The G8 and Global Health Governance

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Paper prepared for a conference on "Global Health Governance: Past Practice: Future Innovation," sponsored by the Centre for International Governance Innovation (CIGI), the Institute of Population Health, University of Ottawa, the G8 Research Group, Munk Centre for International Studies, University of Toronto, and Rotary International, Ottawa and Waterloo, November 10-12, 2005. We gratefully acknowledge the support of the Social Sciences and Humanities Research Council of Canada and the research assistance of Laura Sunderland, and members of the G8 Research Group. Draft of November 11, 2005.

Introduction

Since 1975, global health governance has undergone a major change, driven by new physical challenges and by the way the old multilateral global health organizations have responded. During this time the dominant conception of global health governance and the resulting policy paradigm have shifted from being centred on the medical absence of disease to being focused on socioeconomic well-being, resource availability, poverty reduction, and ecological integrity (Pannenborg 1979). This shift was first pushed by the World Health Organization (WHO), at the apex of its strength in the 1970s, through an ambitious human rights initiative called Health for All. The emerging reality of intensifying globalization and the leadership of the WHO also drove the world from a concept of health as a national issue, which had dominated health policy during the previous century, toward a more internationally focused global approach to health governance.

Yet three decades after this great transformation, the old WHO has proven inadequate in addressing the major health challenges and crises of a rapidly globalizing, post–Cold War, post-911 world. The rapid spread of HIV/AIDS through the West and then the rest of the world was the first sign of the failure of global health governance from the old multilateral and regional organizations. The cumulative body count from the continuing chronic afflictions of malaria and tuberculosis, the re-emergence of old diseases once on the verge of extinction such as polio, the eruption of bioterrorism with the anthrax attacks on America after 911, the assault from severe acute respiratory syndrome (SARS) in 2002-03, and the subsequent threat of an avian flu pandemic have compounded that failure. At the same time, the failure has fuelled the search for a new generation of global health governance for the twenty-first century world.

In response, the Group of Eight (G8) major market democracies, created in 1975, as part of a new generation of global institutions, took up the challenge and developed health as a regular emphasis after the advent of rapid globalization in 1996. Starting narrowly with health research on diseases within the G8 countries, the G8's agenda soon broadened to address the major illnesses afflicting the world as a whole. At first the G8 worked to support the WHO and broader United Nations (UN) system in raising the money they needed but were unable to attract on their own. This process culminated in the creation of the Global Fund to Fight AIDS, Malaria and Tuberculosis in 2001. However, as the twenty-first century began, the G8 found it necessary to launch its own independent initiatives to deliver global health directly. This phase started with the 2001-02 move to develop the G8 Africa Action Plan, and the new attention and institutions to combat bioterrorism that the shock of September 11, 2001, brought. At the 2003 Evian Summit,

the G8's Health Action Plan directly tackled some of the world's most terrible diseases, which the WHO and broader UN system had been unable to combat successfully. By the 2004 Sea Island Summit, the G8 was focused on specific interventions such as developing an HIV/AIDS vaccine and the eradication of polio. Gleneagles in 2005 continued this thrust.

After a decade of this increasingly active and ambitious G8 effort, it is important to ask how effective the G8 has been as an emerging centre of global health governance, and why has it worked when the old multilateral organizations have failed. Only on the empirical and explanatory foundation provided by answers to these questions can reliable innovations be designed and developed to improve global health governance in the years ahead.

These questions about the course, causes, and consequences of the G8's performance in governing global health have provoked a growing debate among scholars and other observers over the G8's record and the contribution it can and should make. The debate ranges widely among the critics who think the G8 has done too little, done too much of the wrong thing, or failed to deliver the good promises it has made to supporters who claim the G8 has already filled some gaps, has the potential to do much more, and is delivering a new generation of health governance for a globalizing world.

In this debate, the first school of thought comes from those who see the G8 as a great fundraising failure (Lewis 2003). Here the G8's proper role is narrowly confined to raising massive amounts of new money, with few conditions attached, for the old organizations of the UN system that have been unable to induce their own members to provide the necessary sums. Acknowledging the failure of the old international organizations to deal adequately with the HIV/AIDS pandemic and arguing for a human right to health, these critics highlight the low level of financial commitments made to provide antiretroviral drugs for HIV/AIDS in developing countries. They see the failure caused by the political lobbying of the United States government for the protection of the intellectual property rights of the world's most powerful pharmaceutical companies and by the G8's easy acceptance of a dominant America's approach. Stephen Lewis (2003), an advocate employed by the UN as Special Envoy on HIV/AIDS in Africa, has referred to this placements of intellectual property rights and international trade law above the alleged human right to health as "mass murder by complacency." A second cause he regularly alludes to is the common attitude of racism shared by G8 members and others in a largely wealthy white West.

A second school sees the G8 as having a much broader role, but failing to deliver the promising new directions now required (Labonte et al. 2004, Labonte and Schrecker 2004). Here the G8's failure to improve health outcomes in the face of a new generation of disease flows from the collateral damage caused by its members' attachment to neo-liberal principles in the economic and social policy areas that are vital in generating health. As Ronald Labonte (2004,228) and his colleagues put it: "With respect to such an agenda that begins seriously to redress the human health and development catastrophes arising in the wake of contemporary globalization, the G8's response can best, if disturbingly, be described as fatal indifference."

A third school also sees more of a G8-wide than an American-inspired failure, but locates the cause in institutional rather than ideological factors, notably the G8's search as an informal, summit-level institution for short-term public relations success (Foster 2002, 2003, *East African* 2003). In this view of the G8 as an informal institutional failure, the G8's proper role is again broader than that of merely a UN supporter on health. But the G8's focus on other issues and its narrow audience lead it to fail. Thus, in the lead-up to the 2002 Kananaskis Summit, John Foster (2002) concluded that "other priorities and photo opportunities may transcend the issue of follow-up and fulfillment" on the G8's global health file.

A fourth school argues, in contrast, that the G8 is emerging as the global health governor of last resort, as a consequence of the poor performance of the old multilateral organizations and the high technical and economic capacity of members (Price-Smith 2001, 2002). This school sees the UN organizations as having failed in addressing the world's new health needs. It thus perceives the G8 as a useful supplement and the governor of last resort and gap filler for an inadequate WHO. Andrew Price-Smith (2001, 178-179) concludes that the G8's recent involvement in health stems from this weakening of the WHO, and from the G8's ability to pick up the pieces of the failed global health regime. He argues that the technical and economic capacity of the G8 will make it the most appropriate leader for the development of a badly needed "global disease containment regime."

A fifth school sees the G8 as the potential governor of globalization in the health field as a whole (Savona and Oldani 2003). It argues that the G8 has already forged the new path for global health governance for an era where globalized markets threaten to overwhelm states. Paolo Savona and Chiara Oldani (2003, 100) claim that the G8 began by providing leadership as a consultative forum in the oil crisis of the 1970s and has since become a global decision centre. The G8 is suited for global health governance because it adheres to the proper role of international organizations: "not to plunder nations' residual sovereignty but to recover some shares of it from the market on behalf of national authorities."

A sixth school views the G8 as the emerging centre of twenty-first century global health governance, due to the inclusive, multi-stakeholder model on which it is now based (Bayne 2000, 2001, Aginam 2004, 2005). Nicolas Bayne (2001, 34) attributes the G8's success in dealing with global health to its mobilization of "intellectual, human and financial resources from all available quarters — government, business, and NGOs active in the field." According to Bayne, the "most promising advance" of the Okinawa Summit in 2000 came in health, with the summit's call for a partnership to reduce the prevalence of AIDS, tuberculosis and malaria. This call was answered the following year at Genoa with the establishment of the Global Fund — a landmark initiative in its integration of governmental and non-governmental actors. Its task-oriented collaboration between the private and public sectors represents the model for the future of global health governance (Orbinski 2002).

Despite the growing diversity and dynamism of the debate, there has as yet been no full-scale analysis of the G8's actual performance in global health governance or of the forces that propel it in particular ways. Activists and analysts such as Lewis, Foster, and Labonte et al. focus on the many problems that remain rather than on the efforts made to provide solutions. They often ignore the G8 members' high compliance with the health commitments produced by the G8. Those such as Price-Smith who emphasize the mismanagement of funds by the WHO and the capacities of the G8 in disease containment do not explain how the highly politicized G8 can adequately address broader global health needs. Nor do they examine the actual performance of the G8 in global health governance to see if its members' capacities can handle the requirements of a multifaceted disease containment regime. Savona, Oldani, and Bayne highlight the G8's integration of private and public actors as its primary contribution. But they do not show how this drives successful performance by the G8 in providing global health. Nor has Bayne provided a detailed tracing of the process by which G8-centred multi-stakeholder networks produce the G8's many health deliberations, principles, commitments, and compliance.

This study presents the first systematic analysis of the G8's performance in global health governance. Part 1 defines health as a policy area within the G8, examines the G8's domestic political, deliberative, directional, decisional, delivery, and development of global governance

performance in health, and identifies the overall patterns that this performance has produced. Part 2 addresses the major causes of these patterns, exploring in turn the six factors highlighted by the concert equality model that has proven to explain G8 governance in other policy areas and overall (Kirton 2005a, 2004).

This analysis shows that since the onset of rapid globalization in 1996, the G8 has emerged as an effective, high-performing centre of global health governance across the board. This emergence has unfolded in several stages. In 1996 and 1997, under Franco-American leadership, the G8 summits moved to deliberate and decide on global health issues in a substantial way. In the years 2000-01, under Japanese and Italian leadership, the G8 became a permanent high-performing centre of global health governance, more than doubling its health deliberations and decisions, delivering its decisions to a very high degree, and starting to mobilize new money to this end. In 2002-03, under Canadian and French leadership, the G8 began to articulate new directions and produce new peaks in its deliberative, directional, decisional, and development of G8-led global governance performance. In 2005, it took a step-level jump in the new money it mobilized for global public health.

