than fundamental. Furthermore, there is concern about the sustainability of that departure in the uncertain world of G8 summity. This concern is deepened by the limited attention paid to African issues at St. Petersburg beyond a rather self-congratulatory 'update on Africa', by the lack of progress on such key long-standing issues as secure financing for the Global Fund to Fight AIDS, Tuberculosis, and Malaria, and by the apparent collapse of the development round of World Trade Organization (WTO) negotiations just weeks after St. Petersburg.

This approach taken in this chapter is distinctive in several respects. First, it is concerned with policies that affect health, but not only with health care. A substantial body of research, to which Canadians have been important contributors, demonstrates that various aspects of social and economic systems are at least as relevant to the health status of a particular population as is its access to health care (Evans and Stoddart 1990, 2003; Evans, Barer, and Marmor 1994; Heymann *et al.* 2005). These are referred to generically as social determinants of health, and are the focus of a multinational commission established in 2005 by the World Health Organization (see WHO 2006b). Second, the chapter is concerned not only with whether the G8 fulfilled or failed to fulfil its summit commitments with respect to Africa, but also — indeed, primarily — with the adequacy of those commitments when measured against the scale of the region's needs and their appropriateness in view of what is known about the social determinants of health. These determinants are shaped by the broader social and economic policy context, which has been referred to as 'those central engines in society that generate and distribute power, wealth, and risks' (Diderichsen, Evans, and Whitehead 2001).² The approach taken here therefore incorporates a critique of the effects on the social determinants of health of the dominant development policy model that has been adopted with respect to Africa.

The G8 made a commitment at the 2001 Genoa Summit to 'make globalisation work for all [its] citizens and especially the world's poor' (G8 2001). Immediately following this statement was the claim that 'drawing the poorest countries into the global economy is the surest way to address their fundamental aspirations'. This formulation sidesteps the crucial question of on what terms (and on whose terms) such countries are to be integrated. The operative model has been described as the Washington consensus, after John Williamson's (1990) codification of the development policy wisdom of the time; it has alternatively been referred to as neo-liberal globalisation, in its representation of a retreat from post-war norms of at least partial social provision to the 'non-redistributive laissez faire liberalism of the seventeenth and eighteenth centuries, which held that the main function of government was to make the world safe and predictable for the participants in a market economy' (Jaggar 2002, 425). Regardless of terminology, little serious disagreement exists on either the broad outlines of the model, emphasising the liberalisation of trade (especially imports) and financial flows, deregulation, privatisation of state-owned economic entities, the scaling back of government subsidies, and a retreat from other forms of social provision on the grounds that even if affordable they encourage economic inefficiency, or the consistency with which key institutions in the industrialised world promoted it throughout most of Africa.³

The governments of G7 countries were not alone in promoting this model, of course, and the lead role was often assumed by multilateral institutions: the World Bank, the International Monetary Fund, and, more recently, the WTO.⁴ However, the G8 nations '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). They also account for roughly 75 percent of the annual value of development assistance expenditure, and their deep pockets are among the resources that provide them with formidable advantages in trade negotiations and dispute resolution proceedings, both within and outside the framework provided by the WTO (Jawara and Kwa 2003). Hence, there is a third respect in which the approach taken here is distinctive, and explains the title of this chapter. 'Breaking faith' implies the existence of an obligation (in this case, on the part of the G7/8 countries) that has not been lived up to, whether the obligation is derived from a previous promise or from some other source. One can identify at least four such sources, in addition to specific commitments that were made at annual summits.

Population Health and the G8: Why Care?

First, obligations may be said to arise from the sheer disparity between the resources available to the world's affluent minority and the modest cost of medical and public health interventions that would save literally millions of human lives per year. On this line of argument, 'radical inequality' is ethically reprehensible both because simple arithmetic suggests that it is so easily avoidable (Pogge 2005b) and because of the incommensurability of needs that remain unmet for millions and wants that are easily satisfied by the winners in the global economy: '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' (Shue 1996, 10). The argument is broadly analogous to the rule of rescue (McKie and Richardson 1982), with the distinction that the lives in question are 'statistical lives' that do not belong to identifiable individuals. Although popular acceptance neither validates nor vitiates an ethical argument, it should be noted that the extent to which an obligation to provide access to health care or key social determinants of health on grounds of disparities and affordability would be accepted by G8 electorates even with respect to their fellow nationals is unclear and varies among the countries in question. Solidarity, for example, is widely invoked in discussions of access to health services in some European jurisdictions, but is absent from the vocabulary used in Canadian discussions of the same issue (Flood, Stabile, and Tuohy 2002; Giacomini *et al.* 2004). This point is revisited at the end of the chapter.

