Domestic Politics and Global Health:
Getting Inside the Black Box of G8 Policies? [1]

Ted Schrecker[2], Ronald Labonte,[3] David Sanders [4]

1. Introduction: Why the G8?

The G8 nations (the Group of 7 industrialized countries plus Russia) "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). The G8 provide roughly 75 percent of the world's development assistance; their deep pockets, organizational resources and superior bargaining power provide them with formidable advantages in trade negotiations and dispute resolution proceedings. In other words, their decisions matter for the well-being of literally billions of people outside their own borders. Although the G8 "lacks the two main characteristics of more structured international governmental organizations (IGOs): a constitutive intergovernmental agreement, and a secretariat" (Hajnal, 2005), its annual Summits and periodic ministerial meetings – in particular, meetings of finance ministers – have emerged as important fora for coordinating social and economic policy. Above and beyond providing an opportunity for announcing policy initiatives and resource commitments, 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).

The first major G7 statement on health was only issued in 1996, but with the exception of the 2004 Summit hosted by the United States health issues have become increasingly prominent on Summit agendas (Kirton & Sunderland, 2005). In assessing the effects of G8

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[2] Scientist/Associate Professor, Department of Epidemiology and Community Medicine, Institute of Population Health, University of Ottawa, Canada; tschrecker@sympatico.ca .

[3] Canada Research Chair, Globalization and Health Equity; Professor, Department of Epidemiology and Community Medicine, Institute of Population Health, University of Ottawa, Canada; rlabonte@uottawa.ca .

[4] Professor and Director, School of Public Health, University of the Western Cape, South Africa; dsanders@uwc.ac.za .

policies on the health of people outside their borders, it is important to keep in mind that population health is affected by various aspects of the social and economic context, which can be usefully classified under the headings of social stratification, differential exposure, differential vulnerability and differential consequences (Diderichsen, Evans & Whitehead, 2001). These elements of context are referred to generically as social determinants of health (SDH), and are now the focus of a multinational Commission established by the World Health Organization (http://www.who.int/social_determinants/en/).[5] SDH, including but of course not limited to the characteristics of health systems, are in turn shaped by the broader social and economic policy environment, crucially including "those central engines in society that generate and distribute power, wealth and risk" (Diderichsen et al., 2001). Transnational economic integration ('globalization') is a key element of that environment (Schrecker & Labonte, 2006b; World Bank, 2007), and has been actively promoted by the G8 and the institutions that they dominate. Thus, analysis of the health implications of G8 policies is inseparable from a broader critique of the health consequences of globalization, although providing that critique is not the primary objective of this paper.

The approach taken here is distinctive in several respects. First, as noted we are concerned with health care and health systems as just one determinant, among many, of the health of populations. Second, and in keeping with our previously published work on the G8 and population health, we are concerned not only with assessing the extent to which the G8 have fulfilled commitments made at Summits and in the intervening periods, but also with 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 the relations among globalization, social determinants of health, and health outcomes. In other words, we 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 the right thing. Third, we adopt an explicit commitment to health equity – "the absence of disparities in health (and in its key social determinants) that are systematically associated with social advantage/disadvantage" (Braveman & Gruskin, 2003: 256) – and view the G8 as having multiple obligations in this regard. Our reasons for this view are described in section 2 of the paper. In section 3, we provide a selective report card on recent G8 performance with respect to the crucial, and interrelated, triad of development assistance, debt relief and trade policy. In

[5] The authors are respectively Hub coordinator, Chair and member of the Globalization Knowledge Network that will support the work of this Commission until the end of 2007. However, all views expressed here are exclusively their own.

section 4 we carry out a preliminary inquiry into a range of explanations for that indifference, with specific reference to informing advocacy strategies.

2. The G8 and Global Health: Why Care?

Some international relations scholars are sceptical about applying ethical criteria to the actions of nation states, viewing as unrealistic any expectation that they will be driven by considerations other than national self-interest. An alternative perspective, which is gaining prominence, holds 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).[6] Recent official initiatives that reflect this concept of international obligations at least by implication include the Millennium Project, the Commission for Africa established by the British government in advance of the 2005 G8 Summit, and some elements of the Helsinki Process on Globalization and Democracy (a joint undertaking of the governments of Finland and Tanzania). A much longer list of civil society initiatives could also be cited, but the point is simply that the normative perspective we adopt here is more than just an academic conceit. Five supporting arguments can be identified; these overlap to some degree and are not mutually exclusive.

First, the G8 have committed themselves to "make globalization work for all [their] citizens and especially the world's poor," claiming that: "Drawing the poorest countries into the global economy is the surest way to address their fundamental aspirations" (G8, 2001). This formulation sidesteps the crucial question of on what terms (and on whose terms) integration into the global economy is to proceed. The operative model has been variously described as the Washington consensus, after Williamson's codification of the development policy wisdom of the time (Williamson 1990) and, alternatively, as neoliberal globalization: a return 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).[7] Regardless of terminology, little serious

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[6] This perspective is congruent with a long tradition of rigorous, engaged scholarship in international relations by such leaders in the field as Susan George (whose work is honoured in a special session at ISA 2007) and Richard Falk.

[7] The scope of the retrenchment that is being promoted by key multilateral institutions is clear, e.g., from the World Bank's Social Protection Sector Strategy (Holzmann & Jörgensen, 2001).

disagreement exists on the broad outlines of the model: liberalization of trade (especially imports) and financial flows, deregulation, privatization of state-owned economic entities, scaling back of government subsidies and a retreat from other forms of public social provision on the grounds that even if affordable they encourage economic inefficiency. The governments of G7 countries[8] have promoted this model both individually and through their dominant role in the World Bank, IMF and more recently the World Trade Organization (WTO), leading one group of social scientists to comment that: "For 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). Because an expanding body of research demonstrates that "globalization, as we know it today, is fundamentally asymmetric. In its benefits and its risks, it works less well for the currently poor countries and for poor households within developing countries" (Birdsall, 2006: 1), it can be argued that the G8's commitment creates an obligation on their part to adopt policies that reduce the relevant asymmetries or, at the very least, do not exacerbate them.

Second, the G8 share the commitment of the broader international community, as represented by the United Nations General Assembly, to supporting achievement of the Millennium Development Goals (MDGs; see http://www.un.org/millenniumgoals/index.asp) by specified target dates, usually the year 2015. The MDGs have received increased attention from development policy agencies (United Nations Development Programme, 2003; Browne et al., eds., 2003) as "the best summary of the efforts undertaken by the international community over the past 40 years to find a path for sustainable development for all members of the global community" (Global Forum for Health Research, 2004: 12). Three of the Goals, which involve reducing child and maternal mortality and reversing the spread of HIV/AIDS, malaria, and other communicable diseases, are explicitly health-related. 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.

The MDGs and associated targets are ambitious relative to the size of the challenge, yet in many respects modest in their aspirations.[9] An assessment prepared for a World Health

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This is not, however, a phenomenon confined to the developing world; see e.g. Fudge & Cossman (2002) and Burke, Moore & Shields, eds. (2000) on Canada and Hacker (2004) on the United States.

[8] Reference to the G7 in this context reflects the fact that Russia was not involved in the promotion of market-based economic development models during the 1980s or, except domestically and within a limited sphere of influence in the former Soviet bloc, the 1990s.

[9] See Pogge (2004) on the modesty of the poverty reduction target (reducing by half, in the year 2015, the proportion of the world's people living on less than $1/day) when viewed against

Organization forum held in January, 2004 concluded that: "Even if economic growth accelerates ... and even if progress toward the gender and water goals were to be substantially accelerated, the developing world will wake up on the morning of January 1, 2016 some way from the health targets – Sub-Saharan Africa a long way" (Wagstaff, Claeson et al., 2003: 2.12). More recent syntheses of available evidence offer similar prognoses, at least in the absence of greatly intensified policy efforts on the part of the industrialized world (World Health Organization, 2005; United Nations, 2006b). Because of their dominant role in the international economy and in key multilateral institutions, it is *prima facie* reasonable to ascribe to the G8 a substantial share of responsibility for ensuring the achievement of the MDGs, [10] and this ascription of responsibility informs our evaluation of their performance.