This rapidly rising G8 performance in global health governance has been led by almost all G8 countries, with each adding important components to the cumulative edifice when serving as Summit host. Such effective action by this concert of equals has been driven by those deeper forces that the concert equality model of G8 governance highlights. The most powerful cause has been the increasingly equal vulnerability of each G8 member to a new generation of infectious disease, as the early AIDS assault on America rapidly spread to all G8 members made Russia — recently recruited as a member of the G8 — the G8's most infected member and then proliferated across Africa, which secured major attention and attendance at G8 summits since 2001. In the face of this rapidly expanding global vulnerability, the old organizations of the UN system, led by the WHO, have proven increasingly ineffective. In contrast, the G8 countries alone possess the globally predominant and internally equal overall and specialized capabilities needed to combat the new diseases on a global scale. Their core common principles of open democracy and social advance bring them close to their newly democratic African partners and make them comfortable with the multi-stakeholder approaches most appropriate to combat the new generation of disease. Since 2001 the high political control at home of the popularly elected G8 leaders has allowed the same seven individuals to come to an unprecedented five summits in a row. Here they have met face to face each year with the same four core African partners in the still constricted and cozy leaders-dominated G8 club.

Looking ahead, the 2006 G8 Summit, hosted for the first time by Russia, will feature some new G8 leaders, and few if any African ones. But the position of Russia as the most vulnerable G8 partner should continue to propel the G8's emergence as an effective centre of global health governance in the years ahead. Indeed, Russia's choice of health as one of its three summit priorities suggests that G8 health governance may be greater than ever before (Panova 2005, Savostiyanov 2005). The rapid spread of avian flu globally and into Russia and other G8 countries, constitutes a second shock out of Asia after SARS. It has already led the Russian hosts to add avian flu to their 2006 St. Petersburg Summit agenda. The outstanding challenge is to ensure that Russia's G8 Summit builds on the particular strengths of the G8 as a centre of global health governance and deepens the G8's institutional capacity to deliver its promise in the years ahead. Developing a stand-alone comprehensive multi-stakeholder G8 health ministers institution and making Russia a member of the G7's Global Health Security Initiative (GHSAI) are important steps forward in this regard.

Part 1: The G8's Growing Health Governance

The new health paradigm that emerged in the 1970s expanded the dominant conception of health beyond disease or health care to include a host of related concerns. Health itself is thus defined here most basically as the human condition of being sound in body, mind, and spirit, and free from physical disease, infirmity, or pain. But health is also considered in its relationship with economy and society, as the heavy burden of HIV/AIDS in sub-Saharan Africa highlights. The complexities of human health are also seen in its influence on the politics of cross-border relations or its implications for bioterrorism, and other issues of particular concern to the G8.

In the G8 context, health can usefully be divided into two categories: core health, where health is the ultimate welfare objective, and health-related issues, where health is an instrument affecting other welfare outcomes. Core health encompasses the human condition of health, the presence or absence of life, disease, or pain, and the efforts made toward maintaining a healthy human condition. Core health issues thus include infectious diseases (such as HIV/AIDS, malaria, tuberculosis, polio), medical research, the healthcare system, improved health as a function of development (development for health), health promotion, medicine and treatment, global collaboration and resource mobilization for health, the current global health organizations (notably the WHO, UNAIDS, and the multilateral development banks), and bioterrorism. Health-related issues dealt with the specified ways in which health instruments affect outcomes on, or are affected by, other policy areas, such as debt relief (for the benefit of health systems in developing countries), information and communications technology (ICT) to improve healthcare facilities, or environmental issues (which affect human health).

This study analyzes the G8's health performance on both core health and health-related issues by assessing how the G8 has performed the six basic functions of international institutions. These functions are as follows: 1) domestic political management in member countries; 2) deliberating on specific global issues and setting the global agenda; 3) directing particular principles and norms to prevail; 4) deciding on clear, concrete, future-oriented, collective commitments or rules, with at least minimal levels of precision and obligation; 5) delivering on these commitments through subsequent implementing action that constitutes compliance; and 6) the development of global governance through creating or guiding international institutions to which future tasks can be delegated (Kirton and Kokotsis, 2003).

Domestic Political Management

At first glance, the domestic political management of the G8 in health has been a failure. The violent protests that erupted and the death of a protestor at the 2001 Genoa Summit highlight the growing disapproval of G8 summits by domestic publics in member countries (see Appendix A). On health specifically, there has been significant criticism in the media of the G8's handling of HIV/AIDS in Africa and the lack of sufficient funding from the G8.

However, the summits have also provided a positive domestic political image for leaders. U.S. president Bill Clinton's focus on Africa at Denver in 1997, which coincided with the beginning of his second term in office, allowed him to gain recognition and approval for his liberal politics. Canadian prime minister Jean Chrétien placed Africa on the agenda at Kananaskis in 2002 as part of his outgoing leadership legacy. Most recently, the virtually unanimous domestic media approval British prime minister Tony Blair received for his 2005 Gleneagles Summit was in part fuelled by its prominent attention to and action on African health (Kirton 2005b).

Deliberation

As an annual meeting group of leaders, the G8 summits inherently reflect the priorities of both individual leaders and the global priorities of the time. These priorities can be assessed by examining the publicly released collectively issued documents produced from the summits. The paragraphs on health contained in these documents show how health is dealt with in terms of a percentage of the total topics discussed by the G8 and of the amount of space allotted each individual topic within the health issue area (Appendices A, B, C, D).

There has been a steadily increasing interest in health since the subject first appeared on the G8's core agenda in 1982. This increase has been punctuated by six dramatic peaks that have lasted for one or two consecutive summits. In general, these peaks reflect a health environment that changes dramatically as new diseases suddenly emerge. This was the case with both AIDS and SARS, and when bioterrorism raised its international profile during both the 1991 and 2002 Iraq wars.

The first peak occurred with the introduction of health to the agenda in 1982. Health arose in relation to the use of biotechnologies to reduce disease (as well as famine and overpopulation) in developing countries (G7 1982). This reference represented the first step toward acknowledging the role the G8 could play in improving health facilities. It represented a large percentage of the overall agenda because of the relatively small size of the communiqué (only 20 paragraphs in total).

The second peak occurred with the Venice Summit in 1987. Here the Italian host released the "Chairman's Statement on AIDS," a four-paragraph separate statement calling for greater support of the WHO's programs (G7 1987). Although an oral statement had been made by the chair at London in 1984 on the subject of cancer, this was the first separate publicly released document pertaining entirely to health.

The third peak came in 1990 and 1991 with the emphasis on biological weapons. Although more part of the health-related rather than core health agenda, the threat of disease outbreaks from bioterrorism was highlighted as a result of the war with Iraq and the concerns over Iraq's biological weapons program. Another driver was the timely review conference for the Biological Weapons Convention that took place in September 1991.

The fourth peak was in 1996 and 1997 as the summits changed their focus from health issues that directly affected the G8 to a more global orientation. The 1996 Lyon Summit produced substantially more paragraphs on health than any previous summit (nine of 296 total paragraphs). This text focused on the need for restructuring the WHO, in particular dealing with HIV/AIDS and other infectious diseases. By Denver in 1997 infectious diseases in the developing world took centre stage (WHO 1997). Although there was a subsequent slide, health commitments remained strong in 1998 with Britain's "Rollback Malaria" initiative taking the spotlight at Birmingham.

The fifth peak came in Okinawa in 2000. It came with a bang, led by the greatest percentage of paragraphs on core health for any summit in the G8's history. Okinawa focused on health in developing countries, and acknowledged for the first time the link between health and poverty. It declared: "Health is key to prosperity. Good health contributes directly to economic growth whilst poor health drives poverty. Infectious and parasitic diseases, most notably HIV/AIDS, TB and malaria, as well as childhood diseases and common infections, threaten to reverse decades of development and to rob an entire generation of hope for a better future. Only through sustained action and coherent international co-operation to fully mobilize new and existing medical,

technical and financial resources, can we strengthen health delivery systems and reach beyond traditional approaches to break the vicious cycle of disease and poverty" (G8, para. 26).

The Okinawa Summit also saw the commitment to a "new global partnership" to reduce the prevalence of HIV, tuberculosis, and malaria. This became the Global Fund that was created at Genoa in 2001 (Zupi 2001). Despite the significance of the health issue area at Okinawa, attention slipped subsequently until Evian 2003.

Pushed by the implication of the SARS outbreak of 2002-03 and a renewed initiative to eradicate polio, Evian represented the sixth peak in the G8's health agenda and attention. The summit saw the release of an entire collective document (out of 15 in total) devoted to health issues. Health had become a major component of the G8's social agenda, comprising a significant portion of the leaders' deliberations.

The health peak of 2003 was, like the others, short lived and driven by the year's health preoccupation of SARS. Although the number of paragraphs devoted to health and health-related issues in 2004 was higher than the peak of 2000, the percentage of health in the overall agenda was the lowest it had been since 1998 at 5.4 percent. (The peak of 2000 had been higher than 14 percent, while 2003 had come in at 11.6 percent.) Moreover, the fight against AIDS showed a dramatic turn toward the role of medical research and pharmaceutical companies in finding an AIDS vaccine and away from the more urgent needs of AIDS treatment and prevention required by individuals in sub-Saharan Africa and other high prevalence areas. In addition, following the 2002 Iraq war's focus on weapons inspections and terrorism, biological weapons once again became a major component of the health-related agenda.

Direction Setting

As a group composed of the eight most influential countries, the G8 has a large role in setting the principles, norms, defining ideas, and epistemes that guide global governance. These principles are highlighted in the introductory paragraphs and chair's summary or "chapeau" of the summit communiqués. They offer a reflection of the central thoughts and ideas that guide the leaders' meetings and discussions over the course of the summit and the direction they wish the global community to follow.

During the twentieth century neither health nor health-related issues had ever been mentioned in the summit chapeaus or introductory paragraphs. This changed with the twenty-first century move to issuing a chair's statement as the summit's defining capstone document, reflecting only what the leaders actually discussed. Within the chair's statement, health principles started to appear (Appendix E). The process culminated at the 2005 Gleneagles Summit, where health, in relation to Africa, was given a prominent place.