Second, the international community, to the extent that the membership of the United Nations General Assembly (UNGA) fits that description, has committed support for achievement of the MDGs by specified target dates, usually 2015 (see Appendix). Three of the goals involve reducing child and maternal mortality and reversing the spread of HIV/AIDS, malaria, and other communicable diseases; these are explicitly related to health. Four others directly address crucial social determinants of (ill) health, such as extreme poverty, undernourishment, living in slums, the subordination of women, and lack of access to education, safe water, and basic sanitation. An assessment prepared for a WHO forum held in 2004 is typical in its conclusion that 'even if economic growth accelerates ... and even if progress

toward the gender and water goals is substantially accelerated, the developing world is likely to wake up on the morning of January 1, 2016, some way from the health targets; in Sub-Saharan Africa, it may be a long way' (Wagstaff and Claeson 2004, 42). More recent syntheses of available evidence have offered similar prognoses, at least in the absence of greatly intensified policy efforts on the part of the industrialised world (UN 2005; WHO 2005b). Given the dominant role of the G8 in the global economic and geopolitical order, it seems reasonable to ascribe to them a substantial share of the responsibility for this impending policy failure.

Third, in a world in which an increasingly dense network of trade and investment flows and 'government networks' links rich and poor across national borders, it may be reasonable to search for loci of past and current causal responsibility (who makes what happen?) in that set of networks (see Slaughter 2005). Thomas Pogge has developed an extensive corpus of work elaborating this line of argument with specific reference to the global persistence of poverty. His position can be summarised as follows:

We are not bystanders who find ourselves confronted with foreign deprivations whose origins are wholly unconnected to ourselves. In fact, there are at least three morally significant connections between us and the global poor. First, their social starting positions and ours have emerged from a single historical process that was pervaded by massive grievous wrongs ... Second, they and we depend on a single natural resource base, from the benefits of which they are largely, and without compensation, excluded ... Third, they and we coexist within a single global economic order that has a strong tendency to perpetuate and even to aggravate global economic inequality (Pogge 2001, 14–15; see also Pogge 2002; Pogge 2005a, 2005b).

Two elements of that order are singled out for special attention by Pogge: the 'resource privilege', which describes the international community's willingness to allow rulers to dispose of natural resources within their borders with scant concern for the well-being of their subjects (as in the appropriation of billions of dollars in resource revenues by Mobutu Sese Seko and Sani Abacha, among others), and the 'borrowing privilege', which maintains the collectibility of debts incurred by rulers on behalf of the countries they govern, without scrutiny of the extent to which subjects have consented to those financial obligations. This latter privilege has quite specific implications for development policy, as indicated in the subsequent discussion of the issue of odious debt. 'Given these connections,' concludes Pogge (2001, 15), 'our failure to make a serious effort toward poverty reduction may constitute not merely a lack of beneficence, but our active impoverishing, starving, and killing millions of innocent people by economic means'.

Fourth, obligations related to development and population health may also arise from international human rights law. Key texts include the 1948 Universal Declaration of Human Rights, which states that 'everyone has the right to a standard of living adequate for the health and well-being of himself and of his family' (UN 1948, art. 25); the 1966 International Covenant on Economic, Social, and Cultural

Rights, never ratified by the United States, which specifies the ‘right of everyone to the enjoyment of the highest attainable standard of physical and mental health’ (Office of the High Commissioner for Human Rights 1966, art. 12); and General Comment 14 of the UN Economic and Social Council (2000, para. 33), which sets out states’ specific legal obligations ‘to *respect, protect* and *fulfil*’ the right to health.⁵ Even apart from the 1966 covenant, Pogge argues that specific duties follow from article 28 of the Universal Declaration of Human Rights: ‘Everyone is entitled to a social and international order in which the rights and freedoms set forth in this Declaration can be fully realized.’ At present, no effective supranational mechanisms analogous to the institutions of trade policy and law exist to ensure respect for these requirements, which represents a glaring asymmetry in the world of international relations. Nevertheless, this source of obligations cannot be dismissed as irrelevant, and is indeed the focus of increased attention within the UN system, notably the appointment of a special rapporteur on the right to health (Hunt 2003, 2004, 2005; Office of the High Commissioner for Human Rights 2006).

African Development, Poverty, and Health: Some Necessary Background

Even apart from the scrutiny of compliance with commitments made at G8 summits, then, several sets of reasons exist for ascribing responsibility to the G8, individually and collectively, for changes in the social determinants of health in Africa. The most basic and omnipresent term of the equation is poverty, however defined. According to the World Bank’s figures, in sub-Saharan Africa 313 million people, or almost half the population, live below a standardised poverty line of US\$1 or less per day (Chen and Ravallion 2004). Caution is in order about the use of these figures. It has been argued that the way in which market income figures are adjusted for purchasing power parity bears little relation to real-world prices of basic necessities (Reddy and Pogge 2005). David Satterthwaite (2003) notes that this disconnect may be especially acute in the case of major urban areas, even in the poorest countries: rapid urbanisation in the developing world may therefore mean that the extent to which the World Bank’s estimates understate the global extent of inability to meet basic needs is actually increasing over time. And poverty, when treated as a dichotomous variable (poor/non-poor), has the disadvantage of implying that different kinds of redistributive obligations apply to people depending on whether they fall just to one side or the other of a largely arbitrary divide. The World Bank figures are nevertheless useful in the African context for highlighting the fact that sub-Saharan Africa is the only region of the world in which, according to this admittedly flawed measurement, the number of people living in extreme poverty has increased — indeed, almost doubled between 1981 and 2001. This reflects a disastrous failure of development policy, with far-reaching implications for population health.

