

# THE G8, AFRICA AND GLOBAL HEALTH

A PLATFORM FOR GLOBAL HEALTH EQUITY FOR THE 2005 SUMMIT

Ronald Labonte, PhD

Ted Schrecker, MA



The Nuffield Trust  
The Nuffield Health & Social Services Fund  
UK Global Health Programme

# THE G8, AFRICA AND GLOBAL HEALTH

---

A PLATFORM FOR GLOBAL HEALTH EQUITY FOR THE 2005 SUMMIT

Ronald Labonte, PhD

Ted Schrecker, MA

Foreword by John Wyn Owen CB



The Nuffield Trust  
The Nuffield Health & Social Services Fund  
UK Global Health Programme

# AUTHORS

## Ronald Labonte, PhD

Canada Research Chair, Globalisation/Health Equity  
Institute of Population Health, University of Ottawa  
1 Stewart Street, Ottawa, Ontario  
rlabonte@uottawa.ca  
Board, Canadian Coalition for Global Health Research

## Ted Schrecker, MA

Senior Policy Researcher, Globalisation/Health Equity  
tschreck@uottawa.ca  
Institute of Population Health, University of Ottawa

Research Assistance: Madeline Johnson (MHSc candidate), Jennifer Cushon (MA),  
Renee Torgerson (PhD).

The comments of two reviewers (Anne Coles and Veronica Walford) are gratefully  
acknowledged, but all views expressed here are exclusively those of the authors.

ISBN 1-905030-03-7

© The Nuffield Trust, 2005

Published by The Nuffield Trust  
59 New Cavendish Street  
London W1G 7LP

Telephone: 020 7631 8450  
Facsimile: 020 7631 8451

E-mail: [mail@nuffieldtrust.org.uk](mailto:mail@nuffieldtrust.org.uk)  
Website: [www.nuffieldtrust.org.uk](http://www.nuffieldtrust.org.uk)

Charity Number: 209201

Designed by Nicholas Moll Design  
Telephone: 020 8879 4080

Printed by The Ludo Press Ltd  
Telephone: 020 8879 1881

# TABLE OF CONTENTS

Foreword .....	4
Preface .....	5
Executive Summary .....	7
1. Introduction .....	11
2. Health, the Millennium Development Goals, and Human Rights .....	15
3. Key Policy Domains Affecting Global Health Equity .....	19
3.1 Health Systems .....	20
3.2 Disease-Specific Funding .....	23
3.3 Research for Global Health Equity .....	25
3.4 Socioeconomic Determinants of Health .....	26
3.5 Financing for Global Health Equity.....	28
3.6 New Forms of Taxation for Global Health and Development .....	33
3.7 Debt Cancellation .....	35
3.8 Fair Trade .....	38
4. Conclusion: Beyond the Washington Consensus Towards Global Health Equity .....	43
References .....	45

# FOREWORD

One of the main objectives of the Nuffield Trust Global Health programme is to enhance national responses to global health challenges in the UK and other countries - the emphasis of our work is on analysis with a view to action. The programme builds on the Trust's interests in the implications of globalisation for health of the UK and globally, and to examine the contribution the UK makes and could make to improving global health. A key focus of this programme is on the relationship between health, foreign policy and security. Through commissioned research, discussion papers, conferences, seminars and consultations, the Trust aims to replace the traditional views of health, foreign policy and security with a new paradigm and promote the opportunities for global health that this new perspective provides. Without recognition of this new policy landscape, the Trust feels that the opportunities to address global health challenges from this unique relationship will be missed.

The Nuffield Trust believes that the UK leadership of the G8 provides a unique opportunity to work towards global health equity, particularly with a view to building a strong and prosperous Africa. By viewing the linked issues of health, human development, opportunity and growth, aid and debt relief through the prism of global health equity, the G8 can work towards the challenges facing Africa in these areas. By focusing on the G8, it enables us to consider the role of the world's wealthiest and most economically advanced countries in addressing the challenges of global health through their health, security and foreign policy agendas.

This discussion paper is premised on the principle of global health equity: reducing inequalities in the global disease burden by improving the health of the world's least well off. Poor health represents a major impediment to economic development, which in turn impacts on social well-being and global security. The paper considers how leadership by the G8 can enable fulfilment of the first globally agreed set of development goals, the Millennium Development Goals, and proposes the social, developmental and economic steps that can be taken by the G8 to promote health equity for Africa.

John Wyn Owen CB  
Director  
UK Global Health Programme  
February 2005

# PREFACE

The Group of 8 countries (Canada, France, Germany, Italy, Japan, Russia, the USA, the UK and, with special membership, the EU) includes the world's wealthiest and economically most advanced countries. Their individual and collective decisions or actions play a dominant role in the global economy and politics. Their annual Summits have made numerous commitments, statements of intent and normative assessments/claims related to global economic management, security, development and health. Health has increased in prominence during recent Summits, particularly since the late 1990s. Some key G8 commitments to global health since 1999 include:

- 1) Establishment of the Global Fund to fight AIDS, Tuberculosis and Malaria
- 2) Agreement on TRIPS flexibility for parallel importation of generic drugs
- 3) Establishment of a global initiative to develop an HIV vaccine
- 4) Support for health research on diseases prevalent in Africa, and expanding health research networks focusing on African health issues
- 5) Support to the global polio eradication campaign
- 6) Debt reduction through the HIPC program
- 7) Increased development assistance and, within that, increased aid to health systems
- 8) Improved market access for least developed country exports

Since 2001, Africa has been a particular focus of G8 global health and development commitments. Africa's uniquely high multiple burden of disease – communicable and non-communicable diseases, injury, and the special case of HIV/AIDS – has focused worldwide attention on the health, development, economic and governance challenges faced by many African countries. It has also challenged rich countries to examine their role in reducing Africa's overwhelming disease burden, and to support African efforts to improve its own economic and social development. In 2002, the G8 endorsed the 'made in Africa' plan for the continent's future, NEPAD (New Partnerships for Africa's Development), and established the Africa Action Plan to assist in its implementation.

The G8 endorsed the International Development Goals at their 1999 Summit, which, with some amendments, were adopted by all nations as the UN Millennium Development Goals in 2000. The goals and their targets are flawed in several respects: They are inherently modest (especially the poverty target); they lack specification of an equity dimension, meaning that countries can achieve the targets by *increasing* health disparities between rich and poor within their borders; and they lend themselves too easily to problematic vertical program interventions aimed at particular diseases. However, the MDGs represent the first globally agreed upon set of development commitments, which, if the equity dimension is incorporated within them, imply a massive transfer of enabling resources from wealthy to poorer countries for their accomplishment.

Assessments of the G8's performance in fulfilling its past health and development commitments, or otherwise meeting the challenge posed by Africa's disease pandemics and the development plans laid out in NEPAD, however, have been mixed (Labonte *et al*, 2004;

Centre for G8 Studies). Both health and Africa were less prominent in the 2003 and 2004 Summits than in earlier years. Many sub-Saharan African countries are not only failing to make sufficient progress towards the MDG targets; several are regressing. The reasons are complex, but lack of resources (both financial and human) is a primary one. The 2005 Summit, hosted by the UK, will place Africa (with an emphasis on health and HIV/AIDS) and environment/climate change prominently on the G8 agenda.

This Working Paper summarises past assessments, and lays out a number of policy options that, if adopted and promoted by the G8, would substantially improve African health and development. The Paper is premised upon the principle of global health equity: reducing inequalities in the global disease burden by improving the health of the world's least well off. It also strongly supports, and partly addresses, the concern raised by African research and civil society organisations in response to a consultation on the UK Commission for Africa: That the role of high-income countries in maintaining (or alleviating) poverty in Africa, specifically through policies on aid, trade, debt, intellectual property rights and subsidies, must be critically examined.

## EXECUTIVE SUMMARY

Global health equity refers to reducing the preventable burden of disease that is disproportionately borne by the poor majority of the world's population though improved treatment, health care, disease prevention and creation of the social, environmental and economic conditions that promote health.

Substantial reversals of the global trend in improvements in health of the past 150 years are now evident. Poor health represents a major impediment to economic development, creating a compelling case for investing in health. The international community (including the G8) is committed to the Millennium Development Goals (MDGs), most of which are closely related to health status or the determinants of health. However, it is evident that the goals will not be met, especially not in sub-Saharan Africa, without a major redistribution of resources to the developing world. An emerging body of legal and policy literature makes the case, based on existing international agreements, that health should be regarded as a human right: that is, as an end in itself as well as means to economic development.

The G8 should explicitly declare their support for the provisions of the International Covenant on Economic, Social and Cultural Rights related to health, and adopt an expansive, human rights-based approach to all aspects of their relations with African countries (including, but not limited to, the achievement of the MDGs). This will require a sustained commitment of new resources, for a period beyond 2015, in a number of areas.

**1. Health Systems:** Development assistance for health remains just a fraction of the amount needed, according to authoritative estimates. In particular, more ODA is needed for budget support in health, as distinct from specific projects – and must not be tied to the market-oriented health system 'reforms' promoted by the World Bank in its 1993 *Investing in Health* report, and subsequently. Such measures have repeatedly proved destructive of health equity. The brain drain of health professionals from sub-Saharan Africa is a special concern. In addition to development assistance for health systems sufficient to reduce the incentives to leave, a multilateral agreement on the migration of health professionals is needed, as called for by the New Partnership for Africa's Development (NEPAD) health plan.

**2. Disease-specific Funding:** The G8 must provide a timetable for increasing their financial support for the Global Fund to fight AIDS, Tuberculosis and Malaria, keeping in mind the levels called for by the Commission on Macroeconomics and Health. At the same time, they must take concrete measures to ensure that such 'vertical' programs do not undermine the sustainability of national health systems, as is often the case today.

**3. Research for Global Health Equity:** Funding for health research continues to be concentrated on diseases of the wealthy: the 10/90 gap. The 2005 Summit should produce a timetable of new funding commitments for health research on diseases of the poor, including specific commitments of new money to the Global HIV Vaccine Enterprise. It should also specify mechanisms to ensure the affordability and availability of any vaccines developed as a result.

**4. Socioeconomic Determinants of Health:** Development policy and development assistance need to reflect the importance of key social determinants of health, including education; nutrition and food security; 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. These sectors need to be considered as part of a comprehensive strategy for investing in health, with specific attention to equity concerns.

**5. Financing for Global Health Equity:** That strategy should be developed in the context of a clear timetable for raising ODA toward the long-standing United Nations target of 0.7 percent of gross national income (GNI), with a further commitment to doubling present ODA to Africa within three years. Recent pledges to increase development assistance remain incommensurate with the level of need, based on available estimates of the cost of achieving the MDGs. ODA is not a panacea for development, for a variety of reasons. However, aid can work, and much larger aid flows are required if low-income countries (not just in Africa) are to achieve the MDGs. Aid must not be encumbered with market-oriented conditionalities that reduce its effectiveness and, in particular, undermine equity. And the 'fiscal constraints' that governments invoke to justify their slowness in responding to global health needs must be assessed in the global context of (for instance) US military expenditures and recent tax cuts in the USA and other G8 countries.

**6. New Forms of Taxation for Global Health and Development:** For this reason, a variety of options for global taxation to finance development should be explored. Possibilities include taxes on arms sales and air travel; a carbon tax on high-income countries; a currency transaction tax (the so-called Tobin tax); and withholding taxes on capital leaving a country. These would require considerable multilateral negotiation, but G8 leadership would go a long way toward demonstrating sincerity about making globalisation work for the poor.

**7. 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. Outflows of funds for debt service dwarf inflows of ODA in most developing regions, and the Enhanced Heavily Indebted Poor Countries (HIPC) initiative led by the G8 is totally inadequate, for many reasons. At the 2005 Summit, the G8 must agree to rapid expansion of debt cancellation using 'new money' from national treasuries, and with special consideration of the equity impacts of conditions attached to debt reduction. Further, eligibility for debt cancellation must not be restricted to HIPCs, but must extend to other countries where debt obligations interfere with public provision for basic needs.

**8. Fair Trade:** Although the G8 have consistently promoted global market integration, it is far from clear that such integration will work to the benefit of the poor, or that it is the most effective route to improved health equity. Current trade rules deny low- and middle-income countries the policy flexibilities the rich countries used at earlier stages of their own development. The G8 must take seriously the economic needs of developing countries, by recognising the importance of such mechanisms as special and differential treatment (SDT); by exercising leadership to ensure that human rights – including the right to health – take precedence over trade liberalisation; and by systematically monitoring protectionist policies

of their own members as they adversely affect economic opportunities for the developing world.

The G8 have consistently adhered to the set of macroeconomic policy propositions described as the Washington consensus. Such policies have failed to generate the rapid and broadly shared improvements in health status we know are achievable. The lack of rapid progress toward the MDGs only underscores this inadequacy. The G8 must therefore build on some recent encouraging responses to the crisis of development and health in Africa to move beyond the Washington consensus, to explicit endorsement of a human rights-based approach to health and development, backed up by firm commitments to make the necessary resources available.

# 1. INTRODUCTION

*Global Health Equity* refers to the goal of reducing the preventable burden of disease that is disproportionately borne by the poorer majority of the world's population<sup>1</sup> through improved treatment, health care, disease prevention and creation of the social, environmental and economic conditions that promote health.

The last 150 years have witnessed dramatic improvements in health status worldwide. Beginning in Europe and other wealthier countries in the late 19th through mid-20th centuries, health improvements quickly generalised around the globe. The most dramatic gains over the past half-century have occurred in poorer countries, substantially closing the 'health gap' that previously separated the northern industrialised and southern agrarian worlds. These health gains are variously related to increasing incomes, which improve diet and living conditions, improvements in public health measures, such as potable water and sanitation, and the diffusion of medical innovations, notably immunisation and antibiotics (World Bank 1993: 34-36).

But substantial reversals of this trend are now evident. These reversals affect the poorest and most vulnerable households, communities and nations, leading to widening gaps in health status that parallel disparities in income and wealth. First amongst the causes of these reversals is the pandemic of HIV/AIDS that, alongside other infectious diseases, disproportionately affects poorer populations in Africa, Asia and part of Latin America (UNAIDS 2004). Second has been the collapse of the health and welfare infrastructure of the former Soviet Union, precipitating a decline in health indicators and rise in poverty rates that has almost certainly not yet run its course (Cohen 2000; Field, Kotz and Buchman 2000; Andreev, McKee and Sholnikov 2003; Men *et al.* 2003), partly, but only partly, because of the rapid increase in HIV infections.<sup>2</sup>

---

1 One compelling example: '[A]bout 99 per cent of all the deaths from AIDS, malaria and tuberculosis occur in developing countries' (IMF 2004: 9).