Third, and relatedly, in a world in which an increasingly dense web of trade and investment flows and "government networks" (Slaughter, 2005) links rich and poor across national borders, the operation of those networks must be a starting point for identifying past and current causal responsibility: who makes what happen, and how? Philosopher Thomas Pogge has developed this line of argument with specific reference to the global persistence of poverty; his position can be summarized 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

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the background of expanding global affluence, and *cf.* the MDG 7 target of improving the lives of 100 million slum dwellers per year by 2020 with the estimate that if present trends continue, 1.4 billion people worldwide will be living in slums in 2020 (UN Millennium Project Task Force on Improving the Lives of Slum Dwellers, 2005). It should also be noted that because the MDGs and associated targets are stated on a national average basis, it is quite possible for nations to make substantial progress toward the MDGs without either improving the health status of the worst-off members of their societies or reducing health inequalities (Moser, Leon & Gwatkin, 2005; Gwatkin, 2005).

[10] But not, it must be emphasized, all the responsibility. Consider, for example, the South African government's 1996-2000 economic policies that led to "dismal development and excellent macroeconomic outcomes" (Streak, 2004) with the former including an official unemployment rate of over 30 percent, and its subsequent resistance to public provision of antiretroviral therapy; or the policies that led the United Nations Development Programme to comment that: "Were 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" (United Nations Development Programme, 2005: 30-31).

> perpetuate and even to aggravate global economic inequality (Pogge, 2001: 14-15; see also Pogge, 2002; Pogge et al., 2005).

Pogge singles out two elements of the global economic order for special attention: 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 (think of the appropriation of resource revenues by Mobutu and Abacha, among others), and the "borrowing privilege," which holds that debts incurred by rulers on behalf of the countries they govern are collectable whether or not the rulers' subjects have consented to those financial obligations.[11] "Given these connections," concludes Pogge, "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" (Pogge, 2001:15).

Fourth, beneficence should not be disregarded as a source of obligations that may arise from the ethical distinction between basic needs and discretionary consumption in conjunction with the trivial cost, in the global scheme of things, of meeting unmet health-related basic needs. (Shue, 1996: 10) has 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 the argument's relevance, it has been estimated that making a core set of 23 treatment and prevention interventions universally available in countries where 90 percent of child deaths occur would prevent six million child deaths per year at an annual cost of US $5.1 billion (low estimate: $3.1 billion; high estimate: $8.0 billion), or $887 per life saved (Bryce et al., 2005). Although this figure is admittedly an understatement because it does not include an estimate of the costs of scaling up health systems to support delivery of the relevant interventions, it is nevertheless to compare it, for instance, with annual G8 military expenditures of more than $705 billion in 2005 (Stålenheim et al., 2006).

Fifth, the preceding argument assumes special significance in the context of obligations that may exist under international human rights law. Key texts include the 1948 Universal Declaration of Human Rights (UDHR), which states that: "Everyone 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, which specifies the "right of everyone to the enjoyment of the highest attainable standard of physical and mental health"

[11] This latter privilege has quite specific implications for development policy and population health, by way of the "odious debt" issue, a topic we discuss in more detail later in this paper.

(Article 12); and General Comment 14 by the UN Committee on Economic, Social and Cultural Rights (2000), which sets out states' specific legal obligations "to *respect*, *protect* and *fulfil*" the Article 12 right.[12] Conventional wisdom is that these obligations apply only to the actions of national governments with respect to people living within their borders, but even apart from the 1966 Covenant, Pogge argues that cross-border obligations follow from Article 28 of the UDHR: "Everyone is entitled to a social and international order in which the rights and freedoms set forth in this Declaration can be fully realized." No effective supranational mechanisms analogous to the institutions of trade policy and law exist to ensure respect for these requirements, which arguably represents a glaring deficiency in the institutions of global governance. Nevertheless, this source of obligations cannot be dismissed, and is indeed the focus of increased attention within the UN System, notably through appointment of a Special Rapporteur on the Article 12 right (http//www.ohchr.org/english/issues/health/right/index.htm).

3. The G8 and global health: A selective scorecard

Our initial research on the health implications of commitments made at the 1999 - 2001 Summits found that only nine of 26 key health-related commitments had been fulfilled, and the status of one of the nine (ensuring access to essential medicines as a priority in interpreting the Agreement on Trade-Related Aspects of Intellectual Property, or TRIPS) was ambiguous (Labonte et al., 2004; Labonte & Schrecker, 2004). Subsequent work (Labonte & Schrecker, 2005; Labonte et al., 2005; Labonte & Schrecker, 2006; Schrecker & Labonte, 2006a) used a less formalized procedure for identifying health-related commitments, reflecting growing agreement on the importance of examining development policy's effects on social determinants of health, despite the complexity of the relevant causal pathways. It indicated that, despite a number of promising initiatives, our earlier description of the G8's approach to population health as *Fatal Indifference* remained applicable.

Here we present an assessment that concentrates on official development assistance (ODA), debt relief and trade policy. Although these are by no means the only areas of G8 policy that are relevant to population health[13] – consider, for example, the contrast between

[12] For explication, see Chapman (2002) and Nygren-Krug (2002); for operational examples of the application of each obligation, see Hunt (2007).

[13] Our initial research (Labonte et al., 2004) examined G8 policies with respect to development assistance, macroeconomic policy and debt relief, and trade policy and market access as well as a number of substantive policy fields: health systems, education, nutrition and food security, and environment.

rhetoric and reality with respect to controlling the trade in small arms and light weapons (Box 1) – the policies of the G8 in these areas taken together 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. By policy environment we mean, as an illustration, the extent to which developing country governments face a variety of explicit conditionalities demanded by multilateral lenders, as well as "implicit conditionalities" (Griffith-Jones & Stallings, 1995) generated by the workings of global financial markets. In the absence of efforts to ensure policy coherence (Picciotto, 2005) the potential exists for initiatives in one area (e.g. increased development assistance) to be undermined by lack of action in another (e.g. debt cancellation, market access). This policy triad is therefore essential subject matter for rating G8 performance with respect to population health and the determinants of health, and assumed near iconic status in civil society mobilizations in the "Make Poverty History" campaign that preceded the 2005 Gleneagles Summit.

Box 1. The Small Arms Trade and the G8

Recent research suggests that the consequences of the trade in small arms are even more deadly than was previously thought (Graduate Institute of International Studies, 2005) and it has been identified as an important contributor to armed conflicts over non-mobile resources (United Nations Development Programme, 2005: 172-174). In 1999 and 2000 the G8 made vague comments about the need to "exercise restraint" in conventional weapons trade even as the US and Russia saw their small arms exports to developing countries surge dramatically (Grimmett, 2004). Although the value of the arms trade with developing countries has since declined, the Commission for Africa 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" (Commission for Africa, 2005). At Gleneagles all the G8 could say about small arms control was that they recognized "the need for further work to build a consensus for action" (G8, 2005), and at St. Petersburg no mention at all was made of the need for new multilateral initiatives. In July, 2006 the United Nations conference convened to review progress on the UN's 2001 action program on fighting the small arms and light weapons trade collapsed without reaching agreement on next steps, in part because of resistance from the United States (Fickling, 2006; Control Arms Campaign, 2006).

Development Assistance

It is now widely agreed that many countries will not be able to achieve the MDGs without more, and more predictable, development assistance, sometimes for 20 years or longer. Estimates of the value of additional resources needed to meet the health MDGs range from $25 billion - $70 billion per year between now and 2015, as against existing ODA for health of approximately $12 billion (Gottret & Schieber, 2006; Schieber, Fleisher & Gottret, 2006). To ensure attainment of all the MDGs, the Commission for Africa established by Britain in advance of the 2005 G8 Summit (Commission for Africa, 2005) and the UN Millennium Project (2005) each concluded that approximate doubling of the industrialized world's ODA spending *circa* 2005 would be needed.