Interactions between poverty and ill health are pernicious everywhere. They are pervasive throughout the developing world, particularly in Africa. Inadequate health care sets ‘medical poverty traps’ at the household level, because of medical costs

(user fees, but also costs of transport to often distant medical facilities) and loss of income resulting from inability to work (Whitehead, Dahlgren, and Evans 2001). At the national level, the fundamental finding of the Commission on Macroeconomics and Health (2001), established by the WHO as its first exploration of the linkages between economic development and health, was that improved health can make a substantial contribution to economic growth. Low-cost, demonstrably effective interventions that could save millions of lives per year throughout the developing world are available (Commission on Macroeconomics and Health 2001; Jha *et al.* 2002; Bryce *et al.* 2005). However, a minimal level of health-system functioning is required to deliver even relatively simple interventions such as childhood immunisation; a higher level of both physical and human infrastructure, although still rudimentary by standards of the industrialised world, is required for such services as effective HIV prevention and antiretroviral treatment (ART) (Travis *et al.* 2004; Sanders, Chopra, and Todd 2005). In the words of the Commission for Africa (2005, 188, 190), ‘massive under-investment, along with unsystematic responses to single diseases and unpredictable financing, have left health care delivery at the point of collapse. Poor people are the worst affected’ as ‘health care delivery systems are in danger of disintegrating beyond repair.’

As one illustration of the consequences, immunisation coverage with the six basic vaccines of childhood (against tuberculosis, polio, diphtheria, pertussis, tetanus, measles) has stagnated at a dismal 50 percent to 60 percent in the region (WHO 2005a). The seemingly intractable ‘brain drain’ of health professionals from sub-Saharan Africa is now recognised as perhaps the single most immediate contributor to health system crisis (Chen *et al.* 2004; Friedman 2004; Joint Learning Initiative 2004; WHO 2006a); according to one estimate it costs countries in the region US\$0.5 billion per year in health training investment (Commission for Africa 2005, 192). One recent study indicated that ‘sub-Saharan countries must nearly triple their current numbers of workers by adding the equivalent of 1 million workers through retention, recruitment, and training if they are to come close to approaching the MDGs for health’ (Chen *et al.* 2004). A recent study estimated that the 600 or more South African-trained physicians who have been licensed to practice in Canada since 1993 represented a loss in South Africa’s public training costs approaching CA\$1 billion; or a savings of some CA\$3 billion to CA\$5 billion in foregone Canadian training costs (Labonté, Packer, and Klassen 2006).

The effects of the brain drain are compounded by losses of health professionals to HIV/AIDS and by the internal brain drain of health professionals into the private healthcare sector and into vertical, donor-supported initiatives that address specific diseases or deliver specific interventions, such as the U.S.-funded President’s Emergency Program for AIDS Relief. These programmes, which have historically been favoured by G8 donor countries, routinely offer better salaries and working conditions than are available in healthcare institutions funded from national revenue budgets.

Health Care and Health Systems

The G8 did not rise to this set of challenges at Gleneagles, most conspicuously in their failure to provide adequate financing for the Global Fund to Fight AIDS, Tuberculosis, and Malaria. AIDS and malaria alone are responsible for approximately 3.5 million deaths per year in Africa. The Global Fund, announced by the G8 in 2001 with rhetoric about ‘a quantum leap in the fight against infectious diseases’, estimates that it will need US\$7.1 billion in 2006 and 2007 to fund new projects and continuations of existing work, but had pledges in hand for those years of just US\$1.45 billion at the time of the Gleneagles Summit (G8 2001; Global Fund 2005a; Global Fund 2006a). The effect was, and is, to create tight constraints on the value of grants that can be approved even after scientific merit has been demonstrated in the fund’s competitive technical review process, since the fund ‘can only approve grants if the full amount required for the first two years is covered by pledges from donors in the calendar year of the approval’ (Global Fund 2005a, 34). The September 2005 replenishment meeting raised the total value of funds pledged for 2006–07 to US\$3.73 billion, or just over half the anticipated funding requirement (Global Fund 2005b). This can hardly be seen as the basis for a quantum leap. More fundamentally, the G8 can be faulted for failing to move forward on the need to secure longer term financial support for the Global Fund, which now estimates that funding requirements could be as high as US\$7–8 billion per year, as an alternative to the current practice of periodic replenishment meetings at which the fund, in effect, passes around a hat (Global Fund 2005a, 32; Commission for Africa 2005, 196). At the St. Petersburg Summit, the G8 would commit only to ‘work with other donors and stakeholders in the effort to secure funds needed for the 2006–2007 replenishment period and call upon all concerned to participate actively in the development of a four-year strategy, aimed at building a solid foundation for the activities of the Fund in the years ahead’ (G8 2006).