The twenty-first century priority principles centred on the need for more funding, research, international co-operation, and accessible, affordable medicines for Africa in the fight against HIV/AIDS, polio, malaria, tuberculosis, and SARS, and healthcare reform within the G8. While there was a hint that health for the poor would trump trade values, there was no recognition of health for security or health as a human right (Labonte and Schrecker 2004, 226).

Decision Making

The G8's collective decision-making performance is seen in the number, appropriateness, and ambition of the collective commitments made. Commitments are defined as "discrete specific,

future-oriented, measurable, publicly encoded commitments, often with specified instruments, outcome targets, and timetables or deadlines attached" (Kirton and Kokotsis 2002, 9). As Appendix F demonstrates, health commitments represent 5.5 percent of the total commitments made at the summits from 1975 to 2005. The G8 has been a consistent producer of health commitments since 1996. Following the fourth peak in attention to health that began in 1996 in agenda attention, the G8 has moved beyond merely discussing the issue of health to making clear commitments aimed at change in the global health system.

Prior to 1996, the number of health commitments made by the G8 was insignificant. The single commitments appearing in 1983, 1986, 1991, and 1993 accounted for a very small portion of the total output. These disparate single commitments were somewhat random. This makes the shift in priorities at Lyon in 1996 toward a clear health agenda accompanied by commitments stand out. Since Lyon, an upward trend in commitments shows a sustained and growing G8 interest in health. The summits of 2002 and 2003 produced the highest ratio of health commitments to date.

The progression from the beginning of the upward slope in 1996 to the peaks of 2002 and 2003 was a slow development, both in the number of commitments and in the significance of the commitments themselves. In the period building up to Kananaskis and Evian, Bayne noted the low ambition of the commitments made. Bayne (2002, 147) judged that "in general, the Genoa documents set out clear diagnoses of the problems addressed. But often the G7/G8 response is not to take new policy measures or to provide new resources, but only to intensify exiting actions and coordinate them better."

However at Evian, the tide changed. Not only did the number of health commitments increase, but the significance of these commitments also expanded with a stand-alone health action plan included in the summit documents. While the Evian Health Action Plan focused on "welcoming" and "supporting" other initiatives pertaining to HIV/AIDS, it also made a strong commitment on policy change or resource commitments in providing developing countries with access to essential medicines, vaccine development, and fighting polio. A total of US$500 million was mobilized for polio at the summit, representing the first financial commitment on health to come since the establishment of the Global Fund.

The peaks of Kananaskis and Evian diminished at Sea Island, where the number of commitments on health dropped from 21 commitments (10 percent of the total commitments) to 12 (5 percent). Yet they were narrowly focused on two issues: eradicating polio and developing an HIV/AIDS vaccine. Moreover, Sea Island was the first summit since 1996 where all the commitments made were either aimed at a leading international organization or an independent initiative. No commitments called for the direct support of other initiatives or institutions. The 12 commitments made at Sea Island therefore represent a more directed focus on health issues and a desire to take control of these specific issues. Rather than representing a move toward overall leadership in global health, they seemed to reflect a desire by the G8 to fill the gaps, whether technical or financial, in the specific areas it saw as lagging in development and to provide governance when the present institutions were found lacking.

Delivery

The delivery function of the summit refers to the G8's performance in fulfilling its commitments on the level of an individual country. Assessment of G8 delivery can be conducted in two ways. The first is an examination of key compliance precursors and implementing instruments such as new money mobilized (see Appendix G and H). The second is the actual compliance of G8

members with their collective commitments through a broad range of behaviour in the year after they were made (see Appendix I).

According to the G8 Research Group's compliance data, as supplemented by special studies directed at Africa and health, the G8's compliance with its health commitments at recent summits has very high. It produced the unusual event of perfect compliance with the priority health commitments at Okinawa in 2001.

The assessment of delivery can be divided into two areas: the adherence of the G8 to its commitments through policy changes and other implementing action, and the money it has mobilized in support of its goals. As arguably the most significant G8 health commitment to date, the Global Fund offers a firm foundation for an assessment of both of these areas. The summit documents had not recorded any money mobilized for the Global Fund since the initial start-up grant of US$1.3 billion (see Appendix G and H). Yet compliance with significant, non-financial commitments made to the fund have been high, such as the promise to participate actively in donor and support conferences made at Evian. This was complied with by every G8 country and specifically resulted in increased pledges to the Global Fund by France and the UK (G8 Research Group, Kirton, and Kokotsis 2003, 2004).

In the years immediately following the Global Fund's establishment, there was significant criticism of the lack of financial support provided by the G8. Bayne (2003, 237) observed that at Kananaskis "the leaders ignored the funding pressures on the Global Fund to Fight AIDS, Malaria and Tuberculosis, which they had launched only the year before…the fund already needed replenishment but the leaders made no move to do this." However, although the summit commitments made to the Global Fund have not included concrete financial targets, the G8 nations have improved their donations to the Fund significantly since 2002. This improvement can be seen in an assessment completed by a group of researchers from three international NGOs who have put together an "Equitable Contributions Framework" (see Appendix F). The framework assesses individual country performance by first establishing an appropriate contribution per country for the Global Fund based on a proposed contribution of 0.035 percent of GDP and then tracking the actual contributions made against this framework.

In 2002 the framework showed that none of the G7 countries had come close to reaching the proposed targets, with the United States and Japan having especially abysmal records with marks of 13 and 12 percent respectively. Italy (57 percent), the United Kingdom (44 percent), and Canada (41 percent) were better than average but even so, the funding requests received by the Global Fund far exceeded these contributions (AIDSPAN 2002). As shown in the table in Appendix F, by 2004 this record had improved substantially. The U.S. was now at 117 percent of its recommended contribution for 2004, the UK had reached 140 percent, and Italy led the way with 430 percent of the recommended level. Not as significant but still showing some improvement, Canada and Japan were lagging behind with 51 and 33 percent respectively.

More recently, at a pledging conference on September 6, 2005, US$3.7 billion was pledged to the Global Fund for 2006-07. The list was led by G8 members, with France at US$600 million, Japan at US$500 million, and Britain at US$375 million. The G8's total had risen from US$1.3 billion in 2001 to over US$2.8 billion in 2005 (see Appendix F).

The Development of Global Governance

The final performance dimension is the development of institutions to deal with relevant issues, in this case on health. As seen in Appendix D, from 2002 onward, the G8 has moved from

supporting or directing the G8 system to taking initiatives to build instruments and institutions on its own. The majority of health institutions created at the hands of the G8 have occurred since 1996, consistent with the other functions and the blooming health focus of the time (see Appendix J). However, two institutions on AIDS were established prior to 1996: the International Ethics Committee on AIDS in 1987 (consistent with the agenda focus on HIV/AIDS during the same year) and the Group of Experts on the Prevention and Treatment of AIDS in 1992.

The G8's earlier disregard for health could be explained by the presence of the WHO, as the official body for global health governance, to which the G8 deferred. This connection is supported by the common occurrence of the WHO in summit documents. All of the summits with major health commitments have included calls for support of the WHO's activities. and the "important role" of the organization in combating the world's diseases is frequently mentioned. Overall, the G8 has played a supportive role toward the WHO and other international organizations more frequently than it has taken leadership in global health governance, as shown in Appendix F.

With the establishment of the Global Fund to Fight AIDS, Malaria, and Tuberculosis in 2000, the G8 began a period of increased institutionalization, establishing four other institutions in the years following and beginning annual health ministerial meetings in 2001. The particular health focus of each of the institutions created has been relatively diverse, ranging from the health security to infectious disease. However, three distinct areas of sustained institutionalization appear. First, in 2002 and 2003, immediately following SARS, three institutions were created that focused specifically on the containment of disease outbreaks and establishing better international co-operation. Second, HIV/AIDS has seen substantial G8 governance both through the establishment of the Global Fund in 2000 and the creation of a Global HIV Vaccine Enterprise in 2004. Third, the ministerial meetings were established with the intention of dealing with the issue of biological warfare and security, and yet the post-SARS agenda has shifted its attention to the containment of potential disease outbreaks.

In contrast to the more issue-defined institutions inspired by the G8, the ministerial meetings have shown tremendous flexibility in responding to current health needs. It is clear that the events of 911 and the following concerns over anthrax as a biological weapon led to the initial establishment of the first ministerial meeting on November 7, 2001. The second health ministerial followed up on this and the concerns over terrorism at the time of the Iraq war in March 2002. However, with the outbreak of SARS at the beginning of 2002, the ministers quickly shifted their focus by holding another meeting on December 6, 2002, which produced a substantial document on global disease security.

The Pattern of G8 Performance

The overall pattern of performance of the G8 in health has been a matter of analysis for several scholars, especially with the higher profile it has enjoyed over the last few years. In Bayne's annual assessments of the G8, the health issue area received the highest grade for the establishment of the Global Fund at Genoa in 2001 (see G8 Information Centre website). The University of Toronto's G8 Research Group gave A grades to both Denver and Okinawa on health. The broad picture becomes clear when the overall pattern of performance represented by each of the six functions is shown (see Appendix K).

The G8 became a global health governor at an early stage. Prior to 1996, while there was certainly a lack of any clear focus on health during these years, the overall pattern of activity on health shows interesting connections to emerging health concerns, and not just in terms of

deliberation. The rising awareness of HIV/AIDS in the mid 1980s led to the Chairman's Statement on AIDS in 1987 and to the formation of the International Ethics Committee on AIDS. Both Iraq wars have led to increased agenda attention on bioterrorism and biological weapons.

The post-1996 period was defined by a more external focus, one that took on a fully international health agenda with the introduction of diseases primarily affecting the developing world, such as Ebola and cholera. This period of international health is characterized by a drastic improvement in the summits' performance, beginning with the introduction of global health at Lyon. Lyon saw four commitments, when previously only single health commitments had been made, and truly brought the health issue area to the summits for the first time. However, the pattern of health performance did not consistently improve from one summit to the next and a few summits stand out during this time of high health performance.