2 For an important report from the field, see Specter 2004.

When the G8 countries meet in the UK to consider their best policy responses to reduce this increasing burden of disease, and so improve global health equity, a few simple facts about the powerful link between health and economic development must be uppermost in their decision-making:

**a.** Good health is one of our most important personal assets and desired life goals, irrespective of where we live.

Good health is particularly important for people in least developed and low-income countries. The lack of, or recent decline in, health and social safety nets in many of these countries drives millions of families each year into the 'medical poverty trap' that results from the out-of-pocket costs of treatment and the illness-related loss of income (Whitehead, Dahlgren and Evans 2001). This creates a vicious circle in which the illness costs lead to decreased family nutrition, missed education, migration to less arable lands, increased family powerlessness and still more disease, all of which undermine economic growth. Malaria is slowing African economic growth by up to 1.3 per cent per year (Gallup and Sachs 2000). Short-term estimates of the economic impact of HIV/AIDS generally indicate that it has reduced annual growth rates by 1.5 per cent or less, but UNAIDS (2004: 57; see also Bell, Devarajan and Gersbach 2003) warns that '[f]ew models can capture the economic costs of institutional dysfunction, for example, or the costs of a severe distortion in the supply and distribution of labour power, intergenerational transmission of knowledge and skills, or of the disruption of lifetime capital acquisition and inheritance.'

**b.** Investments in health can yield enormous human and economic benefits. Poverty remains the greatest risk condition for disease, disability and premature death. Reducing poverty through economic growth and domestic redistribution policies will improve health, especially for the least well off. But investing in health also reduces poverty. The US\$300 million investment in global smallpox eradication generated economic benefits 'that probably reach into the tens of billions of dollars per annum' (Global Forum 2004: 5) – gains that compound over time. Improved health contributed as much as one-third to the East Asian 'economic miracle' (Bloom and Williamson 1998). Health investments create a virtuous circle than can disrupt the vicious one of disease – poverty – more disease.

**c.** The virtuous health-development-health circle has several prerequisites. First is a paradigm shift in thinking, where health (or human development more generally) is no longer seen simply as a consequence of economic growth, but as one of its engines.

In this virtuous circle, it is important to be sure which one is the objective (human development) and which one the tool (economic growth) because economic growth will not automatically translate into human development without a clear political will in the public sector (Global Forum 2004a: 11).

A country need not be rich to be healthy, and countries can become wealthier, without parallel gains in health (Lipson 2001: 2).

Other prerequisites that address this political will include: good governance of and equitable access to health services; emphasis on spending in primary health care, immunisation, nutrition and maternal/child health programs that yield the greatest population health gains;

policies to ensure that public programs do not disproportionately benefit the wealthy who are better able to access services; and research into treatments for diseases affecting the world's poor (Global Forum 2004: 10).

Given the highly efficacious and low-cost technologies that exist for improving health (particularly in high-mortality settings), a careful, quantitative reassessment of competing investment priorities for improving living standards will likely conclude that existing ODA [overseas development assistance] and budgetary allocations to health are richly deserving of a substantial boost (Bloom, Canning and Jamison 2004: 15).

The economic argument for investing in health is compelling. Taken to its extreme, global health also becomes an investment in global security. Yet:

[I]nvesting in health as an organising principle for public policy arguably invites a form of economic triage that is inimical to health equity concerns: countries, regions and populations that are prioritised for investments in health will primarily be those offering the greatest promise of economic returns, e.g. because of the availability of expanding consumer markets or the availability of healthy and relatively skilled, yet low cost labour (Schrecker and Labonte in press).

Instrumental arguments have also been advanced in the USA from the perspective of national security: '[W]e shall have to pick our spots and allocate funds to disease prevention with discretion in order to maximise the stability of key states and promote regional stability' (Price-Smith 2002: 178). This opens up the risk of a security triage of health concerns on potentially questionable grounds (see O'Manique 2004).



## 2. HEALTH, THE MILLENNIUM DEVELOPMENT GOALS (MDGS) AND HUMAN RIGHTS

At the 2000 Summit, the G8 committed themselves ‘to the agreed international development goals’ or IDGs (Okinawa Communiqué, ¶13),<sup>3</sup> which in revised form became the Millennium Development Goals (MDGs) endorsed by the United Nations General Assembly in 2000 with a set of targets to be achieved by 2015.<sup>4</sup> Of the eight goals, four (eradicating extreme poverty and hunger, improving maternal health, reducing child mortality, and reversing the spread of HIV, malaria and other diseases) are directly related to health, and three others (achieving universal primary education, promoting gender equality, and ensuring environmental sustainability by inter alia reducing the proportion of people without sustainable access to safe drinking water and basic sanitation and improving the lives of slum dwellers) directly address key social determinants of health. The challenge presented by these goals is formidable in many respects, yet the goals are modest when measured against the amount of human suffering that could be avoided at a cost that is small in the global scheme of things – a point discussed at greater length later in the paper.<sup>5</sup> Perhaps the most authoritative recent assessment of progress, prepared for a World Health Organization conference 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).

Despite their limitations, the MDGs provide one benchmark against which to assess G8 commitments to development and health equity, and clearly on this basis they are not doing well. Another benchmark, especially important as a conceptual alternative to instrumental arguments for investing in health, involves the progressive realisation of health as a human

---

<sup>3</sup> All G8 official documentation cited in this paper is available from the University of Toronto G8 Research Group, <http://www.g8.utoronto.ca>.

<sup>4</sup> The Millennium Development Goals, targets and indicators can be found at the website of the United Nations Statistics Division, [http://millenniumindicators.un.org/unsd/mi/mi\\_goals.asp](http://millenniumindicators.un.org/unsd/mi/mi_goals.asp).

<sup>5</sup> See in particular Pogge (2004) on the limitations of the poverty goal.

right. The International Covenant on Economic, Social and Cultural Rights (ICESCR)<sup>6</sup> is the central international agreement, although not the only relevant one, it refers to ‘the right of everyone to the enjoyment of the highest attainable standard of physical and mental health’. One hundred and forty-five countries are parties to the Covenant, with their performances reviewed by the 1966 Committee on Economic, Social and Cultural Rights (CESCR), one of several treaty-monitoring bodies that report to the UN General Assembly (Nygren-Krug 2002: 10, 34). General Comment 14 of the Committee<sup>7</sup>, issued in 2000, sets out four criteria for evaluation of the right to health:

1. Availability (functioning public health and sufficient health care facilities, goods and services)
2. Accessibility (including non-discrimination and affordability)
3. Acceptability (respectful of human right to dignity and of confidentiality)
4. Quality (scientific/medical appropriateness, adequate personnel and training)

These criteria bear directly on several of the global health equity policy options elaborated later in this Discussion Paper. Moreover, in contrast to the discourse on investment in health, recognising access to opportunities to lead a healthy life as a right implies a corollary recognition of at least some claims on resources necessary to secure the right that do not need to be justified against some external criterion such as future economic productivity. A rights-based position is also more in keeping with a conception of health equity as ‘a values-based commitment to tackle poverty and health, with or without conclusive evidence of aggregate utilitarian gains’ (Braveman and Gruskin 2003: 540).

According to a more recent interpretation by a Special Rapporteur for the UN Commission on Human Rights, the right to health applies not only to ‘*health care*,’ but also to ‘*underlying determinants of health*’ such as ‘access to safe and potable water and adequate sanitation, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health’ (Hunt 2003: ¶23; emphasis in original). This is an important acknowledgement of a public health approach to health promotion, in which actions on social and environmental conditions that lie beyond the traditional health care sector are absolutely essential to the creation, and maintenance, of better health outcomes. General Comment 14 further notes that the right to health ‘is closely related to and dependent upon the realisation of other human rights, including the right to food, housing, work, education, participation, the enjoyment of the benefits of scientific progress and its applications, life, non-discrimination, equality, the prohibition against torture, privacy, access to information, and the freedoms of association, assembly and movement.’ The right to water, in turn, was the subject of its own General Comment (No.15)<sup>8</sup>, adopted in 2002, which affirms ‘the human right to water entitles everyone to sufficient, safe, acceptable, physically accessible and affordable water for personal and domestic uses.’ It stresses that water should be treated as a social and cultural good, and not primarily as an economic good. Economic accessibility requires that direct and indirect costs/charges associated with securing water must be affordable for all.

Development non-governmental organisations (Nelson and Dorsey 2003) and researchers in health ethics (e.g. Austin 2001) increasingly use a rights-based approach in their work, and advocate ‘applying the principles of rights, entitlements and capabilities to the workings of states and markets’ (Nelson and Dorsey 2003: 2014). Crucially, a rights-based approach requires an analysis of the ‘why’ and ‘how’ of inequalities in global health, which generally follow economic inequalities: poverty remains the most basic and important risk condition for disease. African research and civil society organisations responding to a consultation organised for the UK Commission for Africa underscored the need to examine the role of high-income countries in maintaining (or alleviating) poverty in Africa, specifically through policies on aid, trade, debt, intellectual property rights and subsidies.<sup>9</sup>

The G8 has not specifically addressed the right to health at any recent Summit. It does reference human rights generally in the Genoa Communiqué (1999):

We will continue to provide substantial support and assistance to developing and transition economies in support of their own efforts to open and diversify their economies, to democratise and improve governance, and to *protect human rights* (¶27, emphasis added).

The 2002 G8 Africa Action Plan further pledged ‘giving increased attention to and support for African efforts to *promote and protect human rights*’ (¶2.4, emphasis added). However, the context of these comments makes it clear that they refer to a narrower conception of human rights, related primarily to political participation and ‘freedom from’ coercive or repressive state action.

The G8 should therefore explicitly declare their support for the provisions of the ICESCR addressing health and adopt an expansive, human rights-based approach to all aspects of their relations with African countries (including, but not limited to, the achievement of the MDGs). As noted, this position would have important consequences for the level and priorities of official development assistance (ODA) and debt relief. The UK has committed itself to ‘advocate a rights-based approach internationally’ (DFID 2004: 37). which it is uniquely well placed to do as host of the 2005 G8 Summit. Specifically, the G8 should state unequivocally that that health and water are human rights, not commodities; and that their policies will fully support, and in no way diminish, African countries’ abilities to promote and protect the right to health (which includes the right to water). We expand on some of these issues in the following pages.

6 [http://www.unhchr.ch/html/menu3/b/a\\_ceschr.htm](http://www.unhchr.ch/html/menu3/b/a_ceschr.htm)

7 [http://www.unhchr.ch/tbs/doc.nsf/\(symbol\)/E.C.12.2000.4.En?OpenDocument](http://www.unhchr.ch/tbs/doc.nsf/(symbol)/E.C.12.2000.4.En?OpenDocument)

8 <http://www.unhchr.ch/html/menu2/6/gc15.doc>

9 Moderators’ summaries of these consultations are posted on the Overseas Development Institute (ODI) website at <http://www.odi.org.uk/africaconsultation>.

### 3. KEY POLICY DOMAINS AFFECTING GLOBAL HEALTH EQUITY

A recent study of G8 commitments to health identified several policy domains that influence population health outcomes: macroeconomic policies (including conditionalities associated with loans, debt relief and development assistance), debt and debt reduction, health systems, education, nutrition and food security, development assistance, trade and market access, and the physical environment (Labonte *et al.* 2004). These policy domains are interconnected and the health impact of any one policy or set of policies within a given domain is often hard to determine precisely. But it is reasonable to state that achieving global health equity requires, at a minimum, policies that support the following:

1. Equitable, sufficiently funded and universally accessible health systems, with an adequate supply of health professionals.
2. Equitable access to key health determinants: nutrition, education, water, sanitation and housing.
3. Targeted health programs to reduce the burden of specific diseases such as HIV/AIDS on poor populations.
4. Increased research into diseases that affect the world's poor.
5. Increased financing for global health and development.
6. Trade agreements that respect the distinctive economic situation of poorer nations, and recognise that they must be given opportunities to protect domestic markets and support domestic producers comparable to those enjoyed by the industrialised countries at an earlier stage of their economic development.

A necessary, although not sufficient condition for such policies is a substantial and prolonged increase in development assistance to many African countries, for a period extending beyond 2015. Sachs and colleagues (2004) argue convincingly that Africa's 'poverty trap' – a result of poor geography, bad colonial history and an extremely high burden of disease – is insurmountable without such an infusion of new financing. To have a sustained impact, these policies also require good governance that is fair, transparent and representative, and that supports the creation of legal and social institutions conducive to development and growth.

Because this Discussion Paper addresses the G8 countries, it does not dwell on these governance responsibilities except in reference to the conditionalities presently associated with aid or other financial transfers to low- and middle-income countries. In addition, both the donor/lender community and recipient country governments must address equity issues within national borders. Changes in health status and the determinants of health sufficient to meet the MDG targets when measured at the national level may result in little or no improvement in the situation of the poorest or least healthy (Gwatkin 2002). Careful monitoring at the level of small areas, such as counties, reveals differences in the distribution and depth of poverty that are ‘invisible’ at the national or regional scale (Lozano *et al.* 2001; Henniger and Snel 2002). Access to health care often varies dramatically between urban and rural regions, and of course by income within those regions.

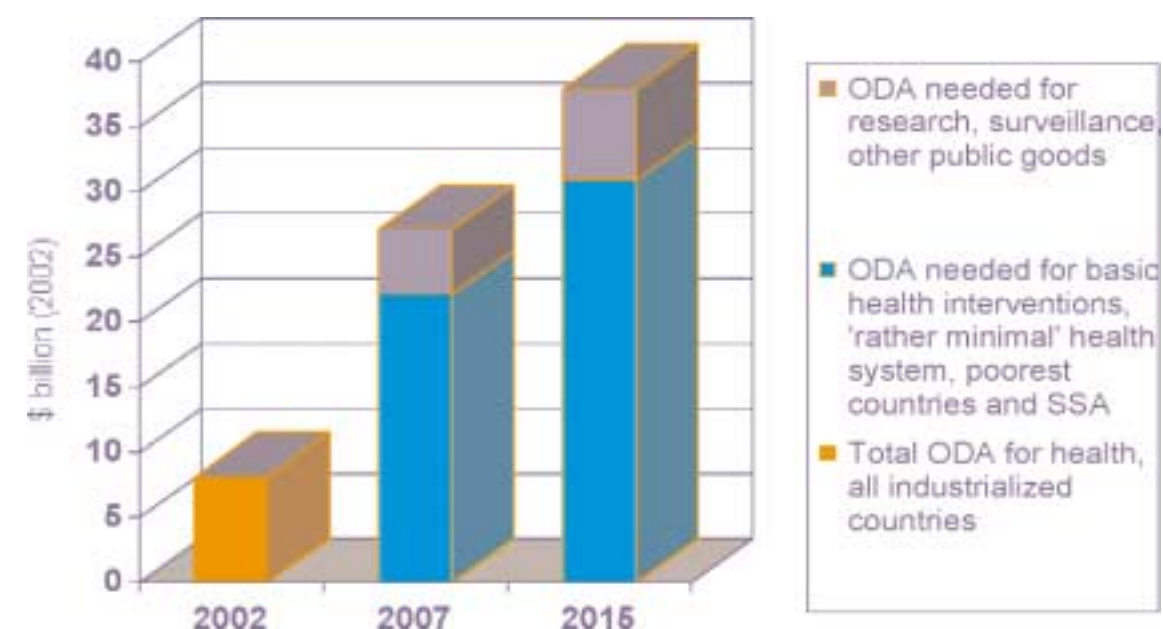
### 3.1 Health Systems

In 2000, the G7 committed themselves to an ‘ambitious agenda’ of ‘deliver[ing] three critical UN targets’ by 2010: reducing the number of HIV/AIDS-infected young people by 25 percent, reducing TB deaths and prevalence of the disease by 50 percent, and reducing the burden of disease associated with malaria by 50 percent (Okinawa Communiqué ¶29). These targets effectively attach numbers to the sixth MDG (‘Combat HIV/AIDS, malaria and other diseases’), but without major increases in the resources available for health care expenditure, these targets are certain not to be met – as is true for the health MDGs more generally. Although the G8 stated in 2001 that ‘[s]trong national health systems will continue to play a key role in the delivery of effective prevention, treatment and care and in improving access to essential health services and commodities without discrimination’ (Genoa Communiqué ¶17), their commitments have fallen far short of the level of need.