Programs such as the Global Fund and the Global Alliance for Vaccines and Immunization (GAVI), although valuable, tend to emphasise funds for specific technical interventions such as new drugs and vaccines. The Global Fund (2006b), for example, targets 49 percent of its expenditure on drugs and commodities, such as ART and new anti-malarials, but only 20 percent on human resources and training; GAVI began by spending 90 percent of its disbursements on vaccines and injectables but only 10 percent on health-system strengthening (Hardon 2001); this ratio has since changed to approximately two thirds and one third (GAVI Alliance 2006). More generally, support for ‘vertical’ programmes, often provided without long-term donor commitments, is unaccompanied by support for strengthening health systems. The Commission for Africa (2005, 196–195) placed special emphasis on this need, arguing for an immediate increase of US\$10 billion in donor support for African health systems including ‘long-term and predictable compensatory funding’ needed to eliminate all user fees for basic health care but excluding the costs of responding to the HIV/AIDS crisis and delivered ‘predominantly through national budgets’ rather

than project-specific funding. In making this recommendation, the commission was arguably responding to long-standing criticisms of how user fees and 'cost recovery' programmes undermine access to health care for the poor and of how donor practices and policies compromise the effectiveness of development assistance for health by fragmenting national efforts to develop integrated health systems and increasing opportunity costs for already overstretched ministries of health (see Lister 2005). Continued lack of a detailed response on the part of the G8, which at past summits has announced highly specific action plans on other topics, is a troubling indication both of the relatively low priority attached to health care as a human right and a lack of understanding of the critical role of health in economic development.

Official Development Assistance

One of the two highest-profile outcomes of Gleneagles was a commitment to increasing official development assistance (ODA) to Africa by US\$25 billion by 2010, driven primarily by pre-summit announcements by France, Britain, and the European Union to raise their aid spending to the long-standing UN target of 0.7 percent of each industrialised country's gross national income (GNI), originally floated in 1970 and cautiously reaffirmed at the United Nations Conference on Financing for Development in Monterrey in 2002. Conversely Canada, the United States, and Japan were conspicuous by refusing to state timetables for reaching the 0.7 percent target. The Gleneagles development assistance commitment can be read as a direct response to the reports of the UN Millennium Project and, in particular, the Commission for Africa, each of which recommended an approximate doubling of the current value of ODA. Some civil society organisations, notably Jubilee Research (2005), were strongly critical of this commitment on the basis that much of it involved not genuinely new money, but rather recycled announcements made in advance of the summit. This is perhaps a less serious limitation than several others.

First, no specific financing mechanisms were described, leaving the prospect that the commitments will fall by the wayside as other, domestic priorities take over the attention of governments. The International Financing Facility (IFF), which was promoted by Britain and recommended both by the Commission for Africa (2005, 333–335) and the UN Millennium Project (2005, 256), was not endorsed at Gleneagles. The IFF would provide new funds for ODA by issuing bonds backed by national governments' pledges of funds up until 2015, although the term of the bonds would be much longer. The proposal has numerous problems, notably the possibility of a major drop in post-2015 development assistance flows and the fact that raising funds through new borrowing rather than taxation would transfer US\$220 billion to presumably wealthy bondholders over a 30-year period (Moss 2005); however, it has the advantage of offering clear assurance that aid commitments will actually be fulfilled. Thus the G8 can be faulted for neither adopting the proposal nor offering a clear alternative that would provide a comparable degree of predictability in terms of the availability of ODA funds. Second, some of the new spending may come in

the form of additional debt relief (as noted below), or may simply offset substantial revenue losses from import liberalisation by developing countries, for instance as a result of the economic partnership agreements now being negotiated between the EU and African countries.⁶ Third, no specific priorities are indicated for aid — as would be suggested by the preceding discussion of the need to strengthen health systems and by the UN Millennium Project's strong critique of current aid priorities as not being aligned with the MDGs. It estimated that just 35 percent of aid to low-income countries, and 20 percent of aid to middle-income countries, provides direct support for achieving the MDGs (UN Millennium Project 2005, 199). The lack of specific priorities for aid may respond to calls for expanded opportunities for recipient countries to select their own priorities, but this has not been a major concern of most aid suppliers historically, and the lack of explicit commitment to supporting the MDGs (or any other set of core objectives related to basic needs) stands in striking contrast to the long history and current persistence of detailed economic policy conditionalities attached to structural adjustment lending and debt relief.

Conversely, the civil society critiques neglect an important positive dimension of the Gleneagles aid commitment: it can be read as rejecting, as did the UN Millennium Project and the Commission for Africa, a scepticism about the value of ODA that is fashionable in some circles.⁷ While properly directing attention to the internal politics and political economy of African countries, the sceptical position fails to attach enough importance to external factors such as the willingness of industrialised world financial institutions to facilitate capital flight, the industrialised world's hunger for natural resources (*cf.* Pogge's discussion of the resource privilege), and the debilitating effects of structural adjustment conditionalities.⁸ In an important shift of the assignment of responsibility, the UN Millennium Project and the Commission for Africa each emphasised donor policies and practices as constraints on aid effectiveness. The UN Millennium Project (2005, 202) argued 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 industrialised world; it identified numerous ways in which aid suppliers should realign their activities with support for the MDGs. Furthermore, in a direct challenge to received wisdom that weak governance or absorptive-capacity constraints seriously limit the potential benefits from short-term increases in ODA, its discussion of Africa argued that the quality of governance in African countries is comparable to that in other regions with similarly low per capita incomes. Incomes are a necessary consideration for comparison purposes because 'good governance requires resources for wages, training, information systems, and so forth' (146) — resources that may simply not be available.

