



A global health equity agenda for the G8 summit

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Summary box

Learning across health systems comes mostly from joint projects

The United Kingdom would benefit from having an organisation like the US Institute of Medicine

Europe should consider building a network of high performance, low cost centres to do complex procedures

The United States is wasting large sums on old fashioned continuing medical education, whereas Britain is modernising professional learning

The US would benefit from system-wide information technology such as that being introduced in England

Conclusions

Learning from other healthcare systems is not straightforward, but all systems face the same fundamental problems of quality, safety, access, usability, availability, and affordability—and all perform suboptimally. We see increasing examples of interaction and learning among systems. Such learning will benefit patients.

Contributors and sources: LQ was a Rhodes scholar in Oxford and is now the chief executive of Ovations, which provides services for seniors in the United States. She also worked with Hillary Clinton on the reform of US health care. Formerly a member of the *BMJ* editorial board, she has worked closely with

staff in the Department of Health and the NHS to establish programmes in England. RS was editor of the *BMJ* and chief executive of the BMJ Publishing Group for 13 years. Before becoming the editor he spent a year at the Graduate School of Business at Stanford in California. LQ and RS produced a list of possible options for transatlantic learning, partly through the experience and reading and partly through asking others on both sides of the Atlantic. RS produced the first draft, which LQ then corrected. Both have read and approved the final version. RS is the guarantor.

Competing interests: Both authors are employees of the UnitedHealth Group, which operates predominantly in America but is hoping to develop its business internationally.

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A global health equity agenda for the G8 summit

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The G8 summit in July could be used to enable developing countries to meet the millennium development goals. What should world leaders commit to?

Substantial reversals of the global trend in improvements in health of the past 150 years are now evident in large parts of the developing world, particularly in sub-Saharan Africa.^{w1} In addition to its intrinsic value as a human right,¹ health is an important contributor to economic development.^{2 w2} This creates a compelling case for investing in health, especially since several cost effective interventions are available that can produce rapid and broadly shared improvements in health.^{3 w3}

The international community is committed to the millennium development goals, most of which are closely related to health status or determinants of health. However, much of the developing world will not meet those goals by the designated date of 2015 unless the industrialised world makes major long term commitments to provide new resources.⁴ Because the G8 countries account for roughly half the world's eco-

nomie activity and dominate the decision making processes of the World Bank and International Monetary Fund, appropriate commitment at the 2005 UK summit could turn the page on decades of neglect and fatal indifference.⁵

Health systems and health research

Developmental aid for health totalled \$8.1bn (£4.4bn, €6.3bn) in 2002, the most recent year for which figures are available.⁶ This is a fraction of estimated minimum needs: \$27bn by 2007, \$38bn by 2015.² Of critical importance is support to curb the spread of communicable diseases in sub-Saharan Africa. The G8 must provide a timetable for increasing their financial

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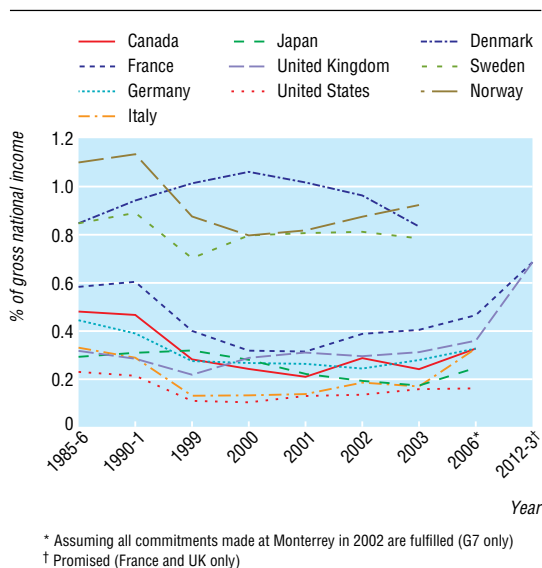


Fig 1 Trends in development aid donated by G7 and selected European countries^{6,7}

support for the Global Fund to fight AIDS, Tuberculosis and Malaria, which has announced a fifth grant competition while acknowledging that it may lack resources for any new projects.