Although the amount has been increasing in recent years, the value of ODA for health from all industrialised countries, not just the G8, was \$8.1 billion in 2002, the most recent year for which figures are available (Michaud, 2003) – and the G8 have consistently avoided concrete Summit commitments to increase funding. In 2001, the WHO Commission on Macroeconomics and Health estimated that making a package of basic, relatively well understood low-cost and low-tech interventions widely available for 2.5 billion people in the poorest countries of the world, including all of sub-Saharan Africa, could save ‘at least 8 million lives *each year* by the end of this decade’ (Commission on Macroeconomics and Health 2001: 11, emphasis in original). It estimated that providing this admittedly ‘rather minimal health system’ (Commission on Macroeconomics and Health 2001: 55-56) would require \$22.1 billion in new development assistance financing in 2007, rising to \$30.7 billion in 2015 (Commission on Macroeconomics and Health 2001: Table A2.6, all figures in constant 2002 dollars). The Commission argued as well for rapidly expanded health surveillance and research on diseases of the poor, bringing its total estimate of the needed donor funds to \$27 billion in 2007, rising to \$38 billion in 2015 (Figure 1).

Commitments made before, during and since the 2002 Monterrey Conference on Financing for Development will have the effect of increasing the real annual value of *total* development assistance from \$58.2 billion to \$76.8 billion by 2006, if all these commitments are fulfilled (OECD 2004: 62). The more recent pledge by two G8 countries, France and the UK, to

**Figure 1.** Actual development assistance for health and anticipated requirements



Source: Commission on Macroeconomics and Health 2001

increase their ODA levels to the long-standing United Nations target of 0.7 per cent of GNI by 2012 and 2013, respectively, should further increase the availability financing for health and development,<sup>10</sup> although the lack of specific commitments to fund health care and health systems remains disturbing. The 2003 Evian Summit Health Action Plan re-iterated the importance of ‘strengthening health systems as a framework for increasing access of the neediest populations of developing countries to health care, drugs and treatments’ (¶2.1), once again without specific funding commitments.

Even before the 2002 G8 Summit, the importance of increasing ODA for budget support (for example to ministries of education and health), as distinct from funding specific projects, was underscored by Paul Collier of the World Bank in a series of consultations conducted in 2002 by the Overseas Development Institute (ODI).<sup>11</sup> Currently, about 40 per cent of development assistance is provided to African countries in the form of budget support, most of it channeled through the multilateral agencies (e.g. the World Bank, the African Development Bank), and much of that in the form of loans rather than grants. Barely a quarter of bilateral aid (27 per cent) goes to budget support (Sachs *et al.* 2004: 170). The raw numbers actually understate a fundamental problem in development assistance for health: bilateral and multilateral aid providers alike emphasise ‘vertical,’ disease-specific programs with short-term targets and time frames. Such programs neglect the importance of supporting health systems, and in some instances actually undermine those systems (see the discussion of disease-specific funding below).

Therefore, donors and lenders need not only to offer substantial increases in ODA for health, but also to increase the proportion provided for budget support. This allows recipient governments to have more autonomy in assigning aid to areas that fit better with their own

<sup>10</sup> France has made a firm commitment, with a timetable. The UK pledge is contingent on maintaining a certain economic growth rate and, as yet, has no firm timetable (MacAskill 2004).

<sup>11</sup> A summary of this meeting is provided at: <http://www.odi.org.uk/speeches/africa2002/meeting5.html>.

priorities for health systems development – a point stressed in the 2004 African consultation conducted by the ODI.<sup>12</sup> Although budget support does not imply an absence of dialogue over how aid will be spent or accounted for, from a health equity perspective budget support must be based upon the best available evidence about:

- Incidence of the burden of disease, to assist in determining intervention areas that will yield the greatest average health improvements while also lessening the health gap between population groups within the country.
- Prerequisites for longer-term health sustainability, which is best achieved through building strong public health infrastructure based upon primary health care and recognition of the underlying socioeconomic determinants of health.

Crucially, budget support must not replicate the market-preferred health system reforms first proposed by the World Bank in its 1993 Investing in Health report.<sup>13</sup> Such policies usually result in ‘high inequalities in access to and utilisation of health services, and the reinforcement of risks of exclusions and barriers to access of the poorest by efficiency-oriented health sector reforms’ (Haddad and Mohindra 2001: 20; see also Schrecker and Labonte in press), core elements of which include increased cost-recovery and private, commercial provision of health services and insurance.

### 3.1.1 Health professionals

Health systems cannot function without physicians, nurses, and a variety of other care providers. Contemporary globalisation has created the conditions for a ‘global conveyor belt’: high-income countries, which once mined low-income nations for their natural resources, now also place the high bids for their human resources, such as health professionals (Huddart and Picazo 2003; Padarath *et al.* 2003; Schrecker and Labonte 2004). Amongst the increasing flow of ‘brain drain’ migrants are physicians and nurses who emigrate to countries like Canada, the UK and the USA.

High-income countries also mine each other for skilled labour, creating a global hierarchy of recruitment. With respect to physicians, some 8000 Canadian-trained doctors now practice in the USA; 25 per cent of practicing physicians in Canada (mostly in rural areas) are foreign-trained, many from South Africa; and almost 80 per cent of rural South African physicians are from other countries, notably Cuba and other sub-Saharan African nations (Martineau, Decker and Bundred 2002). The USA has recently initiated major recruitment of foreign nurses in response to an anticipated shortage, targeting the UK. This will put pressure on the UK to continue its recruitment practices from developing nations. While the ‘brain drain’ metaphor has been critiqued with reference to the role of diaspora communities in remitting finance and knowledge to their home countries, equity questions about the comparative incidence of benefits from emigration remain unanswered (cf. Robinson 2004).

Migration of skilled workers not only deprives countries facing the world’s most severe health crises of needed human resources; it also represents a direct economic subsidy (in the form of

12 The messages exchanged during these consultations are archived on the ODI website at: <http://www.odi.org.uk/AfricaConsultation/messages.html>.

13 The definitive critique is provided by Lister (2004). See Foster (2004) for a discussion of budget support for health systems.

training costs) from poor to rich.<sup>14</sup> Across all low- and middle-income countries, the annual subsidy to the health systems of the affluent OECD countries may amount to more than \$500 million (Ndiaye 2003). Solutions to this problem will not be easy. Voluntary codes of ethics regarding recruitment have not worked.<sup>15</sup> Intra-country solutions are frequently proposed (e.g. increased salaries and support systems or research facilities, which low-income countries cannot afford alone), as are inter-country agreements, including payments to ‘source’ countries to deliberately oversupply health professionals (Stilwell *et al.* 2004). The only viable solution over the long term, despite its obvious political difficulties, is a multilateral agreement on the migration of health professionals, as called for by the New Partnership for Africa’s Development (NEPAD) health plan (NEPAD 2002). Such an agreement would need to: recognise the losses to poorer countries and compensate for these in some fashion (at minimum, the estimated costs of training); extend to multilateral development agencies and international NGOs whose recruitment of professionals for specific projects may create an internal brain drain from the public sector (discussed below); and take the form of a binding agreement with meaningful implementation and enforcement provisions.

### 3.2 Disease-Specific Funding

In 2001, the G8 announced the establishment of the Global Fund to Fight AIDS, Tuberculosis and Malaria, claiming that it would fulfil the previous year’s commitment ‘to make a quantum leap in the fight against infectious diseases and to break the vicious cycle between disease and poverty. .... We are determined to make the Fund operational before the end of the year. We have committed \$1.3 billion’ (Genoa Communiqué ¶15). The short-term financial promise was kept, but it exemplifies the problem of the *adequacy* of such promises.

G8 countries to date have pledged \$4.36 billion to the Global Fund (76.5 percent of total pledges, not including contributions made through the European Union); at the moment, total pledges amount to \$5.7 billion.<sup>16</sup> That is the amount of money the Fund has to work with. However, the Commission on Macroeconomics and Health recommended that, as part of the expanded development assistance for health discussed in the preceding section of the paper, the Global Fund be scaled up to around \$8 billion *per year* by 2007. In June 2004 the Global Fund’s Director of External Relations warned that ‘unless our major donors make renewed and increased commitments, it is hard to see how any new round [of funding] could be financed in 2005 or 2006,<sup>17</sup> and in November 2004, the Fund’s board agreed to issue a call for proposals for a new round of funding, ‘mindful that such a Call must be consistent with resources forecast to be available at the end of 2005’.<sup>18</sup>

14 The World Health Assembly adopted a motion on the ‘International migration of health personnel: a challenge for health systems in developing countries’ (WHA57.19, 22 May 2004) that, while specifying the problem, did not commit to any particular solution and avoided any reference to compensation for training costs.

15 The UK’s National Health Service Code on Recruitment, which proscribes recruiting from 150 poor countries, including those in sub-Saharan Africa, fails partly because it does not apply to private hospitals or recruitment agencies. Once nurses from these countries are in Britain, they can apply for work at the NHS, which can hire them without abrogating its Code (Hinsliff 2004).

16 Updated information about commitments to the Fund can be found at: <http://www.theglobalfund.org/en/files/pledges&contributions.xls>.

17 *Global Fund Observer (GFO) Newsletter*, Issue 26 (June 2004); <http://www.aidsplan.org/gfo/archives/newsletter>.

18 <http://www.theglobalfund.org/en/about/board/ninth/>.

In other words, the Fund's operations rely on incremental, ad hoc commitments of funds, and – as in the case of overall development assistance for health – are supported at a level far lower than that indicated by the most authoritative assessment available.

The financial crunch extends to other disease-specific funds and programs. One example with special relevance to Africa: In 1998 the WHO's Roll Back Malaria campaign set a target of reducing the number of malaria deaths by 50 percent between 1998 and 2010, and 75 percent by 2015. The annual value of donor financing for malaria control was recently estimated at \$100 million, as compared with the \$1.5-\$2.5 billion per year that would be needed to achieve the target (Narasimhan and Attaran 2003). The G8 has been more successful in its modest polio-eradication campaign, committing in 2004 to finance the \$120 million 'funding gap' experienced by the WHO Polio Eradication Initiative (G8 Commitment to Help Stop Polio Forever: ¶5).

Several systemic problems arise with the expanded provision of disease-specific funds from external sources (Waddington 2004):

- They are not necessarily compatible with a sector wide (budget support) approach.
- They may lead governments to focus on demonstrating success with reference to short-term, disease-specific indicators that may or may not be relevant to longer term health sector development priorities.
- Neglected diseases of local or regional importance, such as sleeping sickness and leishmaniasis, are now left out of the criteria for special funds.
- Earmarked funds rarely provide support for the additional health personnel required to deliver and implement funded projects.

The multiplication of new disease-specific programs is also creating coordination problems because of the number of meetings, site visits and program/project reports (Radelet 2004).

A survey of donor practices in 11 recipient countries ranked the five highest burdens for countries as: donor-driven priorities and systems, difficulties with donor procedures, uncoordinated donor practices, excessive demands on time, and delays in disbursements. The need for greater donor coordination and commitment to enhance harmonisation has become a mantra in international policy circles. Yet, the funding environment at the country level grows more complex (Brugha *et al.* 2004: 99).

Budget support for health systems is preferable to vertical funding for all these reasons. Vertical (disease-specific) funding *can* contribute to global health equity if it is guaranteed over multiple years (to allow for predictability in country budgeting), and includes a ring-fenced budget that goes directly to national or regional health ministries for overhead costs of integrating new programs into national or regional publicly financed health systems).<sup>19</sup>

19 Lister, Ingram and Prowle (2004: 30) suggest a proportion of 30 per cent to 40 per cent, based on the overhead charge routinely charged by universities on research contracts to recover their infrastructure costs. More important than a generalized figure is recognition through all donor-driven vertical programs of some requirements for infrastructure support, negotiated with each country, preferably in the context of pooled multilateral and bilateral resources. In this respect, we fully support the UK government's position to focus its efforts on 'strengthening...health systems' in countries where there are vertical programs, and otherwise not supporting stand-alone vertical interventions 'that weaken national systems and responses' (DFID 2004: 45).

Perhaps most importantly, external funding programs must emulate the UNAIDS 'three-one' approach: Within countries, disease-specific interventions have *one* action framework, *one* coordinating authority and *one* monitoring and evaluation system, regardless of the number of sources of financial support. It is also important that donors and lenders work together along the lines identified by the UK in its 2004 HIV Strategy Paper to create *one* funding pool within recipient countries, which combines all bilateral and multilateral contributions (DFID 2004).

### 3.3 Research for Global Health Equity

Research is crucial to improving global health equity, as noted in the statement issued at the close of the 2004 Global Forum for Health Research in Mexico City (Global Forum, 2004b) and in the contribution to the Forum by the World Health Organisation's Health Equity Team (Östlin *et al.*, 2004). Partly in response to the work of Canadian global health researchers, the 2002 G8 Africa Action Plan (¶6.4) contained specific reference to 'supporting health research on diseases prevalent in Africa, with a view to narrowing the health research gap, including by expanding health research networks to focus on African health issues, and by making more extensive use of researchers based in Africa'. The 2003 Evian Summit's health plan reiterated this pledge, committing the G8 to 'encourage research into diseases affecting mostly developing countries' (¶4), including 'support world-wide the development of research on health technologies for prevention (including vaccines), control, treatment and cure for these diseases,' 'work with developing countries to increase their own ability to contribute to research and development on these diseases' and 'encourage research into these diseases, in our countries too' (¶4.1). Evidence from Canada suggests considerable action on this recommendation, with upwards of C\$8 million in new team-based research funding. France is supporting research networks in Africa, while Japan has established two African research centers (G8 Implementation Report by Africa Personal Representatives to Leaders on the G8 Africa Action Plan, 2003).