Okinawa in 2000, given an A+ by the G8 Research Group, was extremely strong in its deliberation (30 mentions of health on the agenda), decisional (11 health commitments), and compliance (a perfect score by all nations) functions. Consistent with the focus on international health, Okinawa brought guinea worm and onchocerciasis (river blindness) to the G8's agenda, diseases virtually unheard of in G8 countries. As the strongest summit to date, Evian saw sweeping success in almost all functions; infectious diseases and treatment (specifically AIDS in the developing world) was the major focus of the core health agenda being backed up by clean water and sanitation in the health-related agenda. Sea Island maintained this correlation between high performance and an international health agenda, despite a slight drop in the number of commitments made. It mobilized US$3.3 billion for the eradication of polio and health.

Part 2: Causes of the G8's Growing Health Governance

The G8's overall performance in health is characterized by an increased performance in the years of major health crises as well as the drastic improvement in health performance since Lyon 1996. This rapidly rising G8 performance in global health governance has been delivered through the leadership of all G8 countries, with each adding important components to the cumulative edifice when each has served as summit host. In an effort to uncover some of the reasons behind this pattern of behaviour and gain a deeper understanding of the factors that lead to high performance by the G8, this section builds on the existing theories by looking at six causal factors specified by the concert equality model of G8 governance and applies them specifically to international health. These six factors are the shared health vulnerability of G8 members, the diminishing health performance of other international organizations, the equalizing capability of G8 members, health as a common principle between G8 members, political control and capital, and the constricted participation and membership of the G8.

The Intensifying Equal Health Vulnerabilities of the G8 and the World

The most powerful cause of the G8's growing health governance has been the increasingly equal vulnerability of each G8 member to a new generation of infectious disease, as the early AIDS assault on America has rapidly spread to all G8 members, made the recently recruited Russia the leading source of new infections within the club, and spread in an Africa that has become the dominant agenda priority and attending partner of the G8 summits since 2001.

Vulnerability to health threats can be assessed by demonstrating whether or not each of the G8 member nations are equally vulnerable to the issue and therefore share a common incentive to act.

A strong single measure of vulnerability is the number of new infections of the primary new generation disease, HIV/AIDS, in each of the G8 countries (see Appendix L).

The data show that the G8's growing health governance was a direct, rational response, by G8 members to the physical vulnerability of proliferating new infections within and across their societies. Yet it was also punctuated by a psychological vulnerability, as the governors and publics in G8 countries were shocked into greater action when important physical thresholds were crossed (Picard 2003).

The physical assault began first in the United States, Canada, and France in the early 1980s. By 1985, for the first time, all of the G7 countries recorded new incidents of HIV/AIDS. By 1987 the number of cases was quickly mounting in almost all G7 countries. At the time, the U.S. was taking the brunt of the disease burden, with the number of newly infected individuals in America skyrocketing to 28,599 in 1987. Compounding the physical assault was a psychological one, for AIDS had begun to cause widespread panic in the American public as the disease itself was still largely mysterious to medical researchers.

Driven by this rise in AIDS cases and public anxiety, the 1987 summit introduced AIDS and infectious disease to the leaders' collective documents. The chairman's statement highlighted the vulnerability the G7 felt to the disease by speaking to the severity of the disease, addressing the panic it was causing in the public by calling for increases in public education and asking the medical community to further studies for prevention and treatment. In 1987 HIV/AIDS was perceived as an issue requiring immediate G7 attention, as it was the only infectious disease the G7/8 leaders would discuss prior to Denver in 1997. And it was the shock of this initial vulnerability, rapidly spreading equally among all G7 members. that brought AIDS to the G8 agenda. Indeed, HIV/AIDS was only mentioned once more at the summits before 1996.

During the 1990s the physical assault on all G7 countries from HIV/AIDS continued. The peak number of new cases a year came for the U.S. in 1993, France in 1994, Italy and Canada in 1995, and Germany in 1996. With a majority of G7 members now so severely afflicted, HIV/AIDS returned to the summit agenda in a major way and never left again. In 1996 the G7 summit added to HIV/AIDS as a subject of attention the equally mysterious diseases of Ebola, as well as the merely exotic ones in G7 countries of malaria, TB, cholera, and pneumonia. This broadening was consistent with a new fact and fear that intensifying demographic globalization was bringing the old diseases still prevalent in poorer countries into a long secure G8. At the same time, where fact and familiarity were high and fear was low, the G8 left the diseases alone. Persistent diseases, which account for significant deaths in G8 nations, such as cancer and heart disease, received almost no attention at the summits.

By 2001, the G8 crossed three new physical thresholds — a new peak in the average number of new infections across all G8 countries, in Japan, and in the G8's newest member, Russia. In the U.S., the declining incidence of new cases stopped in 2000 and started a slow rise again. Indeed, in 2001, the number of new cases in Russia jumped up to 88,253, the highest number ever recorded in any year for any G8 country, including the U.S. itself at its 1993 peak.

The years 2002-03 brought a second shock from a new source, in the form of SARS. Although the Asian-bred disease exempted the United States, it struck hard in its deadly form in its two G8 Pacific partners, Canada and Japan, while infecting Russia as well. It drove home the deadly lesson that even advanced G8 countries with world class and well-funded healthcare system were vulnerable to diseases that developed in very poor countries, and that were half a world but only one plane ride away from home. While SARS saw rather low levels of morbidity and mortality,

its unknown cause and cure created a compounded sense of shock and panic, and relatively high level of agenda attention after the first outbreak in 2002. The impact of the awareness SARS created for global collaboration was clearly felt at the summits. In 2003, the year following the 2002 SARS outbreak, the G8 at Evian produced the highest summit on record in both health deliberation and commitments; two institutions were established, money was mobilized, and compliance was higher than average. It can be concluded from this pattern that emerging health threats and the public concern surrounding them have been largely responsible for introducing new health issues to the G8 agenda during this initial period.

The shock of SARS thus drove home a further recognition of reality: the vulnerability of the global health system itself in an age where national defence at the border by sovereign territorial Westphalian major powers was virtually irrelevant.

The Poor Performance of the Old International Health Organizations

The second cause of the G8's growing health governance has been the poor performance of the old organizations of the UN system, led by the WHO, in the face of this rapid proliferation of vulnerability from the new diseases on a G8-wide and global scale (Cooper 1989, Howard 1989, Zacher 1999).

The vulnerability of the global healthcare system in this new era has been highlighted by scholars who have called for stronger international collaboration, including David Fidler (2002, 2003), Ilona Kickbusch (2003), and Andrew Price-Smith. In her evaluations of the WHO, Ilona Kickbusch (2000, 983) has emphasized how the old system has been overwhelmed by several forces: "the increasing number of actors in the international health arena; the increasing privatization of medical care and the growing global health care market; increased importance of health intelligence, data and surveillance for economic development and trade; increased feeling of threat through new and reemerging diseases; and increased awareness of health as a human right."

This constellation has led to conflicts between global governance institutions and private industry, such as the debate over access to essential medicines for HIV/AIDS in Africa. There is an inherent instability as the number of actors on the global health stage increases without the mechanisms necessary for increased collaboration. The result is that either emerging diseases go unnoticed or there is not the necessary cross-sector collaboration between national health systems and the pharmaceutical companies responsible for vaccine or antidote development, as has been the case with river blindness.

The G8's adoption of issues such as river blindness sought to fill the gap in collaboration and address this vulnerability of the global governance system. At Kananaskis, the G8's Africa Action Plan referred to "supporting relevant public-private partnerships for the immunization of children and the elimination of micro-nutrient deficiencies in Africa" (G8 2002, para. 6.3). The deliberation on public health issues at the summits has focused on building these types of private-public partnerships and attempting to build trust among the actors in global health.

Such gap filling efforts were propelled most powerful by the failure of the old international health organizations, notably the WHO and UN. The financial reports contained in the WHO World Health Assembly documents reveal that in the years between 1996 and 2001, as the HIV/AIDS pandemic proliferated throughout the G8 and the globe, the budget of the WHO did not undergo its usual biannual increase. At this time G8 health performance grew strongly. There was also a post-1995 increase in G8 agenda attention on support for the WHO and UN systems.

This period was also a time of increased attention to HIV/AIDS by the G8, an issue for which the WHO has received widespread criticism both from within the organization itself and from the larger international community. To be sure, with current infection rates now exceeding 40 million worldwide, it is clear that no international institution is doing enough of the right things in responses. Yet it is not surprising that there are those who are critical of the WHO's response. Moreover, those within the UN system have also recognized that its own internal failures in handling the crisis have contributed in part to its severity: "we have to admit that the way global targets were set is not conducive to success simply because the HIV pandemic was acknowledged but not internalized" (Jan Vandemoortele of the United Nations Development Programme, quoted in Foster 2003). In an overt display of its lack of confidence in the WHO's handling of the AIDS crisis, the UN itself took the Global Programme for AIDS, which was the WHO's largest program, out of the WHO's sole control in 1993 (Godlee 1994, 7). It created UNAIDS instead.

Responding to the WHO's perceived inadequacies, the G8 first focused on making commitments that supported the organization in its efforts, as well as taking independent initiatives of its own. Yet by 2001, the G8 came to the conclusion that support for a failing UN system was in vain. An Italian presidency document released at the Okinawa Summit stated: "The experience matured in the past twenty years demonstrates that aid provided by the international community has contributed to a significant improvement in the health conditions of millions of people. However, at the beginning of the third millennium, 'Health for All' targets agreed upon in 1978 have yet to be reached; today, 880 million people are excluded from the most basic access to care and public services" (section 1.3).

High G8 Health Capability

The third cause of growing G8 health governance is the globally predominant and internally equalizing capability of club. In sharp contrast to the limited capacity and poor performance of the old multilateral organizations, the G8 countries increasingly possess the globally dominant share of the overall and specialized capabilities required to combat the new diseases, and share these among G8 members in a way that enables and requires all to contribute in a materially meaningful way.