Reflecting Britain's identification of African development as a priority for the 2005 G8 Summit, one of its highest profile outcomes was the promise to increase annual ODA to Africa by $25 billion by 2010, driven primarily by the pledge of the European Union (EU) to raise members' aid spending to a long-standing United Nations target of 0.7 percent of Gross National Income (GNI), originally floated in 1970 and cautiously reaffirmed at the Monterrey Conference on Financing for Development in 2002. Canada, Japan and the United States offered increases in aid levels but did not commit to reaching the target, and all G8 countries currently lag behind some non-G8 countries that have exceeded the 0.7 percent target consistently (Figure 1). The focus on African development was a function of the priorities of British Prime Minister Blair, and can be justified in a number of ways. To provide just one example, sub-Saharan Africa is the only region of the world in which, based on the World Bank's admittedly contentious (Reddy & Pogge, 2005) $1/day poverty line, the number of people living in extreme poverty has *increased* – indeed, almost doubling between 1981 and 2001 (Chen & Ravallion, 2004). This reflects a disastrous failure of development policy, with far-reaching implications for population health.

Some civil society organizations[14] 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. ODA spending figures for 2005 include major one-off debt cancellations for strategically important and oil-rich Iraq and Nigeria; without further new commitments, which have not yet been forthcoming, overall ODA spending may actually decline in 2006, for which data are not yet available, and 2007 (United Nations, 2006a). The fact that no specific financing mechanisms for mobilizing new money were described either at Gleneagles or at the 2006 Summit in St. Petersburg lends weight to this concern. Some of the additional spending may simply offset substantial revenue losses from import liberalization by developing

[14] See Jubilee Research (2005). Jubilee Research is the successor organization to Jubilee 2000 UK, which led a campaign that collected 24 million signatures on petitions in more than 60 countries urging cancellation of poor country debts.

Box 2. Development Assistance for Health: The G8 Drop the Ball

Many developing countries' spending on health is only a fraction of the amount needed to provide basic health services; ironically the poorest countries tend to be those where the proportion of out-of-pocket health care expenditure is highest. (Gottret & Schieber, 2006) The G8 took the lead in establishing the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria, and hailed it at the 2001 Summit as promising "a quantum leap in the fight against infectious diseases." However, the Global Fund is seriously underfinanced: as of June 2006, it was facing a shortfall of $2.1 billion relative to *minimum* estimated resource needs of $5.5 billion for 2006-07,* with a "realistic" estimate of its resource needs for that period stated as $10.9 billion; additional resource needs for 2008-2010 were estimated at $7.2 billion (a bare minimum) to $23.2 billion (Banati, Greene & Ferazzi, 2006). The problem of underfinancing is compounded by the Fund's lack of a stable, long-term financing mechanism; it relies instead on periodic replenishment meetings at which it essentially passes a hat among donors.

Neither at Gleneagles nor at St. Petersburg did the G8 make specific commitments to closing this gap, offering only to "work with other donors and stakeholders in the effort to secure funds needed for the 2006-2007 replenishment period and call[ing] upon all concerned to participate actively in the development of a four-year [financing] strategy" (G8, 2006) Thus, even for their flagship initiative rooted firmly in a familiar biomedical approach to health, the G8 have failed to match rhetoric with resources. Further, total ODA for health (of which commitments to the Global Fund are just a part) from *all* countries was estimated at $12 billion in 2004 (Schieber, Fleisher & Gottret, 2006) – a substantial recent increase, but well off track to reach the $27 billion in new donor funds by 2007 that the Commission on Macroeconomics and Health identified as necessary to support "a rather minimal health system" in all low-income countries (Commission on Macroeconomics and Health, 2001).

* Former UN Special Envoy Stephen Lewis has commented that these estimates of resources needed to support the Global Fund are "illusory. Because 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" and "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" (Cook, 2006).

countries, for instance as a result of the Economic Partnership Agreements (EPAs) now being negotiated between the EU and African countries.[15] Even if ODA commitments to Africa are fulfilled, questions will remain about the future of health equity elsewhere in the developing world, notably because more than 70 percent of the world's most desperately poor people

[15] See Stevens & Kennan (2005), 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 does indicate that the impact of this loss will depend on the speed and sequencing of trade liberalization, and does not provide a regional breakdown of impacts.

actually live outside Africa: there are, for example, 100 million more such people in south Asia alone than in Africa (Chen & Ravallion, 2004). As well, the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria, the G8's flagship global health program when it was announced, remains drastically underfunded and precariously reliant on short-term financing (Box 2).

Conversely the 2005 commitments, whatever their shortcomings, may be seen as a decisive rejection of a fiscally convenient scepticism about aid effectiveness that remains fashionable in some circles.[16] To address predictable objections, it must be stressed that increases in the value of ODA are a necessary rather than a sufficient condition for achieving the MDGs. Major improvements are needed in quality of aid administration (in both donor and recipient countries), as are redirections of aid. According to the UN Millennium project just 14 percent of aid in low-income countries, and 27 percent in middle-income countries, directly supports meeting the MDGs (UN Millennium Project, 2005:199), providing a useful if imperfect indicator of how little aid meets basic needs. The Millennium Project and the Commission for Africa each 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). It remains to be seen whether the burden of proof has been shifted decisively enough to the aid sceptics, and whether the necessary commitments of new resources will be forthcoming.

Debt Relief

External debt has been recognized for almost 20 years as undermining developing countries' ability to meet basic needs (Cornia, Jolly & Stewart, eds., 1987; Cheru, 1999). 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

[16] For key statements of the sceptical position see Killick (2005), de Renzio (2005) and the earlier work of van de Walle (2001); for counterarguments see e.g. Foster (2004), Conyers & Mellors (2005) and White (2005). The sceptical position also involves a distinct normative claim about the appropriate uses of aid. Thus, while the Millennium Project emphasizes the importance of using aid more effectively in support of the MDGs, 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."

provide development assistance with one hand and then withdraw it in debt servicing with the other" (UN Millennium Project, 2005: 35). For every region of the developing world except sub-Saharan Africa, financial outflows to service external debt consistently exceed development assistance received (Figure 2). In sub-Saharan Africa, because ODA 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 exceed debt service payments.

Over the past ten years, the G8 has led the industrialized world in committing a total of $58 billion to partial cancellation of the debts of up to 40 countries, 32 of them in Africa, under the enhanced Heavily Indebted Poor Countries (e-HIPC) initiative, making possible increases in public spending on health and education in several recipient countries (Gupta et al., 2002). At the same time, HIPCs' 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, and three – Mali, Mozambique and Bolivia -- had actually experienced *increases* in these obligations as of 2005 (United Nations Department of Economic and Social Affairs, 2005: 148). This may be partly because debt relief is often used 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 programs including health and education (International Monetary Fund & World Bank, 2005: Table 2:37).

At Gleneagles, the G8 agreed to a proposal that had previously been accepted by the G7 Finance Ministers to cancel an additional $40 - $56 billion of debts owed by HIPCs 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 commitment, which has now been formalized as the Multilateral Debt Relief Initiative (MDRI),[17] was a welcome and overdue next step. At the same time, crucial issues remain unresolved, and sometimes unaddressed. Development assistance to countries that receive additional debt relief under MDRI will be reduced by some or all of the amount (Joint World Bank/IMF Development Committee, 2005; Tomitova, 2005), thus repeating the pattern in which development assistance declined substantially in the late 1990s after the start of the original HIPC initiative (Killick, 2004: 6-7). The process of granting debt relief under MDRI will continue to minimize creditors' losses even at the expense of meeting basic needs in debtor countries: at the insistence of the G7 (Martin,

[17] http://web.worldbank.org/WBSITE/EXTERNAL/TOPICS/EXTDEBTDEPT/0,,contentMDK:20634753~menuPK:64166739~pagePK:64166689~piPK:64166646~theSitePK:469043,00.html (accessed August 7, 2006)

2004) a “sustainable” debt load has been defined with reference to forecasts of future export earnings. An alternative definition of sustainability instead works backward from estimates of the minimum public expenditure required to meet basic needs, only then determining how much (if any) of the public budget should be devoted to debt repayment; this approach implies a need for far more extensive debt cancellation, for a much larger number of countries (UN Millennium Project, 2005; United Nations, 2005; Mandel, 2006a).