Nevertheless, funding for health research continues to be concentrated on diseases of the wealthy. Using the 'DALY' (Disability-Adjusted Life Years), a controversial but nonetheless standardised metric for comparing not only mortality but also morbidity, the Global Forum for Health Research estimates that average global health research funding per DALY is US\$73.00. Support for research on the three major diseases crippling much of southern Africa (and probably parts of other large and more populous regions, such as India and China, in the near future) – HIV/AIDS, tuberculosis and malaria – is only US\$8.40 per DALY (Global Forum 2004c). Very little is being invested on understanding and fighting diseases that affect primarily the poor in tropical regions, such as schistosomiasis and leishmaniasis. Therefore, the 2005 Summit should produce a timetable of new funding commitments for health research that more accurately reflects the global burden of disease, and that explicitly includes research on health systems and the determinants of health.

HIV/AIDS remains the single most formidable challenge to health and development in Africa, and increasingly in other regions. The ultimate success of HIV infection control requires development of an effective vaccine, which presents formidable scientific challenges (Emini 2004, Garber 2004). In 2004, the G8 announced support for a Global

HIV Vaccine Enterprise, calling for ‘all stakeholders’ to develop a strategic plan by the 2005 Summit but not making any additional financial commitment. A report in *The Lancet* suggests that the Enterprise will aim to raise \$1 billion - \$5 billion per year, as against current HIV vaccine research funding of \$550 million per year (Walgate 2004). If funding is provided by governments, will it represent new money, or will it be diverted from other important health-related areas of G7 aid budgets? And how realistic is reliance on the private sector to supply such funding? A recent economic modeling exercise concludes that the pharmaceutical industry is unlikely to find vaccine research an attractive investment, particularly since most potential consumers of an AIDS vaccine are in low-income countries (Kremer and Snyder 2004). Thus, the 2005 Summit must not only specify commitments of new money to the Enterprise, but also commit the G8 to mechanisms that ensure affordability and availability of any vaccines developed. Potential solutions to this latter problem include *a priori* purchase agreements, public-private partnerships based on free (but non-exclusive) access to findings of publicly financed research, or direct public financing.

### 3.4 Socioeconomic Determinants of Health

Development policy and development assistance, including but not limited to budget support, need to reflect the importance of key social determinants of health, including:

#### 3.4.1 Education

G8 Support for the Dakar Framework for Action was clearly expressed at the 2000 Summit, and restated in 2001 (Okinawa Communiqué ¶33-34, Genoa Communiqué ¶18), although without identifying the resources that would be made available. The goals of the Dakar Framework are similar to the MDG targets for education: ‘Ensuring that by 2015 all children, particularly girls, children in difficult circumstances and those belonging to ethnic minorities, have access to and complete free and compulsory primary education of good quality’ and ‘eliminating gender disparities in primary and secondary education by 2005, and achieving gender equality in education by 2015’ (UNESCO 2000). The amount of financing pledged at the Monterrey Conference to meet these targets is roughly 10 per cent of the total required (UNESCO 2002a); and a straightforward commitment to ‘support UNESCO in its key role for universal education’ (Genoa Communiqué ¶18) has not prevented that agency from experiencing severe budget constraints (UNESCO 2002b).

#### 3.4.2 Nutrition and food security

The G8 have made vague commitments to supporting agriculture through ODA as an element of poverty reduction (Genoa Communiqué, ¶20) and to ‘target the most food-insecure regions, particularly Sub-Saharan Africa and South Asia.’ Recent G8 Summits, instead, emphasised the need to promote applications of biotechnology, important to some G8 economies but of still contested relevance to nutrition and food security in low-income countries (Labonte *et al.* 2004: 96-115). The major proponent of food biotechnology – the USA – also remains the only G8 country to provide food aid using its own domestic food surpluses (much of it genetically modified) rather than as cash allowing recipient countries

to purchase the specific food items they may need. Indeed, the US food aid program describes itself as ‘designed to develop and expand commercial outlets for US commodities,’ with some of its food aid increasing counter cyclically to declines in world commodity prices (Monbiot 2003).

What is not disputed is the slow pace of worldwide progress toward improving nutrition: ‘The number of undernourished people in the developing world decreased by less than 20 million since the 1990-1992 period used as the baseline at the World Food Summit (WFS). Worse yet, over the most recent four years for which data are available, the number of chronically hungry people actually increased at a rate of almost 5 million a year’ (UNFAO 2003: 30) – a figure that substantially understates the crisis in nutrition, since it refers only to caloric intake and not to micronutrient deficiencies.

The 2003 Action Plan Against Famine noted that the G8 had committed US\$1.4 billion in food aid and development to sub-Saharan Africa since the 2002 Summit, and pledged to reverse its past decline in aid to agriculture. But the plan also states that such aid could be in the form of food, as well as cash (¶3.1); reiterates its commitment to biotechnology, which most sub-Saharan African countries have rejected; and invokes a standard ‘good governance’ reference to helping ‘developing countries to establish sound political and economic governance frameworks’ (¶4.6).

#### 3.4.3 Water, sanitation and housing

G8 donor assistance to water and sanitation has been less niggardly than that provided to health systems, although total donor to water and sanitation has fallen since 1996. A recent review called for a doubling of aid for water and sanitation to improve the chances of meeting meet the MDG targets, and also emphasized the need to increase the proportion of such aid going to poor (rather than middle-income) countries where access to improved water supplies, and especially sanitation, is lowest (Foxwood and Green 2004). The 2003 Evian Summit committed the G8 to ‘playing a more active role’ in assisting countries to achieve these targets, giving it priority in future development assistance but without specifying any amount. While the Evian Summit’s water plan stated G8 ‘support [to] ... countries’ capacity building efforts to develop the skills necessary to provide efficient public services’ (¶1.2), it also specified a requirement for ‘appropriate cost-recovery approaches’ (¶1.1) with ‘targeted subsidies for the poor’ (¶2.2), and committed itself to support ‘public-private partnerships (PPPs), where appropriate and suitable, particularly by inducing private-sector investments’ (¶2.5).

Water and sanitation services historically were largely provided by the public sector, for reasons closely related to their health benefits. Only in the past two decades has a large, oligopolistic private sector presence in these services arisen, primarily the result of macroeconomic policies of ‘privatisation and de-regulation aimed at encouraging private participation in water and waste management projects’ (Bisset *et al.* 2003). Instances can be found in which well-regulated private provision of water creates short-term gains for the poor, but long-term costs may become prohibitive for the poor in the absence of cross-subsidisation (McDonald and Pape 2002; Budds and McGranahan 2003; Labonte *et al.* 2004: 155-159). Developing countries, however, lack a strong tax base to finance effective

regulation in almost any sector. The United Nations Human Settlements Program further warns that it would be a 'serious mistake' to assume that private companies would play a major role in extending water and basic sanitation to poor population groups (UN Habitat 2003b; see also War on Want 2004).

Cost-recovery, even with exemptions for the poor, and private provision of water and sanitation have both been critiqued for their negative impacts on health equity because they force trade-offs between protection for the poor and financial sustainability. (Hilary, 2001; Loftus and McDonald 2001; McDonald and Pape 2002; Center for Public Integrity 2003) The 2004 Sea Island Summit reiterated the Evian Summit pledge on the MDG targets, although emphasising risk-pooling and bond-financed approaches (which have greater equity potential), and incorporating housing for the first time in a specific commitment to help build mortgage markets in developing countries (Sea Island G8 Action Plan: ¶21). Unaddressed was the inflationary pressure that rising wealth is creating on land and housing, which only worsens the health conditions for globalisation's losers (see UN Habitat 2003a).

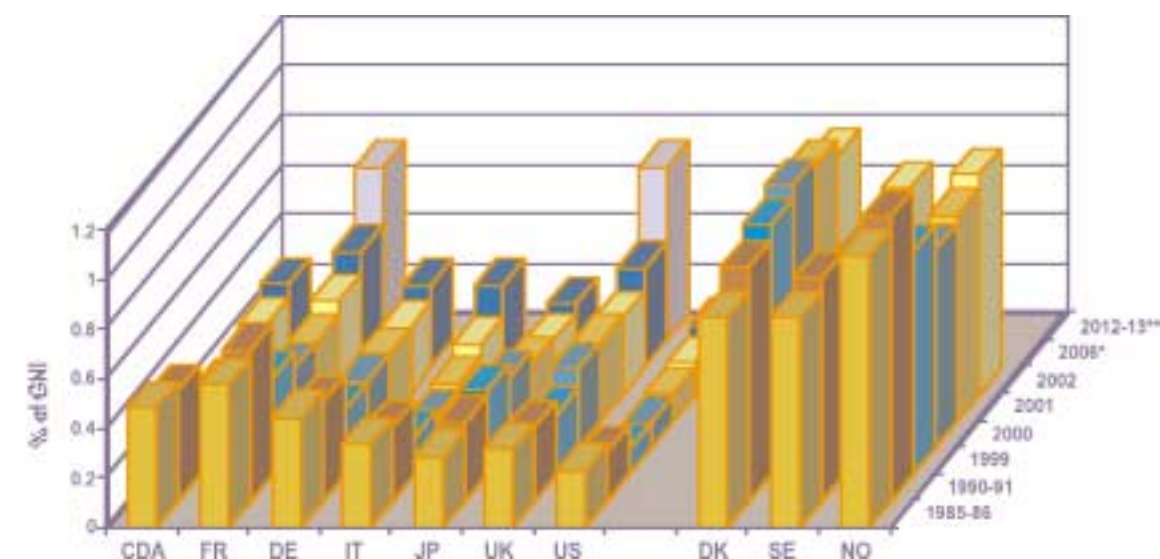
Important as these key health determinants are, we do not advocate specific aid budget ratios or amounts within the overall target of 0.7 per cent of GNI, the importance of which was noted earlier. Each country's sectoral development needs will be different, but the sectors we identify above need to be considered as part of a comprehensive strategy for investment in *health*, and not as disparate areas, and – further – with specific reference to implications for *health equity*.

### 3.5 Financing for Global Health Equity

The value of ODA as a percentage of the total Gross National Income (GNI) of donor and lender countries has slowly declined since the mid-1980s (OECD 2004). The decline in ODA provided by the G8, as compared to the strong performance of other industrialised countries (Figure 2), has been much more pronounced. In 1999, the G8 promised 'to strive gradually to increase the volume of official development assistance' (Cologne Communiqué, ¶29), although subsequent commitments stressed only 'strengthening the effectiveness' of such aid (Okinawa Communiqué, 2000, ¶20). More recent pledges to increase development assistance, while welcome (Figure 1), need to be located in the context of various estimates of the increased annual financing required for health and development: \$40 – 70 billion for the first 7 of the MDGs (Devarajan, Miller and Swanson 2002) and \$20 – 39 billion for the 'service delivery' MDGs (education, health, water supply and sanitation ('Briefing Note' 2003)). Despite increased levels of aid for Africa, analysis by the University of Toronto's G8 Research Centre indicates that G8 compliance with commitments made in its 2002 Africa Action Plan averaged only 29 per cent by the time of the Evian Summit, and a slightly higher 39 per cent just prior to the Sea Island Summit – a lower compliance rate than for non-African G8 commitments. In sharp contrast, compliance with the G8 commitments on terrorism was 100 per cent (Kirton and Kokotsis 2004).

ODA is not a panacea for development. Often, aid serves the geopolitical or economic interests of donor countries. The practice of 'tying' aid to the purchase of goods and services (in the form of technical cooperation) from donor countries is a particular example (Labonte *et al.* 2004: 126-129). As a more general illustration: the US commitment at Monterrey to

**Figure 2.** Trends in G7 development assistance, with selected comparison countries



\* Assuming all commitments made at Monterrey are fulfilled (G7 only)

\*\* Promised (France and UK only)

Source: OECD (2004 and earlier years); Chirac (2003); MacAskill (2004)

increase annual aid spending to \$15 billion by 2006 indicated that new funds would be conditional on 'sound economic policies that foster enterprise and entrepreneurship, including more open markets and sustainable budget policies' (United Nations 2002: ¶8-9). This can be read as code for increasing market access and investment opportunities for US firms. Further, aid has often financed large-scale, environmentally destructive projects with limited relevance to basic needs (Rich 1994; Bosshard *et al.* 2003).

Aid, however, *can* work, and much larger aid flows are required, alongside debt cancellation (see below), if low-income countries are to make progress on the MDGs (including controlling the HIV/AIDS pandemic) and economic development (see e.g. Sachs *et al.* 2004). A recent report by a Commission on Weak States and US National Security, released for the G8 Sea Island Summit in 2004, further argued that increased development assistance was essential to prevent increases in 'failed states' that give rise to, or otherwise support, terrorist networks and activities. The report noted that the USA, although in volume the largest donor country, is one of 'the least generous of all donors in its public spending on development assistance as a proportion of the economy;' and, while requesting a \$21 billion increase for its military in 2004 – indicative what the UN Special Rapporteurs on globalisation and human rights describe as the 'reductionist, militaristic and retrogressive' approach to global security (Oloka-Onyango and Udugama 2003) – the US administration asked for only \$1 billion in additional funding for HIV/AIDS and development assistance. The 'securitisation' of development assistance, as we pointed out earlier, risks a triaging of aid based less on needs and more on a donor's political/strategic interests.

Given authoritative estimates of need and the fact that several donor countries have consistently provided ODA with a value equivalent to or greater than 0.7 per cent of



their GNI, G7 countries must commit to a timetable for attaining this target, as France and Britain have already done. Given the urgency of the need in Africa, this time frame should include a doubling of present ODA levels to that continent within three years. The argument that such commitments are politically unworkable because they encumber future legislators and bind future governments to policies of past regimes has little merit; if nothing more, it is undermined by numerous trade agreements that have had precisely that effect, and sometimes that intent. We address the issue of fiscal constraints in achieving this target in a discussion of the proposed International Finance Facility, below.

Historically, aid has come with conditionalities that can undermine its effectiveness; this is especially true of disbursements from the World Bank and its regional affiliates (Adam *et al.* 2004). Bank conditionality still emphasises macroeconomic policy reforms that, since the early days of cross-conditionality with the structural adjustment programs of the IMF in the 1980s, have been controversial, often ineffective and frequently damaging to health (Cornia, Jolly and Stewart, eds. 1987; see also Stewart 1991; UNICEF 1992: 40-56). The health impacts of structural adjustment policies have proved difficult to separate from the effects of economic crises that preceded their imposition. There is less ambiguity about the generally negative effects these policies have had on health, particularly in African countries (Breman and Shelton 2001). While many of these macroeconomic conditionalities remain, increased emphasis is now also placed on 'good governance,' the criteria for which may reflect ideological beliefs of donor countries more than a genuine concern with transparent systems of political and financial accountability. Moreover, as Sachs and colleagues recently pointed out, 'many of the relatively well governed African countries have been unable to increase the material well-being of their populations', implying that 'Africa's crisis requires a better explanation than governance alone' (Sachs *et al.* 2004: 121-122).