A correlation between high G8 health performance and an increase in the global predominance and internal equality of the G8 members' capabilities (as demonstrated in health by each country's annual health care budget, the number of health facilities, etc.) further helps explain performance variations. The G8's global predominance is highlighted by a comparison of G8 healthcare spending (as outlined in Appendix M) and the healthcare capacity of the developing world. Several developing countries are unable to adequately address their own health needs. The disease burden of these countries has profound impacts on their economic capacity and therefore ability to improve the situation. According to the WHO, "analysis of data from thirty-one African countries during the period 1980 to 1995 showed that the annual loss of economic growth due to malaria has been as high as 1.3% per year" (Brundtland 2000). For G8 nations — the primary development loan providers — this presents an economic load as well as a healthcare burden.

According to the World Bank (2001) statistics, the average health expenditures per capita for developing countries is US$72.4, and for the poorest of the poor in sub-Saharan Africa this number is US$29.3. The Commission on Macroeconomics and Health predicts the financial need for health services in developing countries will reach US$27 billion by 2007. On the other hand, as shown in Appendix L, the G8 average for 2001 was an expenditure on health care of US$1,492

per capita. U.S. spending on the 2003 Iraq war alone exceeded US$87 billion, more than three times the health service needs of developing countries.

This disparity in healthcare budgets and the economic burden that has resulted from the proliferation of disease in the developing world can partly explain the focus on international health since 1996. This is where the greatest need meets a great capacity. The need itself has become more apparent in recent years as AIDS has taken hold of Africa and other developing areas, and each of the G8 nations is certainly capable of providing improved financing for healthcare needs. However, despite the capacity of the G8 to deliver on health care the total money committed to health at the summits combined is an insufficient US$4.9 billion (less than one fifth of projected needs). Promises for official development assistance (ODA) on health outside the G8 structure only accounts for US$6 billion (Commission on Macroeconomics and Health 2001).

The G8's Common Principles of Open Democratic Health

The fourth cause of the G8's growing health governance is the institution's shared common principles of open democracy and social advance. These core values bring the G8 members ideologically closer to their new African partners embracing democratic development and fuel the functionally appropriate, multi-stakeholder approaches most appropriate to combat the new generation of disease.

In theory, health as a principle shared by the G8 leads to higher performance in deliberation and decision making as all the members see the equal value of handling health concerns at the summits. As shown by the World Bank's statistics for the percentage of GDP spent on health care by the G8, health represents a relatively equal preference in country budgets with an average of 9.15 percent (2001) (see Appendix M). Yet again, while these data provide evidence of the shared principle of domestic health care, it does not provide evidence for the G8's international focus, which has defined the years after 1995.

G8 Leaders High Political Control and Capital at Home

A fifth cause of growing G8 health governance is the fact that since 2001 the high political control at home by the popularly elected G8 leaders has allowed the same seven individuals to come to an unprecedented five summits in a row (Bayne 1999).

Political control is measured by the number of years the respective leaders have held their positions and where they are in their election cycle — inferring that leaders with a fresh mandate have maximum political control (Kirton and Kokotsis 2003). This was the case with Tony Blair and the Rollback Malaria initiative, which was brought to the summit by Britain in 1998, the year following his election as prime minister. However, Blair's enthusiasm at the beginning of his term produced a rather weak summit in health overall and it does not explain the peaks of deliberation and decision making that occurred in 2000 and again in 2002-03.

This being said, the political control of G8 leaders can explain G8 health performance through a slightly different reasoning than that originally presented by Kirton and Kokotsis. In light of the two health peaks, it becomes apparent that such trends have tended to occur during the secure years between elections or at the end of a leader's final term. In 2000 the particularly significant peak in health performance occurred as Clinton attended his last summit, and the summit's success can be attributed in part to his desire for legacy and to an all-encompassing effort domestically and internationally to push forward the agenda items he had previously been holding

off on for the sake of popular support. The 2002 Kananaskis Summit's high deliberation and decision-making functions coincided with the outgoing leadership of Jean Chrétien, the summit's host for that year. The Sea Island Summit's focused deliberation and decreased decision making is also consistent with this pattern, as George Bush was going into a very tight race for his second term later that same year and needed to be seen as conservative as well as effective in his commitments.

Overall, this pattern demonstrates that health is a contentious issue domestically, but that it is also important enough to warrant attention when leaders feel they are secure. Although leaders have not been willing to risk their political control by promoting multilateral involvement in international health issues, at times of stability health issues have gained strength in deliberation and decision making.

The Constricted Participation of the G8 Leaders' Club

A sixth cause of growing G8 performance in global health governance is the fact that the G8 summit-driven institutional system has allowed the same G8 leaders to meet face to face on an annual basis with the same four core African partners in the still constricted, G8 club, and reach out to other stakeholders at the ministerial and official level below.

Constricted participation among a select few influential leaders does not appear to explain health performance by the G8. Instead, the evidence points to its opposite — at period of high performance, participation was increased with more input from and dialogue with international health players, including health NGOs and the WHO. Rather than being a detriment to summit performance, health performance has benefited from this involvement and led to greater deliberation, decision-making and compliance.

In his assessment of the Genoa summit, Bayne (2002, 147) discusses the inroads the G8 has made in integrating external actors into the summit process. Since the Birmingham Summit in 1998, additional actors have been accommodated by the summits. The peak of performance at the Okinawa Summit in 2000 coincided with actions by the Japanese chair to consult informally southern countries over the course of the summit. Okinawa saw a higher level of commitments than ever before; it is on record for being the highest summit in deliberation, and the only summit with perfect compliance. Bayne says that by Genoa the G8 had demonstrated its progress in "involving both private firms and non-profit bodies in summit preparation and follow-up."

The involvement of additional participants in G8 health ministerials also supports the contribution of expanded participation to health performance. As detailed in Appendix H, the 2003 health ministerial was attended by Mexico (which has always attended the health ministerials) and the director general of the WHO as external participants. This ministerial was the most productive in terms of both deliberation (assessed by the number of paragraphs produced in the official statement, which totalled 18) and the breadth of issues touched upon (while previous ministerials focused on bioterrorism and health security, 2003 was the first time naturally occurring diseases such as pandemic influenza were mentioned).

One of the reasons for the increases in performance as a result of expanded rather than constricted participation could be the unique terrain that is being negotiated in global health. As Kickbusch (2003?) observed, there are increasing numbers of actors participating in global health governance; non-government organizations (NGOs) have made their voices heard across the international arena and have shown considerable power of persuasion in influencing public opinion and public policy. For example, the Médecins Sans Frontières campaign for access to

essential medicines has played a significant role in altering policy on drug access and the International Baby Food Action Network's global campaign in the 1980s led to the International Code of Marketing on Breast-Milk Substitutes (Fidler 2003, 54). Multinational corporations (MNCs) have also demonstrated their influence as non-state actors in affecting public policy. For example, the lobbying of the U.S. government on the part of pharmaceutical companies has been a major impediment to progress in providing access to antiretroviral drugs for developing countries. The need for the involvement of these players in global health governance is clear and in 2000 and 2003 especially the G8's success in performance appears to be tied to its ability to embrace this reality.

Conclusion

Globalization has brought several complexities to the global health governance arena. The paradigm of health has changed, moving toward a definition that includes a breadth of socioeconomic factors and global targets of health for every individual. There are more players on the field, with health NGOs and MNCs looking to have their say in the decision-making process of global health policy development. And in this era of frequent air travel, the stakes are higher than ever as an infectious disease can travel from one continent to another in a matter of hours. The G8, as an international institution led by an annual summit where leaders can comprehensive address all policy areas across international and domestic domains, and make the connections among them, is well designed to generate the desired global health governance for this new world.

In their annual summits, the G8 has brought health issues to the table in order to arbitrate on the new realities presented by globalization and assist the WHO in its efforts to contain the world's diseases. The first germ of the health issue area on the G8's core agenda appeared out of a rising panic over HIV/AIDS and the apparent threat it posed to the U.S. and Europe. Other health concerns have also come onto the agenda out of public panic over infectious disease, such as SARS and bioterrorism. The six peaks that have occurred in agenda attention reflect the contribution health crises have had in steering the G8's focus.

A shift took place at the Denver Summit in 1996 as the G8 moved away from dealing with health sporadically whenever there was a crisis and began a more focused period of international health governance. This focus on international health continues into the present and has become a sustained period of high performance in several of the G8 assessed performance functions, especially deliberation, decision-making and compliance. Evian in 2003 was the highest performer in all these functions, with an entire collective document devoted to health issues.

Some of the reasons for this sustained period of attention and the numerous commitments that have been made on diseases that do not affect the G8 countries themselves have been explained in assessing several causal variables for the actions of international organizations. The perceived weakness of the WHO, as the leading international health organization, has opened the door for other global organizations, especially those that can facilitate collaboration between the range of participants in the global health system, such as the WHO. The flexibility of the G8 to expand the participants included in its deliberations to NGOs, MNCs, and the existing health organizations has been a great asset in its ability to achieve its health goals.

Overall, the G8 has demonstrated a strong performance in health leading to the invention of the Global Fund to Fight AIDS, Malaria and Tuberculosis as one of its major achievements, which now enjoys substantial financial and political support worldwide. As impressive as its

performance in international health has been, however, it needs to be qualified against the huge gaps in healthcare funding that exist in developing countries and the large capacity the G8 possesses for addressing these gaps. The strengths the G8 can contribute to assisting the WHO in achieving its highly ambitious goal of health for all are significant in helping to define a new global health governance system for today's intensely interconnected globalized world, where deadline disease is just one plane ride away anywhere on earth.