In theory, debt cancellation is preferable to development assistance because it provides more autonomy to countries in how they allocate the newly available resources. However, and as was the case with the e-HIPC initiative, to receive debt cancellation under MDRI countries must comply with macroeconomic policy prescriptions recommended by international financial institutions, which arguably replicate earlier, highly destructive ‘structural adjustment’ programs. In the recent past these have included further import liberalization (Brock & McGee, 2004) and public expenditure ceilings that limit governments’ ability to deliver health services and education even when the requisite funds are available from external sources (Ooms & Schrecker, 2005; Wood, 2006). Finally, the question remains of why “odious debts” incurred by repressive or corrupt governments without the consent of their subjects should be regarded as collectable under international law (Khalfan, King & Thomas, 2003). Echoing Pogge’s critique of the unquestioned extension of the resource and borrowing privileges, the Commission for Africa 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” (Commission for Africa, 2005: 113-4) 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” (Commission for Africa, 2005: 150). However the issue of odious debt has yet to find its way onto the G8 agenda. To illustrate the amounts involved, one recent study estimates that $726 billion of the current debt of 13 developing countries is odious and should be cancelled and, further, that 10 countries should actually receive refunds of $383 billion in past payments on such debts (Mandel, 2006b).

Trade policy and market access

Trade and market access represent the third element of the triad. Development policy protagonists who disagree about much else agree that improved market access for developing country exports is crucial for the economic growth that can support 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 contentious (Birdsall, Rodrik & Subramanian, 2005) and, certainly, no one-to-one correspondence exists between the value of agricultural subsidies in the industrialized world and income lost by producers elsewhere. WTO negotiations begun at Doha in 2001 were promoted as a "development round" in which developing country concerns, including agricultural subsidies, would be given priority. 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" echoed similar exhortations from previous Summits.[18] Only days later, negotiations reached an impasse over the issue of agricultural subsidies (Anon, 2006a; Anon, 2006b). Initial reports blamed the resistance of the United States and some EU countries; there is plenty of blame to go around, and perhaps expectations for the Doha round were always too high (Ricupeiro, 2006), but failure of G8 leadership is nevertheless evident.

Although firm predictions are premature, it seems likely that industrialized countries will continue to shift their emphasis to bilateral or regional negotiations, where disparities in bargaining power and resources are even greater. Even if some of the policy instruments to support domestic firms and industries that industrialized countries routinely used on their path to wealth remain permissible under current WTO disciplines (Di Caprio & Amsden, 2004), they are likely to be precluded in bilateral or regional agreements (Shadlen, 2005). Among the probable casualties: development-friendly implementation of Special and Differential Treatment (SDT) measures, which have been a feature of the multilateral trade policy regime since long before WTO was established. 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 (International Centre for Trade and Sustainable Development, 2003: 17). 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" (World Trade Organization, 2001: ¶44, emphasis added). However, a July, 2004 assessment concluded that "[e]fforts since then to achieve these objectives have

[18] *Cf* e.g. the 2002 claim 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" in the G8 Africa Action Plan (G8, 2002).

come to naught" (Hoekman, 2004) because of deep differences between industrialized and developing countries. Further, a growing number of trade treaties with the United States contain 'TRIPS-plus' clauses (Fink & Reichenmiller, 2005) that undermine hard-won, if still problematic, flexibilities in interpreting the Agreement on Trade-Related Intellectual Property Rights (TRIPs) in order to protect access to essential medicines. At the very least, the G8 have failed effectively to match trade policy with the 2005 commitment 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" (G8, 2005: ¶31), for which purpose such policy flexibilities as those provided by SDT and under TRIPS were and are critical (Garcia, 2004).

Such tensions within trade policy are not surprising, given the obvious pressures on G8 (and other) governments to defend domestic producer interests.[19] The criticisms of the G8 offered here, and in fact the entire concept of 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 & Charlton, 2004:496). Still less has trade policy acknowledged a need to incorporate the issues of fairness and distribution that are integral to linking trade with development and health equity, or with attaining shared objectives like the MDGs (Stiglitz & Charlton, 2005). If hope for a development-friendly future can be found in the current trade policy landscape, it is the belated recognition that a clear commitment to redistributive resource transfers from rich to poor nations, one that is not contingent on subsequent trade policy concessions, may be a practical prerequisite for reviving WTO negotiations (Collier, 2006).

4. Advocating for Health Equity: Ways Forward?

For those of us committed to "a vision of the world where people matter and social justice is paramount," in the words of the chair of the WHO's Commission on Social Determinants of Health (Marmot, 2005; see also Box 3), a crucial question therefore becomes: (how) can G8

[19] At the same time, it is essential to note situations in which elected governments do *not* defend domestic producer interests, or consciously choose to privilege the interests of some domestic sectors over others, as happened when Canada initiated negotiations on the Canada-US Free Trade Agreement that later became the North American Free Trade Agreement, with the inclusion of Mexico.

governments most effectively be influenced to support this vision, doing more good and less harm with respect to global health?

In section 2 of this paper, we argued that the G8 countries, individually and collectively, have obligations with respect to the health of those outside the industrialized world. In section 3, we presented a selective report card on recent G8 performance with respect to those obligations. Is it plausible to expect G8 governments to acknowledge these obligations and adopt appropriate policy responses? On one view, little can be expected given the origins of

Box 3. Health in an Unequal World: Global Ethics and Policy Choices

In 2006, the Canadian Institutes of Health Research awarded a three-year grant to a multidisciplinary group of researchers including two of the authors (R.L. and T.S.) to investigate the need for a new global ethic to guide policy choices that affect health disparities. The funded proposal was organized around three research questions:

1. What international obligations exist to design public policies and economic and political institutions so as to secure access to health for all and to eliminate inequities in such access?
2. Against the background of those obligations, what are the appropriate roles and limits of markets in allocating the resources necessary for access to health?
3. What are the strengths and implications of rights-based approaches to health, and the social determinants of health, as a response to globalization?

The proposal adopts a specific focus on economic institutions, notably on how globalization affects health and its determinants by changing exposures to health risks, the characteristics of health systems, and the structure of household, community and national economies, and on how globalization has been promoted by powerful national governments and multilateral institutions. As the work of this network proceeds, it will be important for members to inform themselves on the state of the research art with respect to the actual processes through which considerations of health-related ethical responsibilities across national borders find (or do not find) their way onto Summit agendas and into the policy repertoire of the G8.

the G8 in an effort to restore the profitability of private investment by coordinating macroeconomic policy (Webb, 2000) – "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" (Gill, 1999: 131). It is essential to situate G8 policies and the origins of the institution itself in the context of domestic and global political economy. On the other hand, the role of the G8 has evolved and expanded, and even those who question both the performance and the legitimacy of the G8 must acknowledge its leadership on issues like debt cancellation and the establishment of the Global Fund (on the latter point see Kirton & Mannell, 2007), and the responsiveness of Summit agendas and outcomes, as exemplified by the Gleneagles development assistance commitments, to the re-emergence of poverty as an international concern (Noël, 2006).

Answering the question posed at the beginning of this section of the paper requires addressing a logically prior one: What explains relevant policy variations among governments – for example, the fourfold variation among the G7 in the proportion of national income spent on development assistance, and the even wider variation among the governments of high-income countries as a whole (Figure 1)? To state the question a bit more polemically, why do more governments not follow the recent Norwegian example of making a commitment to oppose development conditionalities that promote privatization and support only trade policies that will not prevent poorer countries from developing into "welfare societies" similar to Norway's own (Government of Norway, 2006)? Invoking political culture is at best only partly satisfactory; this simply shifts the explanatory focus up one level, to the origins and determinants of political culture and its relationship with the choices of political leaders (Elkins & Simeon, 1979).

In a very preliminary way we highlight here some research findings, having to do in particular with the correlates and determinants of public support for development assistance. Noël & Therien (1995) review earlier literature that in general finds a correlation between domestic redistributive policies and levels of ODA spending; their own analysis indicates a positive correlation between development assistance over the 1971-89 period and the number of "socialist" attributes of a country's welfare state institutions, using the typology of liberal, conservative and socialist welfare states proposed by Esping-Andersen (1990). Our own rough and ready near-inverse correlation of more recent ODA spending with levels of child poverty as defined using the Luxembourg Income Study's standardized cross-national measure (Figure 3) shows a similar pattern, although each comparison features a number of outliers that demand individualized explanations.