Debt Relief

Perhaps the most serious constraint 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). Between 1970 and 2002, African countries borrowed US\$540 billion from foreign sources, paid back US\$550 billion (in principal and interest), but still owe US\$295 billion, according to the United Nations Conference on Trade and Development ([UNCTAD] 2004, 19).

Over the past ten years, the G8 has led the industrialised world in committing a total of US\$58 billion to the partial cancellation of the debts of up to 40 countries, 32 of them in Africa, under the Enhanced Heavily Indebted Poor Countries (HIPC) Initiative. Some G7 members have gone farther in terms of offering the cancellation of debts owed to their governments alone. Although this initiative has made possible increased public spending on health and education in a number of recipient countries (Gupta *et al.* 2002), it has also been widely criticised on several grounds. First, 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 went to reduce debts owed to other creditors, leaving only a third for investing in poverty-reducing programmes including health and education (IMF and World Bank 2005, 35).

Second, according to one pre-Gleneagles estimate, half the debts of the HIPCs would remain unpaid and uncancelled even if all countries received the full amount of debt relief for which they were eligible (Martin 2004). Despite receiving debt relief, two African countries (Malawi and Mozambique) have actually seen increases in their debt service costs, while Uganda and Senegal have seen reductions of less than 25 percent (UN Department of Economic and Social Affairs 2005, 148).

Third, the conditions attached to debt relief for HIPCs, notably the requirement that a Poverty Reduction Strategy Paper (PRSP) be approved by the World Bank and the IMF, have been criticised as replicating an earlier pattern of conditionalities attached to structural adjustment loans (Cheru 2001; Gottschalk 2004). These often increased economic inequality, reduced access to health care, led to deterioration in the social determinants of health, and almost certainly accelerated the spread of HIV infection (Cornia, Stewart, and Jolly 1987; Bijlmakers, Bassett, and Sanders 1999; Cheru 1999; Schoepf *et al.* 2000; Kim *et al.* 2000; Sanders and Sambo 1991; De Vogli and Birbeck 2005). The report of the UN Millennium Project added a further dimension to the critique of PRSPs by noting that 'very few PRSPs are ambitious enough to achieve the [Millennium Development] Goals, *largely because* they have been prepared in a context of insufficient donor assistance' (UN Millennium Project 2005, 49 [emphasis added]).

Fourth, the process of granting debt relief under the Enhanced HIPC Initiative still gives priority to minimising creditors' losses rather than meeting basic needs in debtor countries: at the insistence of the G7 a sustainable debt load has been defined with reference to forecasts of future export earnings (Martin 2004). The UN Millennium Project incorporated many earlier critiques in recommending that "debt

sustainability” should be redefined as “the level of debt consistent with achieving the Millennium Development Goals,” arriving in 2015 without a new debt overhang. For many heavily indebted poor countries, this will require 100 percent debt cancellation. For many heavily indebted middle-income countries, this will require more debt relief than has been on offer’ (UN Millennium Project 2005, 207–208).

At Gleneagles, the G8 agreed to a proposal that had been previously accepted by the G7 finance ministers to cancel an additional US\$40 billion to US\$56 billion of debts owed by HIPCs to the World Bank, the IMF, and the concessional arm of the African Development Bank (AfDB). This commitment, which has now been formalised as the Multilateral Debt Relief Initiative (MDRI), was a welcome and overdue next step, as was a separate partial debt cancellation deal for Nigeria estimated to be worth US\$31 billion (World Bank 2006; Elliott and Wintour 2005). However, questions remain about reliability, since as of early 2005 US\$12.3 billion of commitments under the existing Enhanced HIPC Initiative remained unfunded (UN Department of Economic and Social Affairs 2005, 146). The Gleneagles response also may be inadequate. Notably, it fails to address the debts owed by low-income non-HIPCs other than Nigeria, including those owed to private creditors (Commission for Africa 2005, 328). Development assistance to countries that receive additional debt relief under the MDRI will be reduced by some portion of the amount (IMF 2005), thus repeating the pattern in which ODA declined substantially in the late 1990s after the start of the original HIPC Initiative (Killick 2004, 6–7). As a further indication of the persistence of this pattern, Britain’s Department for International Development (DfID) conceded in April 2006 that its inflation-adjusted spending on development assistance had actually declined between 2004 and 2005 if one subtracted the value of Britain’s contribution to debt relief for Nigeria and Iraq (Gow 2006).

Perhaps of most immediate concern are the conditions that are likely to be attached to debt cancellation. For example, the Nigerian debt deal requires acceptance of ‘intensive surveillance of its economy by the International Monetary Fund’ (Elliott and Wintour 2005). Given Nigeria’s record of corruption and misallocation of resource revenues, such surveillance is not intrinsically undesirable, but the IMF’s past record is grounds for scepticism about whether it will focus on how effectively the Nigerian government directs resources toward basic needs. Since Gleneagles the World Bank 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 — presumably reforms at least partly like those characteristic of the earlier era of structural adjustment (Wroughton 2005). So far 19 countries have reached the ‘completion point’ under the Enhanced HIPC Initiative, meaning they have already been through multiple stages of approvals by the IMF and World Bank; only these countries are eligible for the additional debt relief offered in 2005. Adding new conditions indicates that these institutions and the G8 members that together command effective voting majorities in both are not prepared to relinquish control over the economic and social policies of recipient countries, opting instead for a more extended period of what can only be called forced integration into the global economy.