Thus, since the onset of rapid globalization in 1996, the G8 has emerged as an effective, high-performing centre of global health governance across the board. This emergence has unfolded in several distinct stages. In 1996 and 1997, under Franco-American leadership, the G8 summits moved to deliberate and decide on global health issues in a substantial way. In 2000-01, under Japanese and Italian leadership, the G8 became a permanent high-performing centre of global health governance, more than doubling its health deliberations and decisions, delivering its decisions to a very high degree and starting to mobilize new money to this end. In 2002-03, under Canadian and French leadership, the G8 began to articulate new directions, and produce new peaks in its deliberative, directional, decisional, and development of G8-led global governance performance. In 2005, it took a step-level jump in the new money mobilized for global public health.

This rapidly rising G8 performance in global health governance has been led by almost all G8 countries, with each adding important components to the cumulative edifice when serving as summit host. Such effective action by this group of equals has been driven by those deeper causes that the concert equality model of G8 governance highlights. The most powerful cause has been the increasingly equal vulnerability of each G8 member to a new generation of infectious disease, as the early AIDS assault on America rapidly spread to all G8 members, made the recently recruited Russia the most infected member and proliferated across an Africa that secured major attention and attendance at G8 summits since 2001. In the face of this rapid proliferation of vulnerability, the old organizations of the UN system, led by the WHO, have proven increasingly ineffective. In contrast, the G8 countries alone possess the globally predominant and internally equal overall and specialized capabilities needed to combat the new diseases on a global scale. Their common principles of open democracy and social advance bring them close to their newly democratic African partners and make them comfortable with the multi-stakeholder approaches most appropriate to combat the new generation of disease. Since 2001 the high political control at home of the popularly elected G8 leaders has allowed the same seven individuals to come to an unprecedented five summits in a row. Here they have met face-to-face each year with the same four core African partners in the still constricted and cozy leaders-dominated G8 club.

Looking ahead, the future of global health governance could well be defined by the path set by the striking contrast between two summits in the summer of 2005. On July 6-8, leaders met with their African and systemically significant partners at Gleneagles and issued a document that put health in a prominent place. Two months later, on September 14-15, more than a hundred world leaders met at the UN in New York to issue a document that in its priority passages noted the value or existence of health not at all (UN General Assembly 2005). In there overall documentary output the Gleneagles G8 devoted 15 paragraphs to health, and the New York UN leaders only 10. Diseases such as polio made the G8 but not the UN list. There are thus good grounds for looking to the G8 as the primary global health governance platform on which to innovate in the years ahead.

The G8 seems prepared to respond to the challenge. To be sure, the 2006 G8 summit, hosted for the first time by Russia, will have some new G8 leaders, and fewer if any African ones. But the position of Russia as the most vulnerable G8 partner should continue to propel the G8's

emergence as an effective centre of global health governance in the years ahead. Indeed, Russia's choice of health as one of its three summit priorities suggests that G8 health governance may be given more prominence than ever before (Panova 2005, Savostiyanov 2005). The rapid spread of avian flu globally and into Russia and other G8 countries, constituting a second shock after SARS, has already led the Russian hosts to add avian flu to their St. Petersburg Summit agenda. The outstanding challenge is to ensure that Russia's G8 builds on the particular strengths of the G8 as a centre of global health governance, and deepen the G8's institutional capacity to deliver its promise in the years ahead. Developing a stand-alone comprehensive multi-stakeholder G8 health ministers' institution (perhaps along the lines of the North American Commission for Environmental Cooperation) and making Russia a member of the G7's Global Health Security Initiative are important steps forward in this regard.

References

Aginam, Obijifor (2005), *Global Health Governance: International Law and Public Health in a Divided World* (University of Toronto Press, Toronto).

Aginam, Obijifor (2004), "Salvaging Our Global Neighbourhood: Critical Reflections on the G8 Summit and Global Health Governance in an Interdependent World," *Law, Social Justice, and Global Development Journal* vol. 1 <ejl.warwick.ac.uk/global/04-1/aginam.html>.

AIDSPAN (2002), "Equitable Contributions Framework for the Global Fund, Based on GDP," <www.aidspan.org> (April 2004).

Bayne, Nicholas (2003), "Impressions of the Kananaskis Summit, 26-27 June 2002," in Michele Fratianni, Paolo Savona and John Kirton, eds., *Sustaining Global Growth and Development: G7 and IMF Governance* (Ashgate, Aldershot), pp. 229-239.

Bayne, Nicholas (2002), p. 147.

Bayne, Nicholas (2002), "Impressions of the Genoa Summit, 20-22 July 2001," in Michele Fratianni, Paolo Savona, and John Kirton, eds., *Governing Global Finance: New Challenges, G7 and IMF Contributions* (Ashgate, Aldershot), pp. 199-209.

Bayne, Nicholas (2001), "Managing Globalisation and the New Economy: The Contribution of the G8 Summit," in John Kirton and George von Furstenberg, eds., *New Directions in Global Economic Governance* (Ashgate, Aldershot).

Bayne, Nicholas (2000), *Hanging in There: The G7 and G8 Summit in Maturity and Renewal* (Ashgate, Aldershot).

Bayne, Nicolas (1999), "Continuity and Leadership in an Age of Globalization" in Michael R. Hodges, John Kirton, and Joseph P. Daniels, eds., *The G8's Role in the New Millennium* (Ashgate, Aldershot), pp. 21-43.

Brundtland, G. (2000), "Speech to Winterthur Massive Effort Advocacy Meeting," World Health Organization, Geneva, October 3, <www.who.int/director-general/speeches/2000/english/20001003_massive_effort.html> (April 2004).

Commission on Macroeconomics and Health (2001), "Macroeconomics and Health: Investing in Health for Economic Development" <www3.who.int/whosis/cmh/cmh_report/report.cfm?path=cmh,cmh_report&language=english> (November 2005).

Cooper, Richard (1989), "International Co-operation in Public Health as a Prologue to Macroeconomic Co-operation," *Can Nations Agree? Issues in International Co-operation*, (Brookings, Washington DC), pp. 178-254.

East African (2003), "G8 Failed to Tackle the Toxic Politics of Drug Making and Selling," June 10.

Fidler, David (2003), *SARS, Governance, and the Globalization of Disease* (Palgrave Macmillan, London).

Fidler, David (2002), "Global Health Governance." Discussion Paper No. 3 written for the Department of Health and Development and the World Health Organization, May 2002.

Foster, John (2003), "Canada's Foreign Policy in Health: Signs and Signals from HIV/AIDS." Paper prepared for a workshop on "Canadian Foreign Policy and Health," North South Institute, Quebec City, December 5.

Foster, John (2002), "Canada and International Health: A Time of Testing on AIDS," in Norman Hillmer and Maureen Molot, eds., *Canada Among Nations 2002: A Fading Power* (Oxford University Press, Toronto), pp. 191-208.

G7 (1987), "Chairman's Statement on AIDS," Venice Summit (www.g8.utoronto.ca> (November 2005).

G7 (1982), "Mankind's Vital Spirit Propels it Towards New Fields of Development," Versailles Summit <www.g8.utoronto.ca> (November 2005).

G8 (2003), "Questions about the G8", <www.g8.fr/evian/english/navigation/the_g8/questions_about_the_g8.htm> (April 2004).

G8 (2002), "Africa Action Plan," Kananaskis Summit <www.g8.utoronto.ca> (November 2005).
G8 (2000), "Communiqué," Okinawa Summit <www.g8.utoronto.ca> (November 2005).
G8 Research Group, John Kirton, and Ella Kokotsis (2004), "Evian Interim Compliance Report," February 7 <www.g8.utoronto.ca/evaluations/2003evian_comp_interim> (November 2005).
G8 Research Group (2004), "Evian Final Compliance Report: Health AIDS and Infectious Disease," G8 Research Group, May 31 <www.g8.utoronto.ca> (November 2005).
Godlee, Fiona (1994), "WHO in Retreat: Is It Losing Its Influence," *British Medical Journal*, no. 309 (December), pp. 1491-1495.
Hajnal, Peter (1999), *The G7/G8 System: Evolution, Role and Documentation*, (Ashgate, Aldershot).
Howard, Lee (1989), "The Evolution of Bilateral and Multilateral Cooperation for Health in Developing Countries," in Michael R. Reich and Eiji Marui, ed., *International Cooperation for Health: Problems, Prospects, and Priorities* (Auburn Publishing Company, Dover).
Kickbusch, Ilona (2003), "The Contribution of the World Health Organization to a New Public Heath and Health Promotion," *American Public Health Association*, vol. 93, no. 3, pp. 383-388.
Kickbusch, Ilona (2000), "The Development of International Health Policies: Accountability Intact?," *Social Science and Medicine,* vol. 51, pp. 978-989.
Kirton, John (2005a), "America at the G8: From Vulnerability to Victory at the Sea Island Summit," in Michele Fratianni, John Kirton, Alan Rugman, and Paolo Savona, eds., *New Perspectives on Global Governance: Why America Needs the G8* (Ashgate, Aldershot), pp. 31-50.
Kirton, John (2005b), "Gleneagles G8 Boosts Blair at Home," G8 Research Group, August 1, 2005 <www.g8.utoronto.ca> (November 2005).
Kirton, John (2004), "Explaining G8 Effectiveness: A Concert of Vulnerable Equals in a Globalizing World." Paper prepared for panel on "Explaining G8 Effectiveness" at the annual convention of the International Studies Association, Montreal, March 17-20, 2004.
Kirton and Kokotsis (2003).
Kirton and Kokotsis (2002).
Labonte, Ronald and Ted Schrecker (2004), "Committed to Health for All? How the G7/8 Rate," *Social Science and Medicine* 59, 1661-1676.
Labonte, Ronald, Ted Schrecker, David Sanders and Wilma Mieeus (2004), *Fatal Indifference: The G8, Africa and Global Health* (International Development Research Centre, Ottawa).
Lewis, Stephen (2003).
Orbinski, James (2002), "AIDS, Médecins Sans Frontières, and Access to Essential Medicines," Peter Hajnal, ed., *Civil Society in the Information Age* (Ashgate, Aldershot:) pp. 127-135.
Pannenborg, Charles O. (1979), "Development Trends," *A New International Health Order: An Inquiry into the International Relations of World Health and Medical Relations* (Sihthoff & Noordhoff International Publishers, Alphen aan den Rijn).
Panova, Victoria (2005), "Impressions of the 2005 Gleneagles Summit," G8 Research Group, July 2005 <www.g8.utoronto.ca> (November 2005).
Picard, Andre (2001), "Malaria Cases Soar in Canada," *Globe and Mail*, March 6.
Price-Smith, Andrew (2001), *Plagues and Politics: Infectious Disease and International Policy* (Palgrave Publishers, New York).
Price-Smith, Andrew (2002), *The Health of Nations: Infectious Disease, Environmental Change, and Their Effects on National Security and Development* (MIT Press, Cambridge MA).
Savona, Paolo and Chiara Oldani (2003), "Globalisation: The Private Sector Perspective," in Michele Fratianni, Paolo Savona, and John Kirton, eds., *Sustainable Global Growth and Development* (Ashgate, Aldershot), pp. 99-112.
Savostiyanov, Michael (2005), "Presentation at the Pre-G8 Summit Academic Conference," University of Glasgow, June 29-30 <www.g8.utoronto.ca> (November 2005).