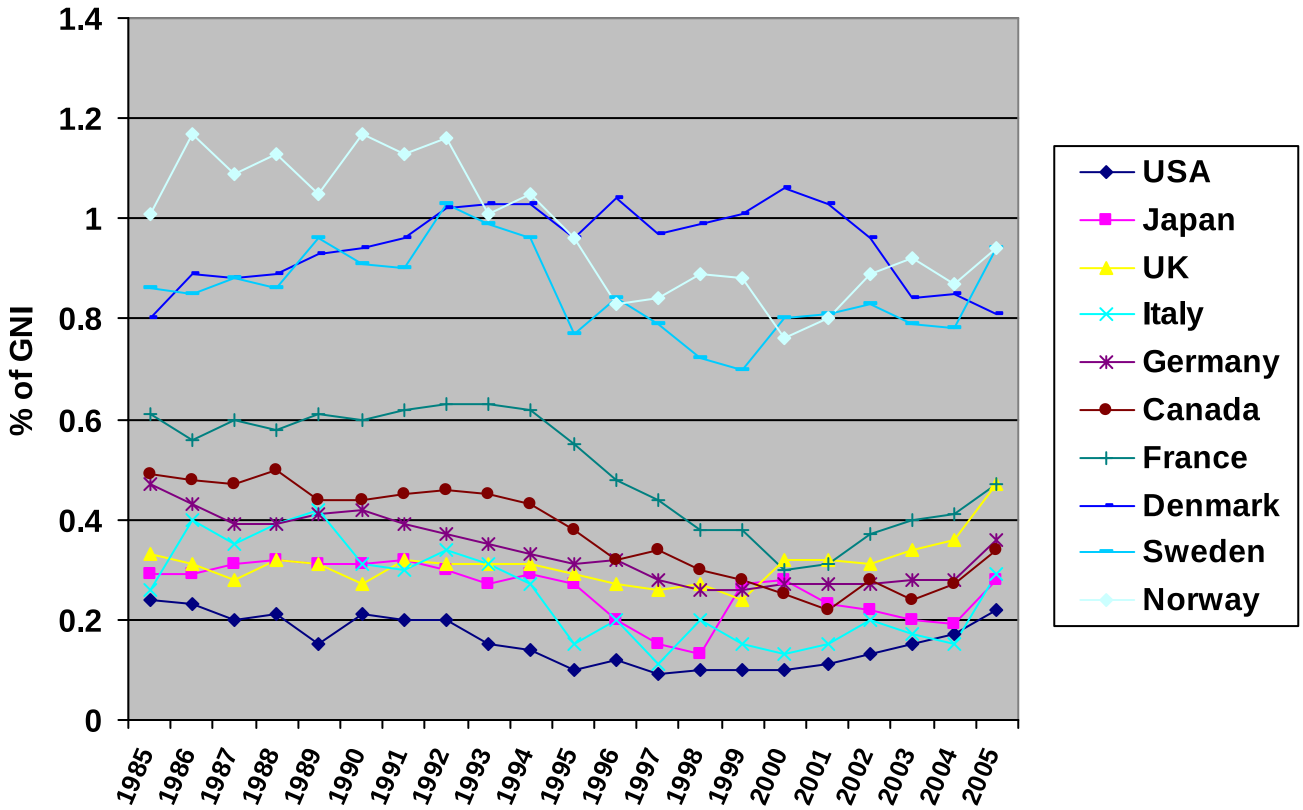
An alternative approach looks at public opinion with respect to redistributive policies within and across national borders. A comparative study of public opinion using Eurobarometer surveys from 1995 reached the seemingly counterintuitive conclusion that support for development assistance was weaker in countries where domestic redistribution was seen as a higher priority. The proposed explanation is that: "When equality has been institutionalized as an important principle, the public acknowledges the results and support for foreign aid is high; when this is not the case and domestic disparities remain important, redistribution at home appears more pressing and international justice less so" (Noël & Thérien, 2002: 645). A further question is whether, and how reliably, policy choices by national governments actually respond to public opinion. A study of aid spending on Africa by France, the United Kingdom, Germany, Denmark and the European Union in the 1990s – i.e., before the resurgence of interest in Africa in advance of the 2005 Summit – concluded that the link between public opinion and decision-making was tenuous at best, while emphasizing the importance of finer-grained case study explanations that focus on distinctive characteristics of national level policy processes (Olsen, 2001). Using a simpler comparison of survey results with development assistance levels, a recent OECD study concluded that high support for ODA does not have a direct influence on decision-makers, but also emphasized that the level of public information about, and media coverage of, development issues was, with the exception of a few countries, extremely low (McDonnell, Solignac Lecompte & Wegimont, 2003).

For purposes of informing advocacy, these findings are useful yet have several limitations. Development assistance is just one dimension of, and a highly imperfect proxy for, a government's overall perspective on development policy and global governance as they affect health. It is certainly conceivable that governments spending comparable proportions of their country's national income on development assistance will do so in ways that have drastically different outcomes. Cross-national statistical comparisons would ideally involve a composite of a particular government's record on not only the value but also the composition of development assistance, the proportion of tied aid, and its stances on debt cancellation, market access, arms control and a number of other issues. The Center for Global Development's Commitment to Development Index (http://www.cgdev.org/section/initiatives/_active/cdi) could possibly be used in this way, but statistical comparisons fail to illuminate either the influences on public opinion or the processes of government decision-making.

If it is assumed for purposes of argument that public opinion matters, at least to the extent that governments in formally democratic countries like the G8 must maintain the support of an electorally decisive plurality, then the issue becomes how to mobilize public opinion. It is to be hoped that research now under way on such questions as the impact of the civil society campaigns in advance of the 2005 Summit will shed more light on how shifts in attitudes toward global justice are likely to be initiated and sustained, and when governments are likely to respond with substantive as well as symbolic actions. On this point, contemporary policy analysis has not systematically explored why and how health and health equity concerns are, or are not, incorporated into the domestic policy stances of departments or ministries of finance, trade, industry, and transportation. A Canadian survey of senior public servants in such departments (Lavis et al., 2003) found them generally receptive to incorporating health concerns, with the notable exception of those working in finance ministries, but often not familiar with the relevant research … and the road from sympathetic attitudes to action can be a long and winding one, in the case of domestic policy and especially in the international frame of reference by G8 Summits.