Finally, the Gleneagles and St. Petersburg summits continued a long-standing refusal to address the question of odious debts (Kremer and Jayachandran 2002; King, Khalfan, and Thomas 2003). The Commission for Africa (2005, 114) correctly pointed out that during the Cold War era, ‘dictators who were enriching themselves through their countries’ oil, diamonds and other resources ... siphoned billions of dollars out of their country [*sic*] using the financial systems of developed countries’ — an illustration of the pernicious interaction of the resource and borrowing privileges identified by Pogge — and cited an estimate ‘that stolen African assets equivalent to more than half of the continent’s external debt are held in foreign bank accounts’ (150).⁹ However, neither the commission nor the G8 seriously proposed that public debts incurred (for example) by Zaire (now the Democratic Republic of the Congo) under Mobutu Sese Seko, Kenya under Daniel arap Moi, Nigeria under Sani Abacha, or South Africa under the National Party between 1948 and 1994 should be regarded as uncollectible.¹⁰ The G8 has never addressed this issue, although it is surely not beyond members’ individual and collective forensic ingenuity to compile an inventory of odious debts and criminalise attempts to collect them by natural or legal persons within their jurisdictions, including both public and private creditors.

Trade Policy

A development policy failure with comparably destructive effects on equitable access to the social determinants of health involves trade. Recent trade policy has required that developing countries accept minimal gains as the price of major concessions, which may foreclose policy flexibilities that the now-industrialised countries used in earlier stages of their own economic development (Chang 2002, 2005). Many developing countries have destroyed their domestic economic sectors, such as textiles and clothing in Zambia (Jeter 2002) and poultry in Ghana (Atarah 2005), by lowering trade barriers and accepting the resulting social dislocations as the price of global integration. Import liberalisation was a key element of structural adjustment programmes; one study found that PRSPs may include ‘trade-related conditions that are more stringent, in terms of requiring more, or faster, or deeper liberalisation, than WTO provisions to which the respective country has agreed’, thus underscoring the continuity of macroeconomic policy prescriptions (Brock and McGee 2004, 20).

Development policy protagonists who disagree about much else agree on the desirability of drastically improving access to industrialised world markets for developing country exports, and in particular on the need to reduce market-distorting agricultural subsidies, often citing estimates issued by the Organisation for Economic Co-operation and Development ([OECD] 2004) that support for agricultural producers amounts to more than US\$300 billion annually. Five years after the commencement of WTO negotiations that were described by the G8 leaders and others in terms of a development agenda, negotiations apparently collapsed in July 2006 — ironically, just weeks after the St. Petersburg Summit — largely because of industrialised country intransigence on agricultural subsidies (‘In the Twilight of

Doha' 2006; International Centre for Trade and Sustainable Development [ICTSD] 2006).

Admittedly, the relations between agricultural subsidies as defined by the OECD and prospects for development are more complicated than acknowledged by many participants in the debates.¹¹ No one-to-one correspondence exists between the value of subsidies, as defined by the OECD, and income lost by agricultural producers outside the OECD. Model-based estimates of the 'welfare gains' from worldwide elimination of agricultural subsidies fail to distinguish winners and losers within developing countries and regions, and in some cases the losses would be substantial, thus undermining the claimed pro-poor, pro-development effect of subsidy cuts. Although improved market access in the developing world may increase the incomes of agricultural producers who are already part of the cash economy, it is likely to have little benefit for larger numbers of producers who are primarily oriented toward subsistence, with occasional local market sales — the problem of 'two agricultures', one of which requires selective domestic subsidy as well as other policy supports if it is to remain viable (Howell 2005; see also Cousins 2006). Finally, some of the most serious, negative trade-related impacts on producers of specific crops are attributable only in part to developed country subsidies. Indiscriminate liberalisation of agricultural imports, which may be part of a larger governmental strategy of embracing the global marketplace even at high cost to particular economic sectors, is also implicated; so too is the increased control of agricultural commodity chains by multinational corporations (MNCs) based in the industrialised world, which tend to maximise profits on a global scale with little concern for the viability of local economies (Weatherspoon and Reardon 2003; McMichael 2005).

This is not to let the G8 off the hook with respect to specific destructive subsidies, but to suggest that the entire issue requires 'a more fine-grained approach, which would differentiate among crops and countries', with more sensitivity to incidence of costs and benefits within developing countries than has been evident in the course of recent multilateral trade negotiations and G8 summits (Stiglitz and Charlton 2005, 45). The events of the summer of 2006 suggest that prospects for implementing such an approach in a development-friendly way have taken a turn for the worse. These events also suggest problems ahead for acting on the tension between provisions in trade agreements and developing countries' need for 'policy space' within which to implement social and economic policies that meet the needs of their own citizens — or, at least, their governments' interpretation of those needs (Chang 2002, 2005; South Centre 2005).¹² One mechanism for providing that flexibility, but not the only one, is the special and differential treatment (SDT or S&DT) provision in trade agreements, which has existed since the founding of the General Agreement on Tariffs and Trade (GATT).¹³ WTO members, including the G7, agreed in 2001 to review 'all special and differential provisions ... with a view to *strengthening* them and making them more precise, effective and operational' (WTO 2001, para. 44 [emphasis added]). However, a 2004 assessment noted flatly that 'efforts since then to achieve these objectives have come to naught' because of deep differences between developed and developing countries (Hoekman 2004).