United Nations General Assembly (2005), "2005 World Summit Outcome." Draft resolution referred to the High-Level Plenary Meeting of the General Assembly by the General Assembly at its 59th Session, September 15.

World Bank (2001).

World Health Organization (1997), "The Denver G8 Summit Highlights Infectious Disease," Press Release WHO/50, June 24, 1997 (www.who.org/inf/pr/1997/pr97-50.html)

Zupi, Marco (2001), "The Genoa G8 Summit: Great Expectations, Disappointing Results," *International Spectator,* vol. 36, no. 3, pp. 57-61.

Zacher, Mark (1999), "Global Epidemiological Surveillance: International Cooperation in Monitoring Infectious Diseases," in Inge Kaul, Isabelle Grunberg and Marc A. Stern, eds., *Global Public Goods: International Cooperation in the 21st Century* (Oxford University Press, Oxford).

Appendix A:
The G7/G8 Core Health Agenda

Year	Total Para.	Total Health Para.	% Health	RCH	HPR	HFD	IFD	MED	HCS	GLC	WHO	MOB
1975	15	0	-									
1976	25	0	-									
1977	49	0	-									
1978	51	0	-									
1979	38	0	-									
1980	54	0	-									
1981	52	0	-									
1982	20	1	5%			1						
1983	22	1	5%	1								
1984	59	0	-									
1985	46	1	2%			1						
1986	45	1	2%				1					
1987	103	4	4%	1	1		1				1	
1988	69	0	-									
1989	122	2	2%				1			1	1	
1990	124	0	-									
1991	172	2	1%									2
1992	143	0	-									
1993	77	2	3%			1			1			
1994	92	1	1%			1						
1995	222	1	<1%								1	
1996	296	9	3%	1		2	2			1	4	
1997	147	10	7%	1		1	1		5	1	1	
1998	129	3	2%			2	1					
1999	169	6	4%			2	2			1	1	
2000	213	23	11%	1	1	4	1	3	1	3	8	1
2001	108	9	8%		1	3		1		1	2	1*
2002	211	6	3%	1		4	1					
2003	427	32	7%	7		3	4	5	1	4	3	5
2004	672	24	4%			1	6	12		2		3
2005	236	15	6%			2	3	8	2			

1. * Announcement of the global fund
2. Legend:

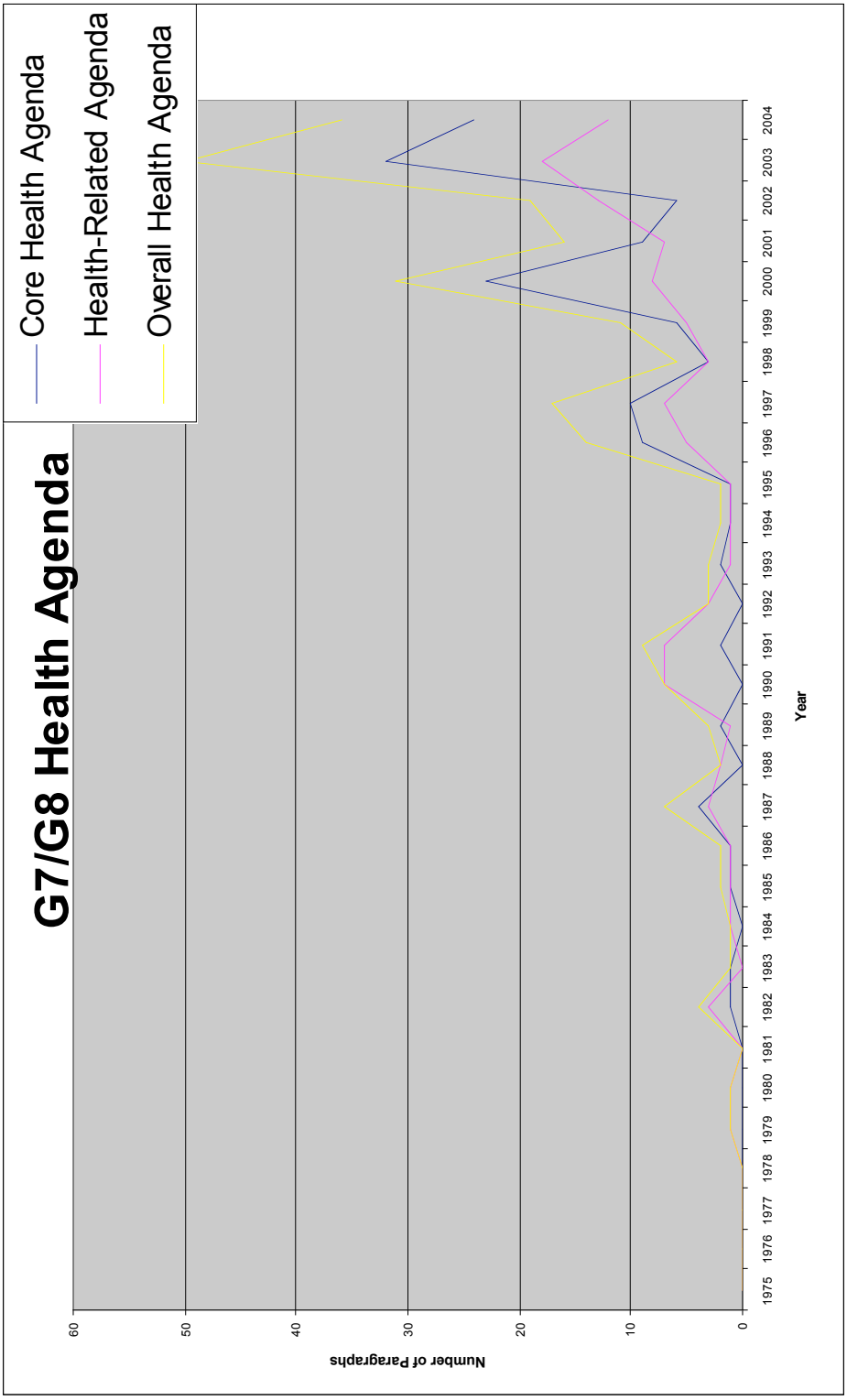
RCH: Health research
HPR: Health Promotion, increased awareness of health issues
HFD: Health For Development
IFD: Infectious Diseases including HIV/AIDS, malaria, tuberculosis, etc.
MED: Medicines, immunization or treatment of infectious diseases
HCS: Health Care System (specifically improvements to the health systems of member nations); includes aging health policies
GLC: Global Collaboration on health information, research, epidemic surveillance
WHO: Support/ suggested reforms to the WHO and UN systems; and MDBs
MOB: Mobilization of resources

Appendix B:
The G7/8 Health-Related Agenda

Year	Total Para.	Total Health Para.	% Health	HIPC	ICT	HIE	HAA	RTM	NUT	SAN	DRG	BFS	HGN	BIO	ENV
1975	15	0	0%												
1976	25	0	0%												
1977	49	0	0%												
1978	51	0	0%												
1979	38	1	3%						1						
1980	54	1	2%						1						
1981	52	0	0%												
1982	20	3	15%									2	1		
1983	22	0	0%												
1984	59	1	2%										1		
1985	46	1	2%								1				
1986	45	1	2%				1								
1987	103	3	3%								1		2		
1988	69	2	3%										2		
1989	122	1	<1%										1		
1990	124	7	6%											6	1
1991	172	7	4%											7	
1992	143	3	2%				3								
1993	77	1	1%											1	
1994	92	1	1%											1	
1995	222	1	<1%											1	
1996	296	5	2%								1		1	2	1
1997	147	7	5%				1			1			1	2	2
1998	129	3	2%	1								2			
1999	169	5	3%	2	1							2			
2000	213	8	4%		2							5		1	
2001	108	7	6%	1		1			1			2	2		
2002	211	13	6%	1	1	1	1		1	3				5	
2003	427	18	4%					2	3	10				2	1
2004	672	12	2%						5	1		3		2	1
2005	236	7	3%			1				1		2			3

Notes: HIPC: Debt relief for health improvements in developing countries
ICT: Information and Communication Technology (ICT) for health
HIE: Health in Education
HAA: Health as AID: medical supplies or health assistance
RTM: Radioactive technology in medicine
NUT: Nutrition or malnutrition as a health condition
SAN: Clean water and sanitation as a health necessity
DRG: health issues related to drug abuse
BFS: Biotechnology and Food Safety
HGN: Human Genome/ bioethics
BIO: Bioterrorism and biological weapons
ENV: health issues related to the environment

Appendix C:
The G7/8 Combined Health Agenda



Appendix D:
The G7/8 Health Agenda by Illness

Year	HIV	MAL	TB	POL	SARS	SP	CHO	EBO	PNE	GW	ON	CI	MH	CrI	PD
1975															
1976															
1977															
1978															
1979															
1980															
1981															
1982															
1983															
1984															
1985															
1986															
1987	9														
1988															
1989	1														
1990															
1991															
1992															
1993															
1994															
1995															
1996	3	1	1				1	1	1						
1997	6														
1998	2	1													
1999	4	1	1												
2000	8	4	4							1	1	1			
2001	8	4	3									1	1	1	1
2002	16	2	3	3							1				
2003	8	3	3		3										
2004	14					1									
2005	5	3	2	1											

Notes:
HIV: HIV/AIDS
MAL: Malaria
TB: Tuberculosis
POL: Polio
SARS: SARS
SP: Smallpox
CHO: Cholera
EBO: Ebola
PNE: Pneumonia
GW: Guinea Worm
ON: Onchocerciasis (river blindness)
CI: Childhood Illnesses
MH: Mental Health
CrI: Chronic Illness
PD: Physical Disability
1. An references is a paragraph in the leader's official documents that refers to the particular disease. Numbers are number of discrete references.
2. Mentions of formal organizations or initiatives are not included (e.g. UNAIDS, Roll Back Malaria, etc.)