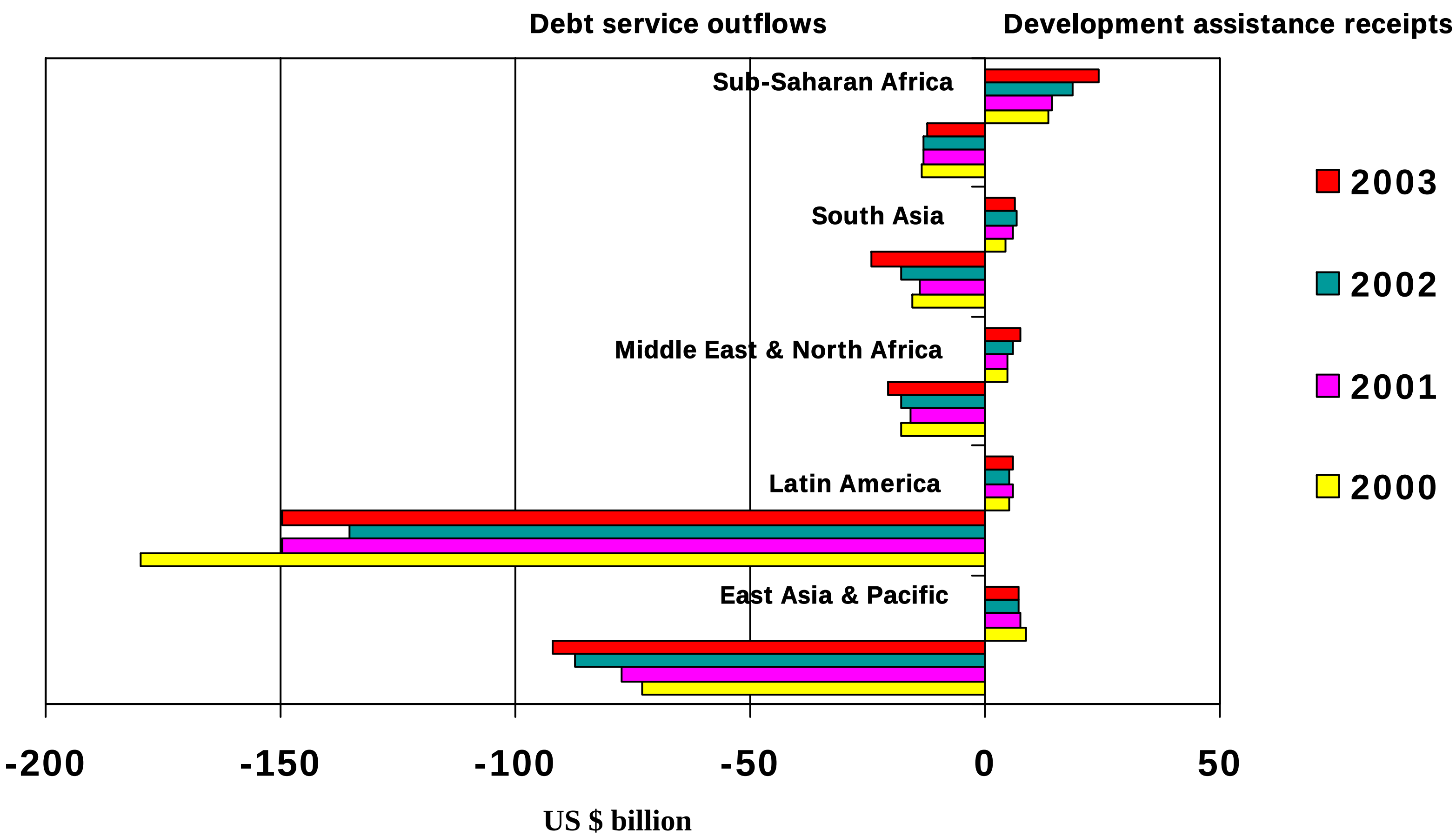
Historical experience in Britain suggests that mobilizing domestic public investment on health infrastructure required the formation of "a cross-class political alliance" involving the bourgeoisie and an expanding working class (Szreter, 1999), with the state taking a far more active role in the provision of public services. Internationally, it is not clear how far such motivations and appeals will take us, especially against the background provided by globalization: production and service provision are now routinely organized across multiple national borders and the relevant work force may be half a world away. Arguably the concept of human security (Chen & Narasimhan, 2003; Secretary-General's High-level Panel, 2004) represents an appeal to shared interests analogous to those invoked by Szreter, although human security is about much more than economics. A detailed exploration of the plausibility and ethical defensibility of the appeal is beyond the scope of this paper, but will need to be undertaken by the research network described in Box 3. This line of inquiry in turn represents one dimension of a core question for future research that links social science with ethics in the study of international relations: as globalization widens the divide between economic winners and losers – a point now conceded even by the World Bank (2007) – under what conditions will it be possible to mobilize the necessary political coalitions either within or across national borders in support of a global development agenda that focuses on health equity?

Figure 1. Trends in development assistance, G7 and selected comparison countries



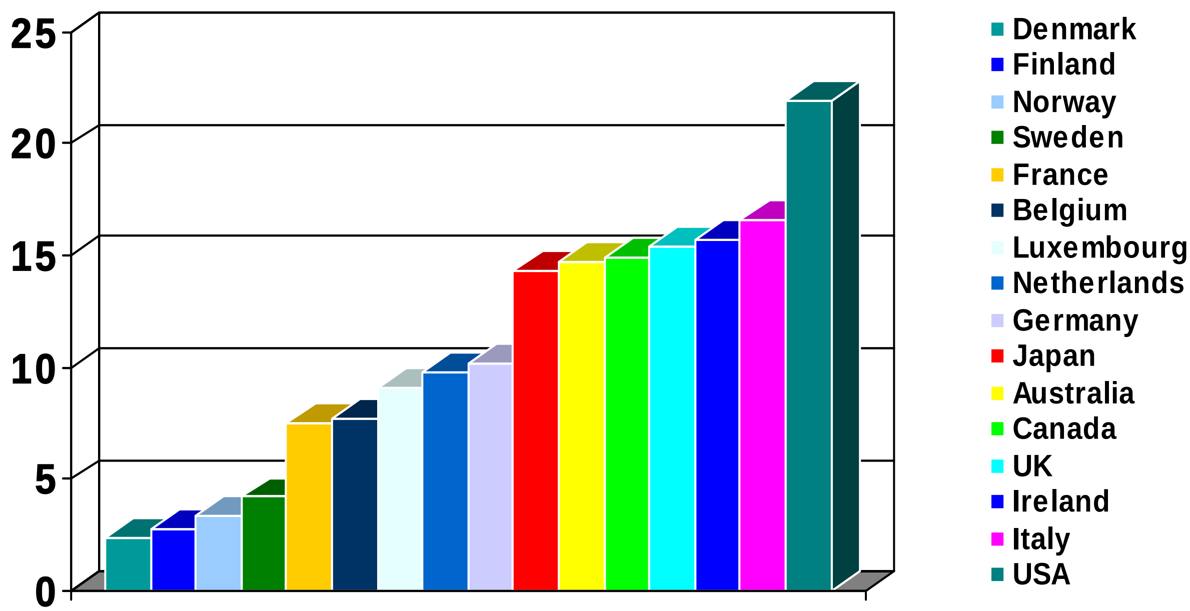
Source: OECD, Development Database on Aid from DAC Members: DAC online; http://stats.oecd.org/wbos/default.aspx?DatasetCode=TABLE1 (accessed December 18, 2006); 2005 figures from OECD Development Assistance Committee (2006)

Figure 2. Debt service and development assistance, by region, 2000-2003



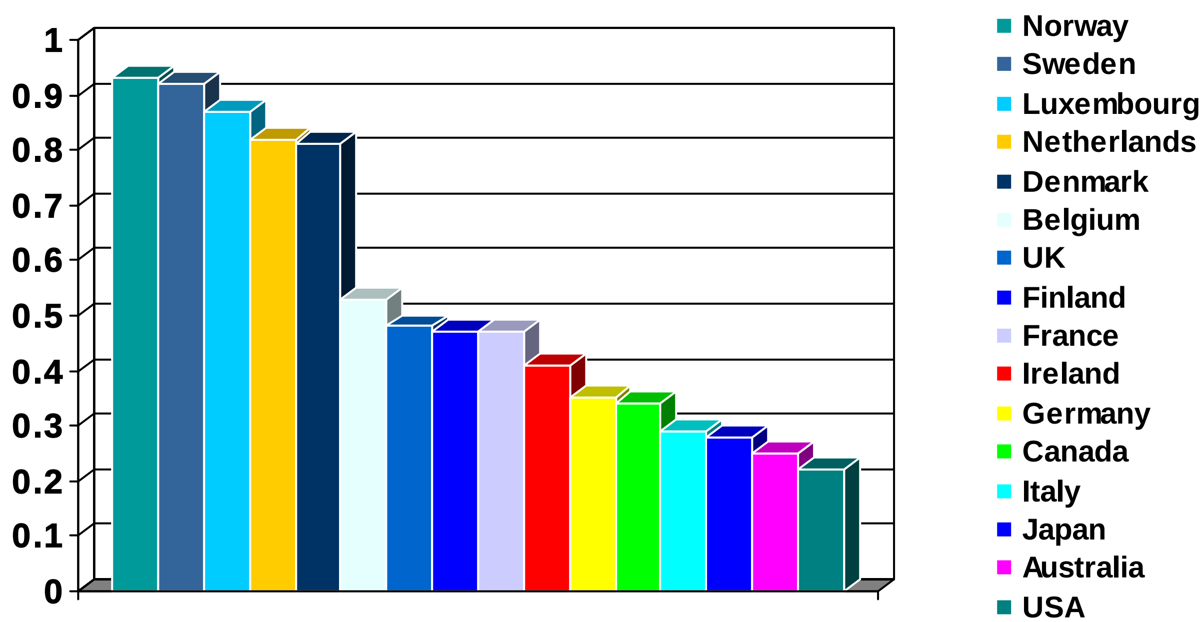
Source: World Bank Data from Econstats, http://www.econstats.com/wb/index_glwb.htm (accessed September, 2006)

Figure 3. A selective comparison: prevalence of child poverty, end 1990s ...