The European Union, in an effort to end or reduce such policy-based conditionality, is focusing on performance-based criteria with an emphasis on health and education (Adam *et al.* 2004). The UK is presently consulting on a new aid policy that emphasises financial accountability in conditionality, i.e. ensuring simply that aid is not diverted to unintended purposes (DFID, Foreign & Commonwealth Office and HM Treasury 2004).<sup>20</sup> This was also one of the key recommendations of the British Overseas Aid Group (2004) to the UK Commission for Africa. Sachs and colleagues (2004: 173) bring these two together by identifying four criteria for their proposed 'big push' in African aid as 'fiscal accountability, institutional strengthening, substantive goal orientation and benchmarking of progress.' They add that 'good governance' criteria currently popular, particularly with the USA, should not be used as a way to punish with aid withdrawals governments that enact

20 The paper, however, contains at least one highly problematic element. It retains macroeconomic (privatization and liberalization) conditionalities (what the paper labels 'sensitive policy areas') if they are mutually agreed upon and subject to the recipient government's parliamentary oversight. If a developing country asks specifically for such conditions – as opposed to a case in which they emerge from 'dialogue' as the policy paper suggests – then so be it. But the notion that such conditions can be 'mutually agreed upon' when one partner has the money and the other does not is silly; and the social scientific claim on which the proposed approach rests (that privatization and liberalization will help the poor) remains contested.

policies with which the donor might disagree, but that do not conflict with their four basic criteria.<sup>21</sup>

Removing macroeconomic policy conditions may be a progressive step to increasing actual levels of assistance. But there is growing concern that G8 (not just United States) ODA is increasingly favouring private rather than public sector development, particularly in formerly public forms of infrastructure. The UK's DFID in 2002 created a \$450 million 'Emerging Africa Infrastructure Fund' that is open only to private companies; and paid £118 million (1997-2002) to private consulting firms promoting or overseeing privatisation projects in developing countries (War on Want 2004).<sup>22</sup> Similarly, C\$150 million of Canada's C\$500 million 'Fund for Africa,' announced at the 2002 Summit, has gone to private or public-private partnerships for water, transport, energy and pipeline infrastructure development (Labonte *et al.* 2004: 125-126). The 2004 Sea Island Action Plan: Applying the Power of Entrepreneurship to the Eradication of Poverty stated that 'enabling the private sector to help poor people prosper should be systematically integrated into development assistance efforts' while the G8 foreign affairs ministers' meeting in September, 2004 adopted the goal of raising US\$100 million in donor support to finance private sector development in the Middle East and North Africa.<sup>23</sup> At issue is whether this emphasis on the private sector marks a retreat from public sector and community-based initiatives, and replicates the pressure toward marketisation and commodification (e.g., of health care and education) that was a central element of structural adjustment conditionalities.

Harmonisation of aid efforts remains another unresolved problem, related to but further complicating the proliferation of disease-specific funding programs. There are now over 75 different aid-disbursing agencies, including bilateral donors, UN system agencies and global and regional financial institutions (Rogerson, Hewitt and Waldenberg 2004). Despite repeated promises, donor harmonisation efforts continue to lag (British Overseas Aid Group 2004) with corresponding administrative costs and implementation inefficiencies in the recipient countries. A G8 commitment to increased budget support through multilateral grants (not loans) or pooled bilateral aid, which incorporates just one conditionality (fiscal accountability) and one mechanism by which this accountability will be provided to all donors in any given country, would be a bold and important step towards both efficiency and equity.

### 3.5.1 The International Finance Facility

The International Finance Facility (IFF), promoted by the UK (HM Treasury and DFID 2003)

- 
- 21 States in conflict, or with entrenched despotic regimes, are a different matter. In such instances Sachs *et al.*, like many others, do not urge withholding of aid (which punishes citizens and prevents the very development that could overcome both conflict and despotism) but enhanced emergency relief, assistance to respected NGOs capable of building and sustaining for a period health, education and other public infrastructures, and aid to domestic civil society organizations as they become capable of doing likewise. Difficulties that might arise in transferring such systems to a more stable and accountable public government in the future should not preclude the urgency of creating such systems in the present.
- 22 The report also cites the program statement of UK Trade & Investment, the official export arm of the government, to the effect that '...the UK is now one of the largest investors in overseas infrastructure, either through the development of new projects or through the management of *existing, previously state owned, assets*' (emphasis added).
- 23 Chairmen's Summary, Preparatory Meetings for Forum on the Future (Washington, DC: Bureau of Near Eastern Affairs, US Department of State, September 24, 2004); <http://www.state.gov/p/nea/rls/36540.htm>.

is a special case of development financing. The IFF proposes to transform the Monterrey (and subsequent) donor pledges for increased development assistance into bonds, repayable by the donor countries after 2015. The effect of issuing such bonds would be to double the amount of financing available for development within a few years. If coupled with debt cancellation, this would bring international development financing closer to the estimates of the amount needed by low- and middle-income countries to meet their MDG targets.

The IFF proposal was first raised at the 2003 Evian Summit, as one of several possible financing instruments. Economic analyses conclude that this sudden increase in development assistance is not beyond the absorptive capacity of recipient countries (Mavrotas 2003). Almost 40 countries and numerous development agencies and NGOs support the proposal, which has been less warmly received by donor nations (Lister, Ingram and Prowle 2004). Among the concerns:

- It depends upon additional pledges of increased aid by donors and, at present, would not bind donors to participate in future pledging rounds.
- Repayments by donor countries could compromise the objective of meeting, or sustaining, ODA levels at 0.7 per cent of GNI after 2015.
- A governance structure that would not simply follow the preferences of individual donors/lenders for disbursement of aid funds would have to be developed
- The IFF could add another layer of administrative complexity to an already crowded field, especially when an increase in funding available as grants through the World Bank could achieve a similar outcome (Rogerson, Hewitt and Waldenberg 2004). If this option were followed, however, Bank grants and lending would have to come with fewer or no conditionalities apart from financial accountability.
- Perhaps most importantly, the IFF as now proposed incorporates strongly market-oriented conditionalities, such as ‘a sequenced opening up of markets to global trade’ and ‘improving the environment to encourage...private sector-led growth’ (HM Treasury – DFID, 2003, ¶1.16). As noted earlier, the health implications of such requirements are contested, and in the past have proved to be highly destructive. A similar statement, that ‘in the last 40 years those developing countries that have been more open, and traded more in the world economy, have seen faster growth rates than those that have remained closed’ (¶3.8) is disputed by many development economists, notably with respect to its confusion of correlation with causation (see Wade, 2002).

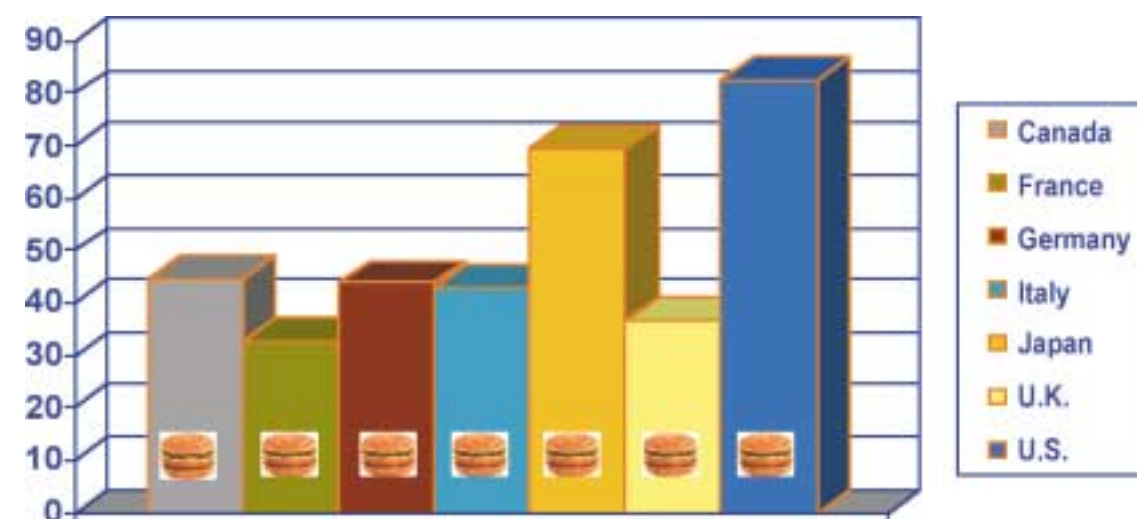
These concerns do not negate the potential usefulness of the IFF, but they must be addressed if the proposal is to be meaningful as a contribution to improving global health equity.

It is also important to put both the rationale for the proposed IFF and its equity impacts into context. According to a 2004 update on the IFF prepared for the media, ‘[d]onors are committed to reaching the target of 0.7 per cent ODA/GNI,’ clearly an overstatement in the case of the USA which has never agreed to this target, ‘but a number have fiscal constraints that will not allow them to increase aid levels in the short to medium term’.<sup>24</sup> This essentially

<sup>24</sup> [http://www.hm-treasury.gov.uk/media/D64/78/IFF\\_proposal\\_doc\\_080404.pdf](http://www.hm-treasury.gov.uk/media/D64/78/IFF_proposal_doc_080404.pdf)

means that G7 governments are unwilling (or unable, because of the anticipated electoral consequences of tax revolt) to raise revenues that are trivial relative to the incomes of their citizens (Figure 3), even when those revenues could be used to save ‘at least 8 million lives each year by the end of this decade’ in the words of the Commission on Macroeconomics and Health. It should further be noted that these ‘fiscal constraints’ are invoked against a background of huge increases in US military expenditures subsequent to the invasion of Iraq; tax cuts favouring wealthy individuals and corporations, especially in the United States<sup>25</sup>; and the failure of G8 countries to close tax havens which are estimated to cost the UK treasury £25 – 85 billion in annual tax revenue (Monbiot 2004) and the US treasury \$10 – 20 billion in annual corporate taxes alone (Browning 2004).

**Figure 3.** Annual cost of increasing development assistance to 0.7 per cent of GNI, Big Macs per capita



Source: 2002 ODA figures from OECD (2004),

Big Mac prices from *The Economist*, April 25, 2002

Finally, assuming a 5 per cent bond interest rate, the IFF would disburse \$500 billion in additional aid up until 2015, at a cost of \$720 billion over the repayment period (HM Treasury – DFID, 2003, ¶4.10). Since bond investors tend to be the ultra-rich, the \$220 billion in interest earnings would most likely go to those individuals or corporate investors whose lower tax rates and easier access to tax avoidance largely created the ‘fiscal constraints’ that HM Treasury and DFID argue necessitate the creation of the IFF in the first place.

### 3.6 New Forms of Taxation for Global Health and Development

In addition to the policy options already discussed, recognition is growing of a need for some global taxation system that could serve similar functions to the progressive income tax regimes in most high-income countries.<sup>26</sup> Taxes on arms trade and international air travel

<sup>25</sup> In the USA, the value of President Bush’s tax cuts for the wealthiest 1 per cent of the population (average annual income just under \$1 million) over the period 2001-2010 will amount to \$689 billion, in contrast to only \$23 billion going to the lowest income quintile (Citizens for Tax Justice 2003).

<sup>26</sup> Revenue estimates in this paragraph are drawn from Clunies-Ross 2004.

have been proposed, although neither would raise substantial revenue (between \$5 and \$20 billion annually). An airline ticket tax, however, could be considered as a source to fund investments in such global public goods as global health research and enhanced global disease surveillance. A carbon tax on high-income countries only (at a rate low enough not to be a drag on consumption) would generate around \$125 billion annually; the rationale for not imposing it universally is that some low-income countries with small populations could pay higher amounts of their income in such a tax than people in high-income countries, rendering it regressive rather than progressive. A currency transaction tax (the so-called Tobin tax, after the economist who first proposed it) of 0.25 per cent would generate up to \$170 billion annually, and would be administratively, if not politically, relatively easy to implement. The tax would also dampen destructive currency speculation and its resulting currency crises, which have consistently generated rising poverty, decreasing services for the poor and increased health disparities, particularly for women and children (O'Brien 2002). Ironically, and despite increased calls for some re-regulation of liberalised capital markets, the G8 continues to support the free flow of capital – for example by committing to ‘promotion of investment treaties’ in 2004 (G8 Action Plan: Applying the Power of Entrepreneurship to the Eradication of Poverty).

Other suggestions for restricting the ability of transnational corporations and wealthy individuals to move assets around the world would be the issuance of one tax identification number that ensured corporate or personal confidentiality, but would allow all jurisdictions that believed they had a tax claim to levy it; and a withholding tax on all capital leaving a country, not only minimising tax avoidance but also stemming capital flight. These latter two are more difficult and require considerable multilateral negotiation. But they are not a priori administratively unworkable, and are areas in which G8 leadership would go considerable distance in demonstrating the sincerity of the 2001 commitment ‘to make globalisation work for all our citizens and especially the world's poor’ (Genoa Communiqué, 2001, ¶3). French President Jacques Chirac is promoting the idea of some combination of these tax measures, primarily emphasising a currency transaction tax, to create a global poverty reduction fund of \$50 billion annually, although the USA opposes such a tax scheme, favouring multilateral debt cancellation instead. There is no reason to regard the two as mutually exclusive, in administrative terms.