From a development policy perspective, 'it is important to see S&DT as a mechanism to deal with systemic imbalances in the trading system. It is not charity, but rather dealing with the reality of an unequal playing field resulting from rules designed by negotiations by unequal partners' (ICTSD 2003, 17). One observer notes that the fundamental question is whether such provisions should be considered temporary measures to facilitate the integration of developing economies into global exchange relationships characterised by dramatic disparities in resources and bargaining power, or whether 'the bottom-line question for the WTO should be what it can do to facilitate development, not what it is willing to allow to ease adjustment' (Garcia 2004, 300). The Commission for Africa (2005, 280–281) similarly mooted the idea of applying to selected WTO commitments a 'development test' that '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.

The events of July 2006 suggest that such measures are highly unlikely if they would create substantial costs for any politically significant domestic constituency in the industrialised world, unless there are also very substantial benefits for comparably influential actors. Further concerns arise from the proliferation of bilateral and regional trade negotiations and agreements, in which disparities between industrialised and developing countries in bargaining power and resources may be even more glaring (World Bank 2004, 27–56). 'WTO-plus' provisions emerging from these settings may vitiate whatever gains in terms of market access and domestic policy flexibility African countries, and others in the developing world, are able to secure within the WTO framework (Shadlen 2005). Unless the WTO negotiating process can be quickly and decisively revitalised, it is likely that the industrialised countries will simply 'go bilateral' or regional, arguably with negative impacts on all developing countries save those few with special bargaining advantages.

Such tensions within trade policy are not surprising. The criticisms of G8 offered here, and in fact the entire concept of the trade negotiations that began in 2001 as a 'development round', imply the desirability of 'a fundamental departure from the system of mercantilism towards a collectively agreed global social welfare function. However, there has been almost no discussion, let alone agreement, on what that function should be' (Stiglitz and Charlton 2004, 496). Still less has trade policy acknowledged the need to incorporate the issues of fairness and distribution that are an integral part of linking trade with development, or with attaining shared objectives such as the MDGs (Stiglitz and Charlton 2005).

Conclusion: What to Expect from the G8?

As noted earlier, it is important to situate these observations in the context of what is known about the social determinants of health — more specifically, with reference to fact '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 and Farmer 2005, 12; see also Farmer 2003). The preceding discussion of the health implications of recent G8 policies and summit commitments is far from exhaustive. For example, no discussion of hunger and food insecurity is provided, although this is one of the most clearly poverty-related determinants of health and more than 800 million people — including 240 million in Africa — are chronically undernourished and a substantially larger number suffer from serious micronutrient deficiencies (UN Standing Committee on Nutrition 2000, 23–32; Food and Agriculture Organization 2005). Neither does this chapter address such crucial issues as lack of regulation of the trade in small arms manufactured in the G8 countries or brokered by individuals or firms within their jurisdiction — a persistent failure of the international community and one with special significance for much of Africa. However, the analysis provided here suffices to raise some fundamental questions about the role of the G8 in a globalising world, and also to demonstrate the value of an explicitly normative approach to the G8 and population health.

To what extent is it reasonable to expect leadership from the G8 on development and global health? The G8 originated as the G6 in response to the economic crises of the 1970s as an effort to restore the profitability of private investment by coordinating macroeconomic policy (Webb 2000) — what Stephen Gill (1999, 131) 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'. Political institutions like the G8 of course evolve in response to both internal and external influences, and heightened recent concern with African development issues is a matter of record. However, expecting leadership from the G8 on issues related to the determinants of health outside the industrialised world may be asking too much, for two related reasons.

First, the fact that summit agendas are determined by the host country is not necessarily conducive to building momentum for complex issues that inherently require high levels of policy coordination, except in the case where a high degree of agreement already exists among G8 governments. This is almost certainly not the case with respect to reshaping development policy in ways that are conducive to widely shared improvements in population health — especially not given the current trend of unilateralism and aggressive defence of national economic interests on the part of the United States. On the other hand, early press reports on the agenda for the 2007 Heiligendamm Summit in Germany indicate that poverty and African issues will both be on the agenda (G8 Research Group 2006). Thus the potential may exist for regaining whatever momentum remains from the grand words at Gleneagles — and, crucially, an opportunity may exist for the Commission on Social Determinants of Health to foreground the linkages among poverty, development, and population health.