Source: Luxembourg Income Study figures in UNICEF (2005)

with development assistance as % of Gross National Income, 2005



Source: OECD Development Assistance Committee (2006)

References

Anon (2006a). In the twilight of Doha. *The Economist*, July 29: 63-64.

Anon (2006b). Doha Round Suspended Indefinitely after G6 Talks Collapse. *Bridges Weekly Trade News Digest, 10,* July 26: 1-4.

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.

Birdsall, N., Rodrik, D., & Subramanian, A. (2005). How to help poor countries. *Foreign Affairs, 84,* 136-152.

Birdsall, N. (2006). *Stormy Days on an Open Field: Asymmetries in the Global Economy,* WIDER Research Paper 2006/31. Helsinki: World Institute for Development Economics Research.

Braveman, P. & Gruskin, S. (2003). Defining equity in health. *Journal of Epidemiology and Community Health, 57,* 254-258.

Brock, K. & McGee, R. (2004). *Mapping Trade Policy: Understanding the Challenges of Civil Society Participation*, IDS working paper 225. Brighton, Sussex: Institute for Development Studies.

Browne, S., De Silva, L., & Tropp, S., eds. (2003). The Millennium Development Goals.. *Development Policy Journal* 3 [April] (entire issue).

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? *Lancet, 365,* 2193-2200.

Burke, M., Moore, C., & Shields, J., eds. (2000). *Restructuring and Resistance: Canadian Public Policy in an Age of Global Capitalism*. Halifax, Fernwood Publishing.

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.

Chen, L. & Narasimhan, V. (2003). Human Security and Global Health. *Journal of Human Development, 4,* 181-190.

Chen, S. & Ravallion, M. (2004). How Have the World's Poorest Fared since the Early 1980s? *The World Bank Research Observer, 19,* 141-169.

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.

Collier, P. (2006). Why the WTO is Deadlocked: And What Can Be Done About It. *The World Economy, 29,* 1423-1449.

Commission for Africa (2005). *Our Common Interest: Report of the Commission for Africa*. London: Commission for Africa. Available:

http://www.unhchr.ch/Huridocda/Huridoca.nsf/TestFrame/f991c6c62457a2858025675100348aef?Opendocument.

Commission on Macroeconomics and Health (2001). *Macroeconomics and Health: Investing in Health for Economic Development*. Geneva: World Health Organization. Available: http://www.cid.harvard.edu/cidcmh/CMHReport.pdf.

Control Arms Campaign (2006). Control Arms: UN world conference on small arms collapses without agreement (press release). Control Arms Campaign [On-line]. Available: http://www.controlarms.org/latest_news/outcomerevcon-pr070706.htm

Cook, D. (2006) Ways to fight the AIDS pandemic [interview with Stephen Lewis, UN Special Envoy for AIDS]. *Africa Report*, October: 109-111.

Conyers, D. & Mellors, R. (2005). Aid Ineffectiveness in Sub-Saharan Africa: The Problem of Donor Capacity. *IDS Bulletin, 36,* 83-89.

Cornia, G.A., Jolly, R., and Stewart, F., eds. (1987) *Adjustment with a Human Face,* vol.1: *Protecting the Vulnerable and Promoting Growth*. Oxford, Clarendon Press.

de Renzio, P. (2005). Increased Aid *vs* Absorptive Capacity: Challenges and Opportunities Towards 2015. *IDS Bulletin, 36,* 20-27.

Di Caprio, A. & Amsden, A. (2004). *Does the new international trade regime leave room for industrialization policies in the middle-income countries?* (Working Paper No. 22). Geneva: Policy Integration Department, World Commission on the Social Dimension of Globalization, International Labour Office.

Diderichsen, F., Evans, T., & Whitehead, M. (2001). The Social Basis of Disparities in Health. In M. Whitehead et al. (eds.), *Challenging Inequities in Health: From Ethics to Action* (pp. 13-23). New York: Oxford University Press.

Elkins, D.J. & Simeon, R.E. (1979). A Cause in Search of Its Effect, or What Does Political Culture Explain? *Comparative Politics, 11,* 127-145.

Esping-Andersen, G. (1990). *The Three Worlds of Welfare Capitalism*. Princeton: Princeton University Press.

Fickling, David (2006). UN arms control conference ends in disarray. *Guardian,* September 7.

Fink, C. & Reichenmiller, P. (2005). *Tightening TRIPS: The Intellectual Property Provisions of Recent US Free Trade Agreements* (Trade Note 20). Washington, DC: World Bank.

Foster, M. (2004). *MDG-orientated sector and poverty reduction strategies: lessons from experience in health, prepared for High-Level Forum on the Health MDGs* . Geneva: High-Level Forum on Health MDGs, World Health Organization. Available: http://www.hlfhealthmdgs.org/Documents/MDGorientedPRSPs-Final.pdf.

Fudge, J. & Cossman, B. (2002). Introduction: Privatization, Law, and the Challenge to Feminism. In B.Cossman & J. Fudge (eds.), *Privatization, Law, and the Challenge to Feminism* (pp. 3-40). Toronto: University of Toronto Press.

G8 (2001). *Communiqué* (Genoa). Available: http://www.g8.utoronto.ca.

G8 (2002). *G8 Africa Action Plan* (Kananaskis and Ottawa). Available: http://www.g8.utoronto.ca.

G8 (2005). *Africa* (Gleneagles, Scotland). Available: http://www.g8.utoronto.ca.

G8 (2006). *Fight Against Infectious Disease* (St. Petersburg). Available: http://www.g8.utoronto.ca.

Corlazzoli, V., & Smith, J. (eds.) (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.

Garcia, F. J. (2004). Beyond Special and Differential Treatment. *Boston College International and Comparative Law Review, 27,* 291-317.

Gill, S. (1999). Structural Changes in Multilateralism: The G-7 Nexus and the Global Crisis. In M. Schechter (ed.), *Innovation in Multilateralism* (pp. 113-165). Tokyo: United Nations University Press.

Global Forum for Health Research (2004). *The 10/90 Report on Health Research, 2003-2004* Geneva: Global Forum for Health Research.

Gottret, P. & Schieber, G. (2006). *Health Financing Revisited: A Practitioner's Guide*. Washington, DC: World Bank.

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

Graduate Institute of International Studies, Geneva. (2005). *Small Arms Survey 2005: Weapons at War*. Oxford: Oxford University Press.

Griffith-Jones, S. & Stallings, B. (1995). New global financial trends: implications for development. In B.Stallings (ed.), *Global Change, Regional Response: The New International Context of Development* (pp. 143-173). Cambridge: Cambridge University Press.

Grimmett, R. (2004). *Conventional Arms Transfers to Developing Countries, 1996-2003.* Washington, DC: Congressional Research Service, Library of Congress.

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.

Hacker, J. S. (2004). Privatizing Risk without Privatizing the Welfare State: The Hidden Politics of Social Policy Retrenchment in the United States. *American Political Science Review, 98,* 243-260.

Hajnal, P.I. (2005). Civil Society's Growing Role Vis-à-Vis The G7/G8. Presented to conference on G05 Global Democracy: Civil Society Visions and Strategies, Montréal, May 31. Available: http://en.civilg8.ru/Civil_and_G8/1647.php.

Hoekman, B. (2004). Policy Space, Coherence and Economic Development: Options for the WTO. New Haven: Yale University, mimeo; http://www.ycsg.yale.edu/core/forms/Project_terms_Reference.doc.

Holzmann, R. & Jörgensen, S. (2001). *Social Protection Sector Strategy: From Safety Net to Springboard*. Washington, DC: World Bank.

Hunt, P. (2007). *Implementation of General Assembly Resolution 60/251 of 15 March 2006 entitled "Human Rights Council": Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health,* A/HRC/4/28. Geneva: Office of the United Nations High Commissioner for Human Rights.

International Centre for Trade and Sustainable Development (2003). *International Dialogue: Making Special and Differential Treatment More Effective and Responsive to Development Needs.* Geneva: International Centre for Trade and Sustainable Development.

International Monetary Fund & World Bank (2005). *Zambia: Enhanced Initiative for Heavily Indebted Poor Countries—Completion Point Document, Country Report No 05/137*. Washington, DC: IMF.

Jaggar, A. (2002). Vulnerable women and neo-liberal globalization: Debt burdens undermine women's health in the global South. *Theoretical Medicine, 23,* 425-440.