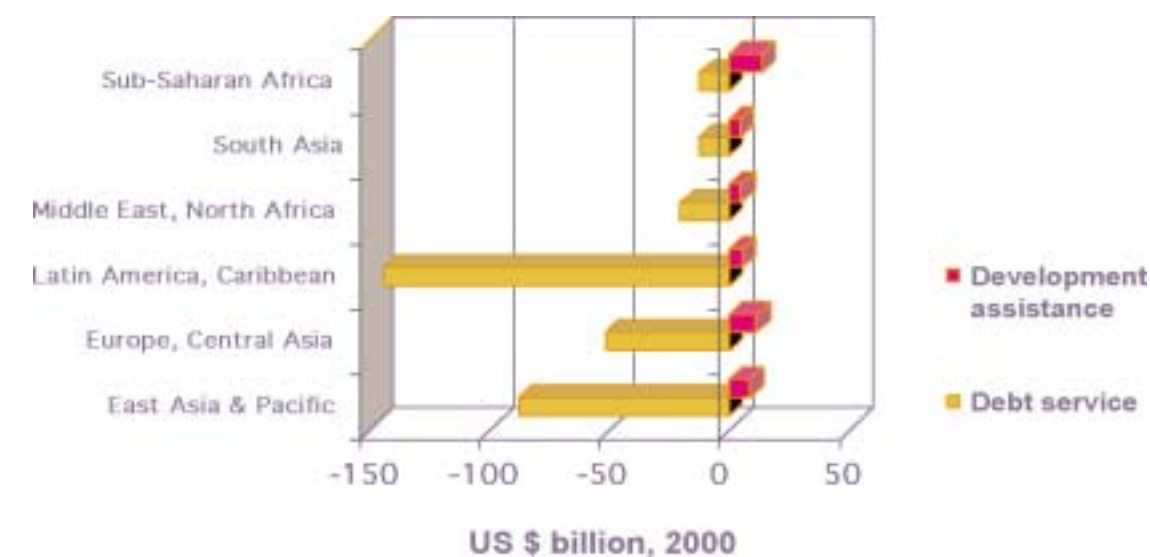
Political feasibility is another matter. Yunker (2004), citing the few econometric studies that have attempted to model such a global income tax scheme, concludes that the depth of global poverty to be rectified would render global income redistribution politically unacceptable to residents of high-income countries. Besides, he notes, ‘so long as rich countries possess the military means to deter and forestall global income redistribution, they will’ (Yunker, 2004: 1110). This observation suggests that while massive economic transfers from high-income to low- and middle-income countries are needed, their form will have to be diverse and not rely upon a single global income tax scheme. Yunker favours enhanced ODA, and developed a global economic model, the ‘World Economic Equalisation Program,’ or WEEP. WEEP simulations found that, with ODA commitments of 2 per cent to 3 per cent of GNI over a 50 year period, the conventional income inequality gap between the world's richest and poorest country would shrink from 500:1, to less than 2:1. While the ODA commitments required are 3 to 5 times greater than 0.7 per cent target reached by only a few of the world's rich

countries, Yunker contends that the costs of such a transfer are within the realm of political acceptability.

### 3.7 Debt Cancellation

The need to increase financing for development extends beyond aid itself, to debt and debt relief/cancellation. As long ago as 1987, the World Commission on Environment and Development pointed out that developing countries' debt burden created a major obstacle to sustainable development. Since then, developing country debt has continued to mount, and in the year 2000 the developing world paid out \$330.4 billion to service its external debt, while receiving \$46.6 billion in ODA (Pettifor and Greenhill 2002); outflows of funds for debt service dwarfed ODA receipts in every region except Sub-Saharan Africa, where the two were roughly in balance (Figure 4). This pattern intensified during the latter part of the 1990s (United Nations 2002a), meaning that in effect, the world's low and middle-income countries have become net exporters of ‘cheap’ capital to the world's wealthiest nations, including the G8 (World Bank 2004: 7).

**Figure 4.** How debt service obligations dwarf development assistance



Source: Pettifor and Greenhill 2002

Many indebted countries already have paid the equivalent of their loans many times over. They remain indebted due to monetarist (high-interest rate) policies pursued by the USA and other G7 countries in the 1980s, World Bank and IMF loan requirements to devalue domestic currencies but repay debts in ‘hard’ currencies (often US dollars) and subsequent escalation in the cost of interest payments and penalties. Journalist Ken Wiwa, the son of Nigerian activist Ken Saro-Wiwa, who was hanged by his government for opposing Shell Oil's destruction of his peoples' homelands, noted bitingly: ‘You'd need the mathematical dexterity of a forensic accountant to explain why Nigeria borrowed \$5 billion, paid back \$16 billion, and still owes \$32 billion’ (Wiwa, 2004). The continent as a whole between 1970 and 2002 borrowed \$540 billion, paid back \$550 billion and still owes \$295 billion (UNCTAD 2004: 19). Nigeria's vice-president further blames the failure of rich nations to prevent corrupt

officials from secreting aid loans into private off-shore accounts: 'odious debt' that, in Nigeria's case, amounted to over \$4 billion (Ozoemena 2004).

The high debt burden of many African countries is generally accepted as a major impediment to its future health and development (UNCTAD 2004); Peter Piot, the Executive Director of UNAIDS, warned at the end of the 2004 International AIDS Conference: 'Africa's crippling debt must be relieved – the \$15 billion annually that disappears down the money pit. That is four times more than is spent on health and education -- the building blocks of the AIDS response' (Piot 2004). And the first draft Work Program for the UK Commission for Africa (2004) notes that 'high levels of indebtedness...lead to human and capital flight and consequent limited capacity, both physical and human' and that failure to tackle this, and other underlying causes, 'would mean the future would be one of continued stagnation.'

Only in 1996 did the G8 begin to take seriously the destructive effects of debt on development and health, when they launched the Heavily Indebted Poor Countries (HIPC) initiative through the World Bank and IMF. In 1999, the initiative was expanded as Enhanced HIPC. In some countries, HIPC has freed up public funds for investment in basic needs like health care and education (Gupta *et al.* 2002). Nevertheless, criticisms of the initiative are many:

- According to Oxfam, in many HIPCs the annual cost of debt servicing will still exceed combined spending on health and primary education after they have obtained the maximum debt reduction for which they are eligible (Oxfam 2001).
- Almost half the total debt of the HIPCs will remain unpaid and uncanceled at the conclusion of the initiative (Martin 2004).
- Eligibility for debt relief depends on World Bank and IMF approval of domestic policies, contained in a Poverty Reduction Strategy Paper (PRSP), that look a lot like the conditionalities attached to structural adjustment in the 1980s and 1990s, and may even prevent countries from accepting new money from the GFATM and other sources of financing for health due to social spending caps.
- Even if all the debts of the HIPCs were cancelled, one estimate is that just \$3.2 billion more per year would be available to their governments for spending on basic needs (Martin 2004); another is that at least \$16.5 billion per year in new development assistance flows, in addition to debt cancellation, would be needed to give those countries a fair chance of meeting the Millennium Development Goals (Pettifor and Greenhill 2002).
- Because eligibility for debt relief under Enhanced HIPC is based on the ratio of exports to debt service obligations, many deeply indebted countries with very high rates of poverty, including Bangladesh, Brazil, Indonesia, Mexico, Nigeria and Pakistan, remain ineligible for debt relief. Essentially, they are not (yet) desperate enough.
- Finally, the relatively modest resources made available through HIPC may also have come at the expense of ODA flows of other kinds. According to Killick (2004: 6-7), 'the introduction of the original HIPC scheme in 1995 coincided with a very sharp fall in total transfers to HIPC countries, to levels which have not since recovered.' Debt

cancellation costs are routinely included as part of a donor country's ODA budget. Thus, the C\$825 million that African countries owe to Export Development Canada (an export credit agency) and the Canadian Wheat Board (a marketing agency that guarantees minimum producer prices for wheat exports) will, as these debts are cancelled over the next few years, be counted as almost 20 per cent of Canada's staged increase in development assistance for African countries (Canadian Council for International Cooperation 2002).

G8 leaders know well the limitations of the HIPC program, and have at different times entertained discussion of expanded multilateral debt cancellation. Two such proposals were promoted in advance of the G7 finance ministers' meeting in October 2004. The USA proposed that the IMF and World Bank write off \$100 billion owed to them by the poorest countries. This would cost the treasuries of the USA and the rest of the G8 little or nothing, but the IMF and World Bank a great deal. The World Bank and its affiliates remain important sources of development financing for poor countries, and the US proposal, launched partly to gain broader support for its efforts to cancel debts owed by oil-rich Iraq, risks sacrificing future aid flows for today's debt cancellation. A UK proposal was more generous. It agreed with the USA on selling some of the IMF's gold reserves to write off poor country debts, but also promised to pay its proportional share of what poor countries owe the World Bank and its African affiliate -- £100 million per year over the next 10 years -- and challenged all G7 countries to do likewise. However, these repayments would come out of countries' ODA accounts (as do all costs of debt forgiveness), essentially meaning that in both proposals developing countries will ultimately pay the costs.

It is frequently argued that complete debt cancellation creates a 'moral hazard' by signaling that debtors can abrogate their responsibilities. However, UNCTAD persuasively argues that continuous debt re-scheduling and debt servicing costs faced by African nations constitutes the truer 'moral hazard,' and that 'a complete debt write-off...becomes a 'moral imperative' as it will guarantee resources to help meet the MDGs in Africa and assure an exit from the debt crisis for the continent' (UNCTAD 2004: 79). Words matter, and the invocation of 'moral hazard' to justify protection of creditors' financial interests, even at substantial and well documented cost in terms of lives lost and human suffering, tells us quite a lot about the real values underlying market-driven economic policies that have been, and continue to be, promoted by the G8. Although the G7 finance ministers agreed in October, 2004 'to resolve Iraq's debt before the end of 2004' (with the advice of the IMF), no agreement on writing off the debts of much poorer and sicker African and Asian countries materialised. Indeed, the language of 'debt sustainability' was re-introduced in the G7 finance ministers' statement (Statement of G7 Finance Ministers and Central Bank Governors, October 2004).

For purposes of health equity, at the 2005 Summit the G8 must agree to rapid expansion of debt cancellation, by way of a program the key provisions of which must include:

- Cancellation must involve 'new money' from national treasuries, and must not require that the World Bank and other development agencies deplete their existing resources.
- Cancellation must not be accompanied by a decrease in other forms of development assistance.

- Great care must be taken with respect to conditions attached to debt reduction. Although the health equity concerns identified earlier in the paper with respect to development assistance apply with equal or greater force to debt reduction, we have also shown that even superficially neutral terms like ‘good governance’ can in fact mean privatisation, deregulation and the pursuit of questionable Public-Private Partnerships (PPPs).
- Eligibility for debt cancellation must not be limited to the HIPC, but must be extended to other low and middle income countries where debt servicing obligations interfere with increased public provision for basic needs such as income support, nutrition, health and education, along the lines described by Hanlon (2000).

### 3.8 Fair Trade

We are determined to make globalisation work for all our citizens and especially the world’s poor. Drawing the poorest countries into the global economy is the surest way to address their fundamental aspirations (Genoa Communiqué, 2001, ¶13).

[G]lobalisation, 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. Because markets at the national level are asymmetric, modern capitalist economies have social contracts, progressive tax systems, and laws and regulations to manage asymmetries and market failures. At the global level, there is no real equivalent to national governments to manage global markets, though they are bigger and deeper, and if anything more asymmetric. They work better for the rich; and their risks and failures hurt the poor (Birdsall 2002: 67-68).

The quoted statement from the 2001 G8 Summit exemplifies the G8’s consistent promotion of trade and investment liberalisation and ‘free’ markets as the only path to development. However, it is far from clear that global market integration will work to the benefit of the poor. This concern is supported by numerous studies challenging the conventional claim that countries that liberalise grow faster and reduce poverty more than countries that do not. Rather, current trade rules deny low- and middle-income countries the very policy flexibilities by which presently wealthy nations (including the so-called Asian tigers) grew and became (at least relatively) rich themselves (Chang 2002). As the recent World Commission on the Social Dimensions of Globalisation (2004: 85) noted, ‘uniform rules for unequal partners can only produce unequal outcomes.’

The illogic of the claim that integration into competitive markets (which by definition produce winners and losers) will somehow produce a ‘win/win’ outcome for strong and weak economies alike continues to be denied by the G8, which as recently as the 2004 Sea Island Summit declared that: ‘Trade liberalisation is key to boosting global prosperity. It is one of the most effective ways to generate economic growth, and represents great potential for development and raising living standards’ (G8 Leaders Statement on Trade, June 9, 2004).

At the 2001 Genoa Summit the G8 ‘agreed ... to support the launch of an ambitious new Round of global trade negotiations with a balanced agenda’ (Genoa Communiqué ¶10) at the forthcoming WTO Doha ministerial, the so-called ‘Doha development round.’ The Doha

process itself dampened that optimism, largely because of industrialised countries’ intransigence on agricultural subsidies (Watkins 2003). Follow-up talks in Mexico ended in acrimony in September, 2003 as it became apparent that the developed countries, notably several members of the G8 (the EU, the USA, Japan) were unwilling to concede much in the area of market access, even while continuing to demand expanded investment opportunities for their own firms (Denny and Elliott 2003; Denny, Elliott and Vidal 2003).

The growing body of evidence casting doubt on the grand assumption that global market integration benefits all has been met with a shift in some G8 rhetoric towards making trade rules fair, but without any shift in G8 countries’ negotiating positions, at the WTO or elsewhere. If anything, the 2004 Sea Island Summit represents a hardening of positions inimical to developing world interests, including commitments to ‘stronger trade rules’ and ‘expanding opportunities for trade in services’ (Sea Island Statement on Trade), as well as to develop ‘pilot projects and actions’ that would ‘promote adoption of to improve transparency in...public procurement...and negotiation and implementation of investment treaties’ (G8 Action Plan: Applying the Power of Entrepreneurship to the Eradication of Poverty: ¶18-19).

Public procurement and investment are two of the four so-called Singapore issues, first discussed at the 1997 Singapore ministerial meeting of the WTO. As priorities, both are strongly opposed by the majority of WTO developing country members, and both were specifically dropped from the negotiating agenda agreed to at the 2001 Doha ministerial – yet they are prominent in the trade policy stance of the G8, neatly repackaged as poverty reduction strategies. The Sea Island Summit was significantly silent on three issues of greatest concern to developing countries: implementation<sup>27</sup>; the lack of rich world movement on trade-distorting subsidies harmful to developing countries; and special and differential treatment.

Special and differential treatment (SDT) has been a feature of the world trading system since the beginning of the GATT, and holds more potential than agreement-specific exceptions for leveling the playing field between rich and poor member nations. SDT bears indirectly but powerfully on health if it enables poverty-reducing economic growth. With the birth of the WTO, however, SDT suffered a ‘massive dilution’ (Das 2000: 8). Rather than meaning a lower degree of obligation by developing countries, SDT now means a longer time frame to fulfill standardised obligations. Moreover, many SDT provisions are written in ‘best endeavour’ language that ‘calls on,’ but does not require, members to take the development needs of poorer countries into account (Jawara and Kwa 2003: 12, 47). Intense lobbying by poorer African and Asian nations led to inclusion in the 2001 Doha Ministerial Declaration (WTO 2001a) of a commitment to review ‘all Special and Differential provisions...with a view to *strengthening* them and making them more precise, effective and operational’ (¶44, emphasis added). WTO members, however, disagree over what ‘strengthening’ means. Developing countries want to modify many agreements to make them more supportive of health and development objectives, partly by granting them more policy flexibility; most high-income countries, including members of the G8, oppose this.<sup>28</sup> And even though the Doha ministerial mandated members to identify ‘best endeavour’ SDT measures and ‘to consider the

<sup>27</sup> The costs of enacting present agreements are estimated to be larger than the annual development budgets of least developed countries (Finger and Schuler 2001: 129).