Second, domestic politics enter the equation. The G8 are formal democracies, in the sense that they operate on the basis of peaceful transfers of power among leaders based on periodic, reasonably open competitions for political office. Political leaders can try to shape the policy preferences of their electorates, as Prime Minister

Tony Blair did in advance of Gleneagles. At the same time, they must continue to appeal to some combination of interests that together comprise a decisive electoral plurality. They must also keep in mind the limits that an integrated global economy imposes even on the rich countries (Fourcade-Gourinchas and Babb 2002; Tanzi 2002). They must also consider the fact that political leaders are by no means the only ones able to engage in value shaping: one such example is Jeffrey Sachs and the mass media exposure of the campaign against poverty (Sachs 2005), but another is Fox News, other elements of Rupert Murdoch's media empire, and the global concentration of media ownership (McChesney and Schiller 2003). When G8 governments fail to engage adequately with the imperatives identified earlier in this chapter, they cannot be assumed to be acting either in isolation from or in opposition to domestic constituencies. A key question therefore becomes, as transnational economic integration (globalisation) widens the divide between economic winners and losers, both within and across national borders, under what conditions is it possible to exercise political leadership and mobilise domestic coalitions in support of a global development and health agenda that explicitly assigns priority to such values as achieving the MDGs?

Notes

- 1 Commissioners included finance ministers from Canada and the United Kingdom, the former director of the International Monetary Fund (Michel Camdessus), several African leaders, and entertainment entrepreneur Bob Geldof. Although the establishment of the commission was initially met with cynicism by development activists and African civil society organisations, its final report was strongly critical of the industrialised countries' past policies on aid, trade, and debt relief. Many of its recommendations, released a few months before the Gleneagles Summit, resembled the more sweeping reform calls of the Make Poverty History civil society campaign.
- 2 The analytical framework set out by Finn Diderichsen and his colleagues (2001) has, with modifications, been adopted by the WHO Commission on Social Determinants of Health (see Solar and Irwin 2005).
- 3 See, for example, Michael Barratt Brown (1995), David Simon *et al.* (1995), Brooke Schoepf *et al.* (2000). Disagreement persists on the relative contribution to development failures in Africa of external factors, including the Washington consensus, and internal factors such as neo-patrimonial systems of rule even in formally democratic states. Notably, Nicolas van de Walle (2001) argues that primary causal responsibility should be ascribed to the latter — a view that closely parallels, if it does not actually inspire, some of the harsher critics of the Commission for Africa's proposals for major increases in development assistance (Killick 2005; de Renzio 2005). Historically, many of the G8 governments have been complicit in supporting these systems of rule (notably during the Cold War); the interdependencies created between many of the G8 countries and African nations by, first, colonisation and, second, global market integration, should caution against dichotomous argumentation on this point. Without minimising the extent of African responsibility for the continent's current health and economic problems, this chapter focusses on the role played by G8 countries in creating or mitigating those problems.

- 4 Reference to the G7 in this context reflects the fact that Russia was not involved in the promotion of market-based economic development models throughout the 1980s and 1990s.
- 5 For an explication, see Audrey Chapman (2002) and the WHO (2002).
- 6 See Christopher Stevens and Jane Kennan (2005, 4), who note that ‘three-quarters of the ACP’, i.e., the African, Caribbean, and Pacific countries with which these agreements are being negotiated, ‘could lose 40% or more of their tariff revenue from the EU, and for over one-third it could be 60% or more’. Their paper indicates that the impact of this loss will depend on the speed and sequencing of trade liberalisation, and does not provide a regional breakdown of impacts.
- 7 For key statements of the sceptical position see the Overseas Development Institute (2005), Tony Killick (2005), and Nicolas van de Walle (2001); for counterarguments see, for example, Mick Foster (2004); Diana Conyers and Rob Mellors (2005), and Howard White (2005). The sceptical position also involves a distinct normative claim about the appropriate uses of aid. Thus, while the UN Millennium Project emphasises the importance of using aid more effectively in support of the MDGs, Killick (19) actually argues that less attention should be paid to the MDGs and poverty reduction, and more to ‘promoting the development of directly productive sectors’.
- 8 On this last point, one recent study applied standard econometric modelling 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 liberalise their economies by the international financial institutions (IFIs) and conditions attached to aid (Kraev 2005)? Based on results from a sample of 22 African countries, the study implies costs of roughly US\$272 billion — about the same amount the continent received in aid during this time. According to Christian Aid (2005, 2), the organisation that commissioned the study, ‘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’.
- 9 Even this estimate understates the economically debilitating effect of capital flight, much of which may admittedly have occurred through legal channels. James Boyce and Léonce Ndikumana (2001) estimate that value of flight capital from 25 African countries between 1970 and 1996, plus imputed interest earnings, was considerably higher than the entire value of the combined external debt of those 25 countries in 1996.
- 10 The Swiss government’s decision in September 2005 to return US\$485 million of Nigerian funds deposited in Swiss bank accounts is ‘a significant step toward the return of funds which have been looted from Africa’, even though this represents only a small portion of the estimated value of resource revenues looted by Abacha and his circle (World Bank 2005).
- 11 This discussion draws in particular on Timothy Wise (2004), Philip McMichael (2005), and John Howell (2005).
- 12 This qualifier is added because numerous examples exist of situations in which developing country governments have adopted policies that actually increased domestic inequalities and potentially undermined access to social determinants of health. Whatever the industrialised world’s appropriate role in such matters, it is difficult to envision a role for trade policy beyond ensuring that flexibilities needed for development are not compromised.
- 13 For description and analysis, see ICTSD (2004), Peter Kleen and Sheila Page (2005), and, for more recent developments, the ICTSD (2005).

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