At the same time, the G8 must ensure that disease specific programmes do not undermine the sustainability of national health systems.⁷ Key measures here include directing more money to supporting health systems⁴; making multiyear commitments to end the uncertainty that surrounds donor driven programmes³; pooling donor resources within countries; and adding a percentage allowance for budget support to cover costs of implementing new disease specific programmes.⁸

Migration of health professionals from sub-Saharan Africa, which already needs one million more health workers,⁹ and from other developing regions is a special concern. Since G8 countries benefit most from this migration, the 2005 summit should begin negotiations on the multilateral agreement on migration of health professionals called for by the New Partnership for Africa's Development health plan.¹⁰

The logic of global markets means funding for health research continues to be concentrated on diseases of the wealthy.¹¹ The 2005 summit should therefore produce a timetable of new sustained commitments for research into diseases affecting poor people, such as the Global HIV Vaccine Enterprise. The summit should also specify mechanisms to ensure the affordability and availability of any vaccines, essential medicines, and diagnostic tools developed as a result of such research, as well as commit to ensuring availability and reduced prices of treatments that promote public health.

Socioeconomic determinants of health

Development policies and aid need to reflect the importance of the key social determinants of health: education; nutrition and food safety; and water, sanitation, and housing. G8 support for all of these areas has

been inadequate and often compromised by an insistence on cost recovery and other market oriented policies that undermine health equity.⁵ Larger donations and multiyear commitments from donors are required in all of these sectors if low income countries are to achieve the millennium development goals.^{3,4}

A comprehensive strategy for increased aid should be developed in the context of a clear timetable for G7 countries to attain the longstanding United Nations target of allocating 0.7% of their gross national income to developmental aid. France has made a firm commitment to reach this target by 2012; the United Kingdom has made a soft promise to do so by 2013. The performance of several other European countries shows that achieving this goal consistently is possible (fig 1). A generic commitment by the G7 to match this performance should be accompanied by a separate commitment to doubling present development aid to Africa within three years. The UK's proposed international finance facility (which would float bonds based on pledged increases) can achieve this, but only if all donor countries commit to a timetable to reach the 0.7% target. Questions remain about the pattern of aid after 2015 under the proposal, and about the logic of paying hundreds of millions of dollars in interest to bond investors rather than channelling these resources directly to meeting basic needs.¹² New forms of global taxation are also an attractive option, although agreement on these would be politically difficult to achieve in the short term. Taxation could be used alone or alongside the international finance facility.¹²

Crucially, development aid must not be encumbered by conditions that undermine equity—for example, placing ceilings on health and education expenditures or requiring cost recovery in the form of user fees. Donors should require no more than fiscal transparency, accountability, and targeting of resources at basic needs. The fiscal constraints that governments invoke to justify their slowness in responding to global health needs must be assessed in the context of (for instance) world military expenditures, recent tax cuts in the United States and other G8 countries, and the trivial cost for the G7 of meeting the 0.7% target (fig 2).

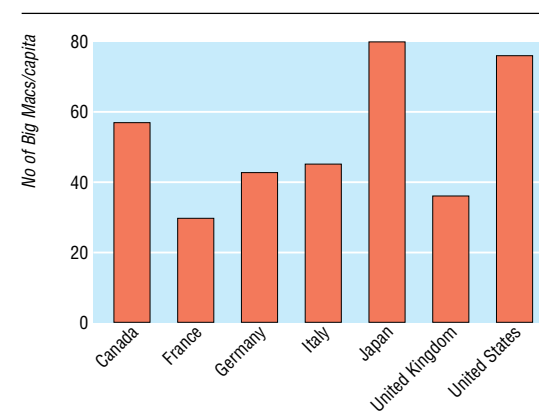


Fig 2 Annual cost of increasing development aid to 0.7% of gross national income. Costs are given in terms of the price of a Big Mac in the listed countries (the Big Mac index¹³), development figures are from 2004,¹⁷ and population figures from 2003¹⁸

Debt cancellation

For almost two decades, the external debt burden of many developing countries has been recognised as a barrier to development and to meeting basic human needs.^{13 w10} Payments to service debts dwarf development aid in most developing regions.¹⁴ Although the Enhanced Heavily Indebted Poor Countries (HIPC) initiative led by the G8 has enabled some countries to increase public spending on education and health, it provides too little debt relief, too late, and for too few countries.¹² In addition, debt relief comes with conditions under the rubric of poverty reduction that closely resemble earlier structural adjustment requirements.^{15 w10 w11} For example, loans from the World Bank and International Monetary Fund have often been tied to liberalising imports, leading to the destruction of local agriculture or small industry.⁵