<sup>28</sup> BRIDGES Trade News Weekly, 6(34), 2002.

legal and practical implications ... of converting them into mandatory provisions' (WTO 2001b: ¶12(i)), no progress was made by the July 2002 deadline, and little progress since (Keck and Low 2004; BRIDGES Trade News Weekly 8(27) 2004).

Strengthening agreement-specific SDT provisions may not be enough. A key issue not yet under discussion in WTO SDT talks is whether such provisions are merely a way of integrating developing countries into the multilateral trading system under one set of rules, or whether they represent a reversal of existing priorities that would subordinate trade liberalisation to development goals (BRIDGES Weekly Trade News Weekly, 8(37), 2004). Similarly, the final report of the United Nations Special Rapporteurs on globalisation and human rights noted that 'it is necessary to move away from approaches that are ad hoc and contingent' in ensuring human rights, including the right to health, are not compromised by trade liberalisation (Oloka-Onyango and Udugama 2003: ¶25). The G8 should take a leadership role with respect to this objective. One solution would be to take the WTO's preamble – which argues that liberalisation is not an end in itself, but a means to improving living standards – and frame it as a general exception for developing countries.<sup>29</sup> Obligations under human rights conventions (such as the right to health discussed earlier) and MDG targets represent internationally agreed upon development goals, and could be used to assess how living standards (crucially including health status and key determinants of health) might be improved. Countries could be permitted to abrogate their liberalisation commitments for the purposes of their progressive realisation of human rights and forward movement on the Millennium Development Goals, or any subsequent multilaterally agreed upon set of international development goals and targets, with adjudication of any disputes under this general exemption to be settled based on a set of criteria emphasising the priority of human rights and/or the MDGs, within an administrative framework not under the direct control of the WTO.

Quite apart from progress toward this longer term objective, the G8 must establish a formal and transparent reporting mechanism to monitor the policies of its own members for what many in the developing world see as hypocrisy in trade policy. For example, the Bush administration is considering limiting textile and apparel imports from China based on the threat of market disruption that they pose.<sup>30</sup> 'Rising imports' would provide sufficient evidence of such disruption, according to the US Commerce Undersecretary for international trade (BRIDGES Weekly Trade News Weekly 8(33), 2004) – the very thing the G8 claims as the benefit of trade liberalisation for developing countries. Furthermore, the USA has engaged in a number of bilateral negotiations in which it has pressured developing countries into accepting more stringent patent protection requirements (so-called 'TRIPS-plus' deals) than those negotiated in the multilateral (hence more globally equitable) WTO forum. French president Jacques Chirac is the only G8 leader of whom we are aware who has publicly criticised the USA for this policy (Boseley 2004).

<sup>29</sup> According to a recent study (Jawara and Kwa 2003) the organization's mandate, as interpreted by its staff, is to promote liberalization over protectionism, even when it may not be in the best development interests of poorer nations.

<sup>30</sup> Impacts will not be confined to the US, however. The expiration of the quota system on textiles in 2005 (when the current Multi-fiber Agreement expires) may threaten the livelihoods of hundreds of thousands of workers in low-income countries such as Bangladesh, Pakistan and several African countries currently benefiting under the USA African Growth and Opportunities Act. Chinese manufacturing capacity and lower-wage labour is likely to lead to a massive relocation of textile global production chains to China, especially those operating in export processing zones.

Finally, the presumption that 'trade not aid' is the best means to promote growth, development and health for the developing world, and especially for low-income African nations, must be abandoned. A recent multi-sectoral study of growth in South Africa, the continent's most advanced economy, concluded that only 'sustained currency depreciation' permitted continued growth, but with the price of continual erosion in domestic income growth, a phenomenon the authors describe as 'immiserising growth' (Kaplinsky, Morris and Readman 2002). In broader terms, Sachs and colleagues (2004: 181) cite various estimates of growth for a number of African countries under different liberalisation scenarios, concluding that:

Even if the Doha trade negotiations yielded African countries the most optimistic of estimated outcomes, these countries' benefits would likely not exceed 1 or 2 percent of GDP per year. Although these benefits would be nontrivial in scale and important for long-term economic development, they would be an order of magnitude less than the level of resources required to achieve the MDGs in the poorest countries. They are not a substitute for the sustained increases in ODA [of 20 per cent to 30 per cent of GDP per year] needed to fund...public investments.

## 4. CONCLUSION: BEYOND THE WASHINGTON CONSENSUS, TOWARDS GLOBAL HEALTH EQUITY

The most effective poverty reduction strategy is to maintain a strong, dynamic, open and growing global economy (Genoa Communiqué ¶13).

Experience shows that, despite the unparalleled opportunities that globalisation has offered to some previously poor countries, there is nothing inherent in the process that automatically reduces poverty and inequality (New Partnership for Africa's Development: ¶40).

It is becoming increasingly clear that globalisation, as the US is promoting it, is intensely unpopular. Why...? The answer is that globalisation, American-style, has left many of the poorest in the developing world even poorer (Stiglitz 2002).

At the core of our study and critique of G8 development policies is their adherence to a set of propositions about development derived directly from neoclassical economics but supported, at best, by weak and contested evidence. G8 development policy – from aid to trade to macroeconomic conditionality – is now packaged in the language of poverty reduction but remains strikingly consistent with the norms first described by John Williamson as the 'Washington consensus': liberalisation, privatisation, deregulation, currency devaluation, private sector enhancement (Williamson 2000). The macroeconomic policies demanded by the World Bank and the IMF, decision-making in both of which is dominated by G8 countries, have consistently reflected these assumptions, calling *inter alia* for reduced subsidies for basic items of consumption, decreased social spending, the removal of trade and investment controls with a special emphasis on increasing export revenues, privatisation of state owned enterprises, and cost-recovery for health and social services, albeit with exemptions for the poor that generally proved ineffective. This economic orthodoxy effectively claims that the *only* route to development is through economic growth and, more importantly, through a set of rules contrary to those used by every other country that has become wealthy in the past. These rules, in turn, appear to be those that are (a) consistent with the financial interests of the G8 countries, and (b) require minimal or no redistribution of income and wealth from the rich world to the poor.

Even if we concede, for purposes of argument, the validity of the neoliberal prescription for growth, we must ask: How long is the long term? How long may the pain last, and how severe may it be, before it ceases to be justified by subsequent gains? And in view of such declarations of purpose as the Millennium Development Goals, do the poor majority of the world's people not have a claim to healthy lives that need not be vindicated with reference to their future economic productivity? The discourse of health as a human right suggests that this consideration of distributive justice must be incorporated into current and future critiques of development policy and its relation to human health.

Some of the G8's more recent responses to the crisis of development and health in Africa (increased aid, possible expansion of debt cancellation, improved market access) are encouraging, necessary but far from sufficient. The 2005 Summit represents a distinctive opportunity for the G8 to move beyond the Washington consensus, to explicit endorsement of a human rights-based approach to health and development, backed up by firm commitments to make the necessary resources available.

## REFERENCES

- Adam C, Chambas G, Guillaumont P, Jeanneney S, Gunning J. 2004. Performance-Based Conditionality: A European perspective. *World Development* 32:1059-70.
- Andreev E, McKee M, V Shkolnikov V. 2003. Health expectancy in the Russian Federation: A new perspective on the health divide in Europe. *Bulletin of the World Health Organization* 81: 778-788.
- Andreev E *et al.* 2003. The evolving pattern of avoidable mortality in Russia. *International Journal of Epidemiology* 32:437-446.
- Austin W. 2001. Using the human rights paradigm in health ethics: The problems and the possibilities. *Nursing Ethics* 8: 183-195.
- Bell C, Devarajan S, Gersbach H. 2003. *The Long-run Economic Costs of AIDS: Theory and an application to South Africa*, working paper. Washington, DC: World Bank, June.
- Birdsall N. 2002. A Stormy Day on an Open Field: Asymmetry and Convergence in the Global Economy. In Gruen D, O'Brien T, Lawson J, eds. *Globalisation, Living Standards and Inequality: Recent Progress and Continuing Challenges*, Proceedings of a Conference held in Sydney, 27-28 May 2002. Canberra: Reserve Bank of Australia, pp. 66-87; <http://www.rba.gov.au/>.
- Bisset R, Flint D, Kirkpatrick C, Mitlin D, Westlake K. 2003, *Sustainability Impact Assessment of Proposed WTO Negotiations, Environmental Services*. Manchester: University of Manchester Institute for Development Policy and Management; <http://idpm.man.ac.uk/>.
- Bloom D, Williamson J. 1998. Demographic Transitions and Economic Miracles in Emerging Asia. *World Bank Economic Review* 12: 419-455.
- Bonnell R. 2000. 'Economic Analysis of HIV/AIDS,' Background Paper for the Africa Development Forum 2000, World Bank/UNAIDS, September



- Boseley S. 2004. America accused of AIDS blackmail. *The Guardian Weekly*, 16 July: 7.
- Bosshard P, Bruil J, Horta K, Lawrence S, Welch C. 2003. , *Gambling with People's Lives: What the World Bank's New 'High-Risk/High-Reward' Strategy Means for the Poor and the Environment*. Washington, DC: Environmental Defense
- Braveman P, Gruskin S. 2003. Poverty, equity, human rights and health. *Bulletin of the World Health Organization* 81: 539-545.
- Breman A, Shelton C. 2001. *Structural Adjustment and Health: A literature review of the debate, its role-players and presented empirical evidence*. Paper No. WG6:6. Cambridge, MA: Commission on Macroeconomics and Health, June; <http://www.cmhealth.org>.
- Briefing Note to the Board: Costing the Service Delivery MDGs: Primary Education, Health & Water Supply and Sanitation. 2003. Washington, DC: World Bank, 9 April; on file with authors.
- British Overseas Aid Group. 2004. Creating wealth for all Africans, submission to the Commission for Africa Secretariat, 30 July. <http://www.christian-aid.org.uk/>.
- Browning L. 2004. Foreign Tax Havens Costly to US, Study Says. *The New York Times*, September 27.
- Brugha R *et al.* 2004. The Global Fund: managing great expectations. *Lancet* 364: 95-100.
- Budds J, McGranahan G. 2003. Are the debates on water privatization missing the point? Experiences from Africa, Asia and Latin America. *Environment & Urbanization* 15: 87-114.
- Canadian Council for International Cooperation Africa-Canada Forum. 2002. *Canadian Economic Relations with Sub-Saharan Africa: Recent Trends*. Ottawa: CCIC; <http://www.ccic.ca/>
- Center for Public Integrity. 2003. The Water Barons (on-line series). Washington, DC: Center for Public Integrity/International Consortium for Investigative Journalism; <http://www.icij.org/>.
- Chang H-J. 2002. *Kicking Away the Ladder: Development Strategy in Historical Perspective*. London: Anthem Press.
- Chirac J. 2003. President of France Jacques Chirac's Address to the U.N. General Assembly. *The New York Times*, 23 September.
- Citizens for Tax Justice. 2003. *Details on the Bush Tax Cuts So Far (as of Fall 2003)*. Washington, DC: CTJ; <http://www.ctj.org/>.
- Clunies-Ross A. 2004. Resources for Social Development. *Global Social Policy* 4:197-214.
- Cohen S. 2000. *Failed Crusade: America and the Tragedy of Post-Communist Russia*. New York: W.W. Norton.
- Commission on Macroeconomics and Health (2001). *Macroeconomics and Health: Investing in Health for Economic Development*. Geneva, Switzerland: World Health Organization; <http://www.cmhealth.org>.
- Commission on Weak States and US National Security (co-chairs: Ambassador Stuart Eizenstat and Representative John Porter). 2004. *On the Brink: Weak States and US National Security*. Washington, DC: Center for Global Development; <http://www.cgdev.org/>.
- Cornia G, Jolly R, Stewart F, eds. 1987. *Adjustment with a Human Face, vol. 1, Protecting the Vulnerable and Promoting Growth*. Oxford: Clarendon Press.
- Das B. 1999. *The World Trade Organisation: A guide to the framework for international trade*. New York: Zed Books.
- Department for International Development. 2004. *Taking Action: The UK's strategy for tackling HIV and AIDS in the developing world*. London: DFID; <http://www.dfid.gov.uk>.
- Department for International Development (DFID), Foreign & Commonwealth Office, HM Treasury. 2004. *Partnerships for Poverty Reduction: Changing aid 'conditionality': A draft policy paper for comment*. London: DFID; <http://www.dfid.gov.uk/>.
- Denny C, Elliott L. 2003. G21 alliance of the poor fights subsidies deal. *The Guardian*, 15 September.
- Denny C, Elliott L, Vidal J. 2003. Alliance of the poor unites against west. *The Guardian*, 15 September.
- Devarajan S, Miller M, Swanson E. 2002. *Goals for Development: History, Prospects and Costs*. Washington, DC: World Bank; <http://econ.worldbank.org>.
- Dollar D. 2002. Global Economic Integration and Global Inequality. In Gruen D, O'Brien T, Lawson J, eds. *Globalisation, Living Standards and Inequality: Recent Progress and Continuing Challenges, Proceedings of a Conference held in Sydney, 27-28 May 2002*. Canberra: Reserve Bank of Australia: 9-36; <http://www.rba.gov.au/>.
- Emini E, Koff W. 2004. Developing an AIDS Vaccine: Need, uncertainty, hope. *Science* 304: 1913-1914.
- Field M, Kotz D, Bukhman G. 2000. Neoliberal Economic Policy, 'State Desertion,' and the Russian Health Crisis. In Kim J, Millen J, Irwin A, Gershman J, eds., *Dying for Growth: Global Inequality and the Health of the Poor*. Monroe, Maine: Common Courage Press: 155-173.
- Finger J, Schuler P. 2001. Implementation of Uruguay Round Commitments: The Development Challenge. In Hoekman B, Martin W, eds, *Developing Countries and the WTO: A Pro-active Agenda*. Oxford: Blackwell Publishers: xxx-xxx.
- 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, December 2004; <http://www.hlfhealthmdgs.org/Documents/MDGorientedPRSPs-Final.pdf>.
- Foxwood N, Green J. 2004. *Making Every Drop Count: An assessment of progress toward the water and sanitation target*. Teddington, Middlesex: Tearfund; <http://www.tearfund.org>.