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.

Jubilee Research (2005). The G8 2005 - What are the lessons? Jubilee Research [On-line]. Available: http://www.jubileeresearch.org/latest/g8110705.htm

Khalfan, A., King, J., & Thomas, B. (2003). *Advancing the Odious Debt Doctrine.* Montréal: Centre for International Sustainable Development Law, McGill University.

Killick, T. (2004). Politics, Evidence and the New Aid Agenda. *Development Policy Review, 22,* 5-29.

Killick, T. (2005). Don't Throw Money at Africa. *IDS Bulletin, 36,* 14-19.

Kirton, J., Kokotsis, E., Corlazzoli, V., Varey, M., Raths, A., & Sunderland, L. (2006). *Gleneagles Final Compliance Report, July 8, 2005, to June 1, 2006* Toronto: G8 Research Group, University of Toronto.

Kirton, J. & Mannell, J. (2007). The G8 and Global Health Governance. In A.F.Cooper, J. J. Kirton, & T. Schrecker (eds.), *Governing Global Health: Challenge, Response, Innovation* (Aldershot: Ashgate.

Kirton, J. & Sunderland, L. (2005). *The G8 Summit Communiqués on Health, 1975-2005* Toronto: G8 Research Group, University of Toronto.

Labonte, R. & Schrecker, T. (2005). *The G8, Africa and Global Health: A Platform for Global Health Equity for the 2005 Summit*. London: Nuffield Trust.

Labonte, R., Schrecker, T., & Sen Gupta, A. (2005). A global health equity agenda for the G8 summit. *British Medical Journal, 350,* 533-536.

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. (2007). Foreign policy matters: a normative view of the G8 and population health. *Bulletin of the World Health Organization, 85,* in press.

Labonte, R., Schrecker, T., Sanders, D., & Meeus, W. (2004). *Fatal Indifference: The G8, Africa and Global Health*. Cape Town: University of Cape Town Press.

Lavis, J. N., Ross, S. E., Stoddart, G. L., Hohenadel, J. M., McLeod, C. B., & Evans, R.G. (2003). Do Canadian Civil Servants Care About the Health of Populations? *American Journal of Public Health, 93,* 658-663.

Mandel, S. (2006a). *Debt Relief as if People Mattered: A rights-based approach to debt sustainability*. London: New Economics Foundation.

Mandel, S. (2006b). *Odious Lending: Debt Relief as if Morals Mattered*. London: New Economics Foundation.

Marmot, M. (2005). Social determinants of health inequalities. *Lancet, 365,* 1099-1104.

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).

McDonnell, I., Solignac Lecompte, H.-B., & Wegimont, L. (2003). Trends in Public Opinion about International Development Co–operation in OECD Countries: An Overview. In I.McDonnell, H.-B. Solignac Lecompte, & L. Wegimont (eds.), *Public Opinion and the Fight against Poverty* (pp. 15-37). Paris: OECD.

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.

Noël, A. (2006). The New Global Politics of Poverty. *Global Social Policy, 6,* 304-333.

Noël, A. & Therien, J.-P. (1995). From Domestic to International Justice: The Welfare State and Foreign Aid. *International Organization, 49,* 523-553.

Noël, A. & Thérien, J.-P. (2002). Public Opinion and Global Justice. *Comparative Political Studies, 35,* 631-656.

Nygren-Krug, H. (2002). *25 Questions and Answers about Health and Human Rights*. Geneva: World Health Organization.

OECD Development Assistance Committee (2006). *Final ODA Data for 2005* Paris: OECD.

Olsen, G.R. (2001). European public opinion and aid to Africa: is there a link? *Journal of Modern African Studies, 39,* 645-674.

Ooms, G. & Schrecker, T. (2005). Viewpoint: expenditure ceilings, multilateral financial institutions, and the health of poor populations. *Lancet, 365,* 1821-1823.

Picciotto, R. (2005). Key Concepts, Central Issues. In A.Trzeciak-Duval (ed.), *Fostering Development in a Global Economy: A whole of government perspective* (pp. 9-20). Paris: OECD.

Pogge, T. (2001). Priorities of Global Justice. *Metaphilosophy, 32,* 6-24.

Pogge, T. (2002). *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.

Reddy, S.G. & Pogge, T.W. (2005). *How Not to Count the Poor,* version 6.2. New York: Columbia University. Available: http://www.socialanalysis.org.

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.

Schieber, G., Fleisher, L., & Gottret, P. (2006). Getting Real on Health Financing. *Finance & Development, 43*.

Schrecker, T. & Labonte, R. (2006a). What's politics got to do with it? Health, the G8 and the global economy. In I. Kawachi & S. Wamala (eds.), *Globalisation and Health*. Oxford: Oxford University Press.

Schrecker, T. & Labonte, R. (2006b). Globalization and social determinants of health: A diagnostic overview and agenda for innovation. Presented to WIDER Conference on Advancing Health Equity, September 29-30. Helsinki: World Institute for Development Economic Research. Available: http://www.wider.unu.edu/conference/conference-2006-2/conference-2006-2-papers/schrecker-290806.pdf.

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.* Aldershot: Ashgate.

Secretary-General's High-level Panel on Threats, Challenges and Change (2004). *A More Secure World: Our Shared Responsibility*. New York: United Nations.

Shadlen, K. C. (2005). Exchanging development for market access? Deep integration and industrial policy under multilateral and regional-bilateral trade agreements. *Review of International Political Economy, 12,* 750-775.

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.

Slaughter, A.-M. (2005). Government networks, world order, and the L20. In J.English, R. Thakur, & A. F. Cooper (eds.), *Reforming from the Top: A Leaders' 20 Summit*. Tokyo: United Nations University Press.

Stålenheim, P., Fruchart, D., Omitoogun, W., & Perdomo, C. (2006). Military Expenditure. In *SIPRI Yearbook 2006* (pp. 295-324). Oxford: Oxford 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.

Stiglitz, J. & Charlton, A. H. (2004). Common values for the Development Round. *World Trade Review, 3,* 495-506.

Streak, J. C. (2004). The GEAR legacy: did gear fail or move South Africa forward in development? *Development Southern Africa, 21,* 271-288.

Szreter, S. (1999). Rapid economic growth and 'the four Ds' of disruption, deprivation, disease and death: public health lessons from nineteenth-century Britain for twenty-first-century China? *Tropical Medicine and International Health, 4,* 146-152.

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.

UN Millennium Project Task Force on Improving the Lives of Slum Dwellers (2005). *A Home in the City*. London: Earthscan.

UNICEF (2005). *Child Poverty in Rich Countries 2005*. Florence, Italy: UNICEF Innocenti Research Centre.

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 (2006a). *International financial system and development: Report of the Secretary-General,* A/61/136. New York: United Nations.

United Nations (2006b). *Millennium Development Goals Report 2006*. New York: United Nations.

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 (2003). *Human Development Report 2003: Millennium Development Goals: A compact among nations to end human poverty*. New York: Oxford University Press.

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.

United Nations Secretary-General (2006). *Recent developments in external debt,* A/61/152. New York: United Nations.

van de Walle, N. (2001). *African Economies and the Politics of Permanent Crisis, 1979-1999*. Cambridge: Cambridge University Press.

Wagstaff, A., Claeson, M., et al. (2003). *The Millennium Development Goals for Health: Rising to the Challenges*. Washington, DC: World Bank.

Watkins, K. & Fowler, P. (2002). *Rigged Rules and Double Standards.* Washington, DC: Oxfam International.

Webb, M. (2000). The Group of Seven and Political Management of the Global Economy. In R.Stubbs & G. Underhill (eds.), *Political Economy and the Changing Global Order* (2nd ed., pp. 141-151). Don Mills: Oxford University Press Canada.

White, H. (2005). The Case for Doubling Aid. *IDS Bulletin, 36,* 8-12.

Wood, A. (2006). *IMF Macroeconomic Policies and Health Sector Budgets*. Amsterdam: Wemos Foundation.

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

World Health Organization (2005). *Health and the Millennium Development Goals*. Geneva: World Health Organization.

World Trade Organization (2001). *Ministerial Declaration,* WT/MIN(01)/DEC/1 [the Doha Declaration]. Geneva: WTO, November 20.