G7 countries must commit new money from national treasuries to expanded debt cancellation without reducing money given to aid development and with special consideration of the effect the attached conditions have on equity. Eligibility for debt cancellation must extend to all countries whose debt obligations interfere with public provision for basic needs; sustainable debt levels must be defined by working back from the level of public investment required to meet the millennium development goals, rather than with reference to exaggerated estimates of future export earnings.¹⁶

Recent proposals to write off much of the debt of the world's poorest countries by selling International Monetary Fund gold reserves should be supported. However, measures will also be needed to compensate developing countries for at least part of the resulting downward pressure on the price of gold. The UK's unilateral pledge to pay back its proportional share of the debts owed to the World and African Development Banks should be followed by all other G8 nations. The G7 finance ministers' commitment in February 2005 "to provide as much as 100 per cent multilateral debt relief" for the 27 heavily indebted poor countries¹⁷ is another positive step; it should be strengthened to refer explicitly to debt cancellation and extended to other countries by the time G8 leaders meet in July.

Finally, the G8 must intensify efforts to close offshore tax havens. The tax avoidance opportunities they provide undermine the fiscal capacity of governments throughout the world and contribute to debt crises by enabling the elite in developing countries to protect their wealth while socialising the costs of debt repayment.⁵

Fairer trade

The G8 have consistently adhered to a statement made at the end of the 2001 Genoa summit: "Drawing the poorest countries into the global economy is the surest way to address their fundamental aspirations."¹⁸ Lack of rapid progress toward the millennium development goals shows that such integration may not improve health equity because of the asymmetric nature of global markets.¹⁹ In particular, current trade rules prevent low and middle income countries from using policies to protect domestic markets and enterprises, such as favouring domestic firms in procurement and



Action to improve health in developing countries is affordable

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limiting intellectual property protection, that rich countries used at earlier stages of their own development.²⁰ Continued barriers to exports of agricultural products from low income countries are a special problem. Tariffs and huge producer subsidies, equivalent to several times the annual value of development aid,²¹ depress world market prices beyond the competitive ability of otherwise efficient producers, such as African cotton growers.^{w12}

Although export driven growth is far from a panacea, the G8 must make firm and transparent commitments to improve market access, unilaterally and through the European Union and World Trade Organization. The G8 must also ensure that its commitment to strengthen provisions for special and differential treatment, historically a key mechanism for levelling the economic playing field, does not become a way of further subordinating the interests of developing countries within the multilateral trading system.¹² Another important step is to ensure that developing countries can actually use the health related exemptions to harmonised intellectual property protection, which will improve access to essential medicines.²²

Rights based approach to health and development

The tsunami in December 2004 underscored the arbitrariness of life and death in the face of large scale natural disaster. The annual toll from easily preventable disease and injury in the developing world represents a disaster on a far larger scale, one to which people are similarly vulnerable based solely on accidents of birth. An unprecedented consensus now exists in the development policy and international health communities about what needs to be done to achieve widely shared improvements in population health and about the relatively modest cost of the necessary policies and interventions.^{3,w3}

Unfortunately, more than a whiff of paternalism and celebrity photo-opportunism is associated with the newly heightened rhetoric of global obligation. An approach to health and development that emphasises human rights^{1 15 w13} offers a compelling alternative to leaving the global market place to meet basic needs. Recognising that the need is not for charity, but for jus-

Summary points

Health is a human right and an essential investment for economic development

Interventions to reverse declining health in developing countries are readily available and affordable.

G7 cancellation of African debt and doubling of development aid is essential

Support for fairer trade rules that strengthen special and differential treatment for African nations is also needed

The cost to G7 countries of these policy reforms is trivial

tics,¹³ the G8 must build on recent encouraging responses to the crisis in development and health⁹⁻¹⁴ and move toward explicit endorsement of a rights based approach, backed up by firm long term commitments to the redistribution of resources across national borders.

This article is based on the Nuffield Trust report, *The G8, Africa and global health: a platform for global health equity for the 2005 summit*,¹² which was launched on 28 February 2005 (www.nuffieldtrust.org.uk/globalhealth/index.php).

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The material for hospital doctors is aimed at doctors in their foundation years (the first two years after graduation). The new curriculum for these years states that trainees must learn generic skills that are necessary to practise as a good doctor. Examples include skills that will enable them to deal with ethical dilemmas and those that will help them work well in a team. We have published learning modules on these subjects: if you want practical and evidence based advice on how to deal with drug

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