- Gallup J, Sachs J. 2000. The Economic Burden of Malaria, Working Paper No. 52. Cambridge, MA: Center for International Development, Harvard University, July; <http://www2.cid.harvard.edu>.
- Garber D, Silvestri G, Feinberg M. 2004. Prospects for an AIDS vaccine: three big questions, no easy answers. *Lancet Infectious Diseases* 4: 397-413.
- Global Forum for Health Research. 2004a. *The 10/90 Report on Health Research, 2003-2004*. Geneva, Global Forum for Health Research; <http://www.globalforumhealth.org>.
- Global Forum for Health Research. 2004b. *Health Research for Equity in Global Health*, Statement at the conclusion of Forum 8 Mexico City, 16-20 November. Geneva: Global Forum for Health Research; <http://www.globalforumhealth.org>.
- Global Forum for Health Research. 2004c. *Monitoring Financial Flows for Health Research 2004*. Geneva: Global Forum for Health Research; <http://www.globalforumhealth.org>.
- Gupta S, Clements B, Guin-Siu M, 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. 2002. *Who would gain most from efforts to reach the millennium development goals for health?* Health, Nutrition and Population (HNP) Discussion Paper. Washington DC: World Bank.
- Haddad S, Mohindra K. 2001. *Macroeconomic Adjustment Policies, Health Sector Reform, and Access, Utilisation and Quality of Health Care: Studying the macro-micro links*. Montreal: University of Montreal/International Development Research Centre.
- Hanlon, M. 2000. How Much Debt Must Be Cancelled? *Journal of International Development* 12: 877-901.
- Henninger N, Snel M. *Where are the Poor? Experiences with the development and use of poverty maps*. Washington, DC: World Resources Institute; 2002;
- HM Treasury – Department for International Development. 2003. London: HM Treasury, January; <http://www.hm-treasury.gov.uk/>.
- Hilary J. 2001. *The Wrong Model: GATS, trade liberalisation and children's right to health*. London: Save the Children; <http://www.savethechildren.org.uk>.
- Hinsliff G. 2004. Crackdown on poaching of African nurses. *Guardian Weekly*, 7 September: 12.
- Huddart J, Picazo O. 2003. *The Health Sector Human Resource Crisis in Africa*. Washington, DC, Bureau for Africa, Office of Sustainable Development, United States Agency for International Development.
- Hunt P. 2003. Economic, Social and Cultural Rights: The right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Report of the Special Rapporteur, Commission on Human Rights, E/CN.4/2003/58. Geneva: United Nations Economic and Social Council Commission on Human Rights; <http://www.unhchr.ch/>.
- International Monetary Fund (IMF). 2004. Checking up on Health. *Finance & Development*, March: 8-9.
- Jawara F, Kwa A. 2003. *Behind the Scenes at the WTO: The real world of international trade negotiations*. London: Zed Books.
- Kaplinsky R, Morris M, Readman J. 2002, The Globalization of Product Markets and Immiserizing Growth: Lessons from the South African furniture industry. *World Development* 30:1159-1177.
- Keck A, Low P. 2004. *Special and Differential Treatment in the WTO: Why, when and how?* Staff Working Paper ERSD-2004-03. Geneva: Economic Research and Statistics Division, World Trade Organization, May.
- Killick T. 2004. Politics, Evidence and the New Aid Agenda. *Development Policy Review* 22: 5-29.
- Kirton J, Kokotsis E. 2004. *An Evaluation of the G8's Commitment to the Kananaskis Pledges*, Discussion Paper prepared for a meeting of the Council on Foreign Relations G8 Africa Roundtable, Washington DC, 4 February. Toronto: G8 Research Centre, University of Toronto; <http://www.g8.utoronto.ca>.
- Kremer M, Snyder C. 2004, *Why is There No AIDS Vaccine?* Working Paper 111. Cambridge, MA: Centre for International Development, Harvard University; <http://www2.cid.harvard.edu/cidwp/111.pdf>.
- Labonte R, Schrecker T, Sanders D, Meeus W. 2004. *Fatal Indifference: The G8, Africa and Global Health*. Cape Town and Ottawa: University of Cape Town Press/International Development Research Centre.
- Lipson D. 2001. *The role of health in enhancing productive capacities in LDCs*. Prepared for the Third UN Conference on Least Developed Countries. Geneva: World Health Organization, April.
- Lister G, Ingram A, Prowle M. 2004. *Country Case Study: UK Financing of International Cooperation for Health*. New York: Office of Development Studies, United Nations Development Programme.
- Lister J. 2004. The impact of global pressures on the reform of health care systems (PhD dissertation). Coventry: Coventry University, June.
- Loftus A, McDonald D. 2001. Of liquid dreams: A political ecology of water privatization in Buenos Aires. *Environment & Urbanization* 13: 179-200.
- Lozano R *et al.* 2001. Mexico: Marginality, Need, and Resource Allocation at the County Level. In Whitehead M *et al.*, eds. *Challenging Inequities in Health: From Ethics to Action*. New York: Oxford University Press: 276-95.
- MacAskill E. 2004. Aim is to meet UN target by 2013. *The Guardian*, 13 July.

- Martin M. 2004. Assessing the HIPC Initiative: The key policy debates. In Teunissen J and Akkerman A, eds., *HIPC Debt Relief: Myths and Realities*. The Hague: Forum on Debt and Development (FONDAD): 11-47; <http://www.fondad.org/>.
- Martineau T, Decker K, Bundred P. 2002. *Briefing note on international migration of health professionals: leveling the playing field for developing country health systems*, Liverpool: Liverpool School of Tropical Medicine.
- Mavrotas G. 2003. The UK HM Treasury – DFID Proposal to Increase External Finance to Developing Countries: The International Finance Facility, WIDER Conference on Sharing Global Prosperity, Helsinki, 6-7 September. Helsinki: World Institute for Development Economics Research; <http://www.wider.unu.edu>.
- McDonald D, Pape J. 2002. *Cost Recovery and the Crisis of Service Delivery in South Africa*. Cape Town and London: Human Sciences Research Council/Zed Books.
- Men T *et al.* 2003. Russian mortality trends for 1991-2001: Analysis by cause and region., *British Medical Journal* 327: 964-969.
- Michaud C. 2003. *Development Assistance for Health (DAH): Recent Trends and Resource Allocation*, prepared for Second Consultation, Commission on Macroeconomics and Health, 29-30 October. Geneva: WHO; <http://www.who.int/>.
- Monbiot G. 2003. Africa's scar gets angrier. *Guardian Weekly*, 12 June: 13.
- Monbiot G. 2004. The super-rich are fleecing us by avoiding taxes, and it should be a matter of public record. *The Guardian*, 28 September.
- Narasimhan V, Attaran A. 2003. Roll Back Malaria? The scarcity of international aid for malaria control. *Malaria Journal* 2.8: 1-8.
- Ndiaye N. 2003. Address to 52nd Session of the WHO Committee for Africa, Harare, 8-12 October. Geneva: International Organization for Migration; <http://www.iom.int>.
- Nelson P, Dorsey E. 2003. At the Nexus of Human Rights and Development: New methods and strategies of global NGOs, *World Development* 31:2013-26.
- New Partnership for Africa's Development (NEPAD). 2002. Health Strategy. Pretoria: NEPAD Secretariat (on file with authors).
- Nygren-Krug H. 2002. *25 Questions & Answers on Health & Human Rights*. Geneva: WHO, <http://www.who.int>.
- Oloka-Onyango J, Udugama D. 2003. *Economic, Social and Cultural Rights: Globalization and its impact on the full enjoyment of human rights*, Final Report, E/CN.4/Sub.2/2003/14. Geneva: United Nations Economic and Social Council Commission on Human Rights; <http://www.unhchr.ch/>.
- O'Brien R. 2002. Organizational Politics, Multilateral Economic Organizations and Social Policy. *Global Social Policy* 2: 141-162.
- O'Manique C. 2004. The 'Securitization' of Africa's AIDS Pandemic: Whose security? Paper prepared for the annual meeting of the International Studies Association, Montreal, March.; <http://www.isanet.org>.
- Organization for Economic Cooperation and Development (OECD). 2004. Development Co-operation: 2003 Report. *DAC Journal* 5.1 [entire issue]. Paris: OECD.
- Östlin P *et al.* 2004. *Priorities for Research to Take Forward the Health Equity Policy Agenda*, Report from the WHO Task Force on Health System Research Priorities for Equity in Health. Geneva: WHO, 15 October; <http://www.who.int/>.
- Ozoemena C. 2004. Atiku in London, in search of stolen wealth. *Vanguard* [Lagos], 22 August.
- Oxfam. 2001. *G8: Failing the World's Children*. Washington, DC: Oxfam International; <http://www.oxfam.org/>.
- Padarath A, Chamberlain C, McCoy D, Ntuli A, Rowson M, Loewenson R. *Health Personnel in Southern Africa: Confronting maldistribution and brain drain*. Harare: Equinet; <http://www.equinet africa.org/>.
- Piot P. 2004. Plenary Address for Closing Ceremony, XV International AIDS Conference: Getting Ahead of the Epidemic, Bangkok, 16 July. Geneva, UNAIDS; <http://www.unaids.org>.
- Pogge T. 2004. The First United Nations Millennium Development Goal: A cause for celebration? *Journal of Human Development* 5: 377-397.
- Price-Smith A. 2002. *The Health of Nations: Infectious disease, environmental change, and their effects on national security and development*. Cambridge, MA: MIT Press.
- Radelet S. 2004. *The Global Fund to Fight AIDS, Tuberculosis and Malaria: Progress, potential, and challenges for the future*. Washington, DC: Center for Global Development, June; <http://www.cgdev.org/>.
- Rich B. 1994. *Mortgaging the Earth: The World Bank, environmental impoverishment and the crisis of development*. Boston: Beacon Press.
- Robinson R. 2004. *Globalization, Immigrants' Transnational Agency and Economic Development in their Homelands*, Policy Paper FPP-04-9. Ottawa: FOCAL-Canadian Foundation for the Americas, October; <http://www.focal.ca/>.
- Rogerson A, Hewitt A, Waldenberg D. 2004, *The International Aid System 2005-2010: Forces for and against change*, Working Paper 235. London: Overseas Development Institute; <http://www.odi.org.uk>.
- Sachs J *et al.* 2004. Ending Africa's Poverty Trap. *Brookings Papers on Economic Activity* Issue 1: 117-240.
- Schrecker T, Labonte R. 2004. Taming the 'Brain Drain': A challenge for health systems in southern Africa. *International Journal of Occupational and Environmental Health* 10: 409-415.

- Schrecker T, Labonte R. In press. What's Politics Got to Do with It? Health, the G8 and the global economy. In Kawachi I, Wamala S, eds. *Globalisation and Health*. Oxford: Oxford University Press.
- Specter M. 2004. The Devastation. *The New Yorker*, 11 October: 58-69.
- Stewart F. 1991. The Many Faces of Adjustment. *World Development* 19:1847-1864.
- Stiglitz J. 2002. The Roaring Nineties. *The Atlantic Online*, October; <http://www.theatlantic.com>.
- Stilwell B, Diallo K, Zurn P, Vujicic M, Adams O, Dal Poz M. 2004. Migration of health-care workers from developing countries: strategic approaches to its management.' *Bulletin of the World Health Organization* 82:595-600.
- UK Commission on Africa. 2004. Work Programme on Policy and Possible Implications for Action. London: Overseas Development Institute; <http://www.odi.org.uk/>.
- United Nations. 2002a. *International Financial System and Development: Report of the Secretary-General, A/57/151*. New York: United Nations; <http://www.un.org>.
- United Nations. 2002b. *Follow-up Efforts to the International Conference on Financing for Development: Report of the Secretary-General, A/57/319*. New York: United Nations; <http://www.un.org/>.
- United Nations Conference on Trade and Development (UNCTAD). 2004. *Economic Development in Africa: Debt Sustainability: Oasis or Mirage?* New York: United Nations; <http://www.unctad.org>.
- UNESCO. 2000. *The Dakar Framework for Action*. Paris: World Education Forum; <http://www2.unesco.org/wef/>.
- UNESCO. 2002a *EFA Global Monitoring Report, 2002: Is the World on Track?* Paris: UNESCO, November; <http://www.unesco.org/>.
- UNESCO, 2002b *Approved Programme and Budget, 2002-2003, 31C/5*. Paris: UNESCO, March; <http://unesdoc.unesco.org/>.
- UNICEF 1992. *The State of the World's Children 1992*. New York: Oxford University Press.
- United Nations Food and Agriculture Organization (UNFAO). 2003. *The State of Food Insecurity in the World 2003*. Rome: UNFAO; <http://www.fao.org/>.
- UN Habitat. 2003a. *The Challenge of Slums: Global Report on Human Settlements 2003*. London: Earthscan.
- UN Habitat. 2003b. *Water and Sanitation in the World's Cities: Local Action for Global Goals*. London: Earthscan.
- Waddington C, 2004, 'Does earmarking donor funding make it more or less likely that developing countries will allocate their resources towards programmes that yield the greatest health benefit?' *Bulletin of the World Health Organization* 82(9):703-708.
- Wade R. 2002. Globalisation, poverty and income distribution: Does the liberal argument hold? In Gruen D, O'Brien T, Lawson J, eds. *Globalisation, Living Standards and Inequality: Recent Progress and Continuing Challenges*, Proceedings of a Conference held in Sydney, 27-28 May 2002. Canberra: Reserve Bank of Australia: 37-65; <http://www.rba.gov.au/>.
- Wagstaff A, Claeson M et al. 2003. *The Millennium Development Goals for Health: Rising to the Challenges*. Washington, DC: World Bank; <http://www1.worldbank.org/hnp/>.
- Walgate R. 2004. G8 support for vaccine initiative draws mixed reactions. *Lancet* 363: 2055.
- War on Want. 2004. *Profiting from Poverty: Privatisation consultants, DFID and public services*. London: War on Want; <http://www.waronwant.org>.
- Watkins K. 2003. *Northern agricultural policies and world poverty: Will the Doha 'development round' make a difference?* Paper presented at the Annual Bank Conference of Development Economics, Paris. Washington, DC: World Bank; <http://wbln0018.worldbank.org>.
- Williamson J. 1990. What Washington Means by Policy Reform. In Williamson J, ed. *Latin American Adjustment: How Much Has Happened?* Washington, DC: Institute for International Economics: 7-38.
- Wiwa K. 2004. Money for nothing and the debt is for free. *The Globe and Mail* [Toronto], 22 May: A19.
- World Bank. 2004. *Global Development Finance: Harnessing cyclical gains for development*. Washington, DC: World Bank; <http://www.worldbank.org>.
- World Commission on Social Dimensions of Globalisation. 2004. *A Fair Globalisation: Creating opportunities for all*. Geneva: International Labour Organisation.
- World Trade Organization (WTO). 2001a. *Ministerial Declaration, WT/MIN(01)/DEC/1*. Geneva: WTO, 20 November, <http://www.wto.org>.
- World Trade Organization (WTO). 2001b. *Implementation-Related Decisions and Concerns, WT/MIN(01)/17*, 20 November. Geneva: WTO; <http://www.wto.org>.
- Yunker J. 2004. Could a Global Marshall Plan be Successful? An investigation using the WEEP simulation model. *World Development* 32: 1109-1137.