Appendix E:
G8 Priority Health Directions

2002 Chair's Summary (References = 2)

We underlined the devastating consequences for Africa's development of **diseases** such as malaria, tuberculosis and HIV/AIDS. In addition to our ongoing commitments to combat these diseases, we committed to provide sufficient resources to eradicate **polio** by 2005.

2003 Chair's Summary (References = 6)

As this contribution should rely more strongly on structural reforms and flexibility, we therefore reaffirm our commitment to:

- implement pension and **health care** reforms, as we face a common challenge of ageing populations;

Health. We agreed on measures to:

- strengthen the **Global Fund** to Fight AIDS, Tuberculosis and Malaria, and other bilateral and multilateral efforts, notably through our active participation in the donors' and supporters' conference to be hosted in Paris this July;
- improve access to **health care**, including to drugs and treatments at affordable prices, in poor countries;
- encourage research on **diseases** mostly affecting developing countries;
- mobilise the extra funding needed to eradicate **polio** by 2005;
- improve international co-operation against new epidemics such as **SARS**.

2004 Chair's Summary (References = 5)

The challenges faced by Africa, including armed conflict, HIV/AIDS, famine, and poverty, represent a compelling call for international cooperation to support the continent's efforts to achieve lasting progress. We met with the Presidents of Algeria, Ghana, Nigeria, Senegal, South Africa, and Uganda, and we committed to… Endorse and establish a Global HIV Vaccine Enterprise to accelerate HIV vaccine development. The United States will host later this year a meeting of all interested stakeholders in the Enterprise; Take all necessary steps to eradicate polio by 2005 and close the funding gap by our next Summit. We have already closed the funding gap for 2004;

2005 Chair's Summary (References = 1)

The G8 in return agreed a comprehensive plan to support Africa's progress. This is set out in our separate statement today. We agreed …to boost investment in **health** and education, and to take action to combat HIV/AIDS, malaria, TB and other killer diseases.

Appendix F:
G7/8 Health Commitments

Year	Overall	Health (core)	Ratio (health/ overall)	Follow/ support IO	Lead IO	Independent of IO
1975	14	0	-	-	-	-
1976	7	0	-	-	-	-
1977	29	0	-	-	-	-
1978	35	0	-	-	-	-
1979	34	0	-	-	-	-
1980	55	0	-	-	-	-
1981	40	0	-	-	-	-
1982	65	0	-	-	-	-
1983	38	1	3%	0	0	1
1984	31	0	-	-	-	-
1985	24	0	-	-	-	-
1986	39	1	3%	0	0	1
1987	54	0	-	-	-	-
1988	27	0	-	-	-	-
1989	61	0	-	-	-	-
1990	78	0	-	-	-	-
1991	53	1	2%	0	0	1
1992	40	0	-	-	-	-
1993	29	1	3%	0	0	1
1994	53	0	-	-	-	-
1995	76	0	-	-	-	-
1996	128	4	3%	0	1	3
1997	111	7	6%	1	3	3
1998	73	4	5%	4	0	0
1999	46	3	7%	1	0	2
2000	163	11	7%	1	5	5
2001	58	3	5%	2	0	1
2002	188	19	10%	2	1	16
2003	206	21	10%	7	4	10
2004	265	12	5%	0	2	10
2005	212	18	8%			
Total	2120	88	5.5% (average)	16	11	49

Lead International Organization (I.O.): The initiative is in collaboration with another International Organization and instigated by the G8, or the initiative is in the form of instructions to another International Organization. **Follow International Organization (I.O.):** The initiative is in collaboration with another International Organization who has acted as the instigator. **Independent:** There is no mention in the initiative of involvement of another International Organization.

Appendix G:
G7/G8 Money Mobilized for Health

Genoa Summit 2001 = $1.3b
"We have launched the UN Secretary-General a new Global Fund to fight HIV/AIDS, malaria and tuberculosis. We are determined to make the Fund operational before the end of the year. We have committed $1.3 billion." (*Communiqué*, July 22, 2001, paragraph 15)

Evian Summit 2003 = $500m
"In keeping with our pledge at Kananaskis to provide, on a fair and equitable basis, sufficient resources to eradicate polio by 2005, we have pledged an additional US$500 million and remain committed to playing our full part to ensure that the remaining funding gap is closed." (*Health: A G8 Action Plan*, paragraph 5.2)

Sea Island Summit 2004 = $3.3b
"In 1988, the world's health ministers unanimously committed to eradicating polio. The G8 countries took up this challenge and together with partners from public and private sectors have raised over $3.3 billion to fund polio immunization campaigns around the world." (*G8 Commitment to Help Stop Polio Forever*, June 10, 2004, paragraph 1)

Gleneagles Summit 2005 = $24b
"Supporting the Polio Eradication Initiative for the post eradication period in 2006-8 through continuing or increasing our own contributions toward the $829 million target and mobilizing the support of others. We are pleased that the funding gap for 2005 has been met." (*Africa*, July 8, 2005, paragraph 18f)

"By contributing to the additional $1.5bn a year needed annually to help ensure access to anti-malaria insecticide-treated mosquito nets, adequate and sustainable supplies of Combination Therapies including Artemisin, presumptive treatment for pregnant women and babies, household residual spraying and the capacity in African health services to effectively use them, we can reduce the burden of malaria as a major killer of children in sub-Saharan Africa." (*Africa*, July 8, 2005, paragraph 18g)

"The US proposes… the $15 billion Emergency Plan for AIDS Relief, an initiative to address Humanitarian Emergencies in Africa of more than $2 billion in 2005, and a new $1.2 billion malaria initiative." (*Africa*, July 8, 2005, Annex II)

"Japan has committed… the $5 billion 'Health and Development Initiative' over the next five years." (*Africa*, July 8, 2005, Annex II)

"[Canada's 2005 budget provides] an additional C$342 million to fight diseases that mainly afflict Africa." (*Africa*, July 8, 2005, Annex II)

Appendix H:
"Equitable Contributions Framework" for the Global Fund, Based on GDP (21 April 2002)

Country	Suggested "equitable annual contribution" to Global Fund ($m.),proportionate to GDP	Total pledge thus far to Global Fund ($m., and as % of column 2)	Estimated portion of total pledge that applies to 2002 ($m., and as % of column 2)
G7 "high Human Development Index" countries:			
United States	3,479	450 (13%)	250 (7%)
Japan	1,646	200 (12%)	68 (4%)
Germany *	658	158 (24%)	35 (5%)
United Kingdom *	498	219 (44%)	67 (13%)
France *	453	151 (33%)	51 (11%)
Italy *	376	215 (57%)	73 (19%)
Canada	243	100 (41%)	38 (15%)
Total for G7 countries:	7,352	1,493	580
Non-G7 "high Human Development Index" countries:			
Spain[a]	195	58 (29%)	19 (10%)
Netherlands[a]	128	125 (97%)	42 (32%)
Switzerland	85	10 (12%)	3 (4%)
Belgium[a]	81	19 (24%)	6 (8%)
Sweden[a]	80	58 (73%)	20 (25%)
Austria[a]	67	4 (5%)	1 (2%)
Denmark[a]	57	2 (4%)	1 (1%)
Finland[a]	42	2 (4%)	1 (1%)
Greece[a]	39	2 (4%)	1 (1%)
Portugal[a]	37	1 (4%)	0 (1%)
Ireland[a]	33	10 (31%)	3 (10%)
Kuwait	10	1 (10%)	0 (3%)
Luxembourg[a]	7	3 (41%)	1 (14%)
Argentina, Australia, Bahamas, Bahrain, Barbados, Brunei, Chile, Costa Rica, Croatia, Cyprus, Czech Republic, Estonia, Hong Kong, Hungary, Iceland, Israel, Lithuania, Malta, New Zealand, Norway, Poland, Qatar, Singapore, Slovakia, Slovenia, South Korea, United Arab Emirates, Uruguay	1 to 161	0 (0%)	0 (0%)
Total for non-G7 "high HDI" countries:	1,648	294	99
TOTALS:			
Total for all 48 "high HDI" countries:	9,000	1,788	679

Total for all other countries[b]	0	33	11
Total for private sector (foundations and corporations)[c]	1,000	101	34
Grand total:	10,000	1,922	725

Source: www.aidspan.org; this chart was included in a report by Tim France (Health & Development Networks), Gorik Ooms (Médecins Sans Frontières), and Bernard Rivers (Aidspan) 2002, and distributed by Health & Development Networks (HDN) (www.hdnet.org).

Global Fund Equitable Contributions Framework (21 May 2004)

G8 Donors	Pledges for 2004 ($m.)				
	Current Pledge	"Current pledge" as % of all pledges	Equitable contribution — what the pledges should be, assuming a 2004 need of $1.4 b.	"Current pledge" as % of Equitable Contribution	Current Shortfall
G7 countries:					
United States	546.8	36.1%	466.7	117%	-
Japan	100.0	6.6%	300.8	33%	200.8
Germany	46.8	3.1%	47.0	100%	0.2
United Kingdom	53.1	3.5%	37.8	140%	-
France	177.7	11.7%	34.1	521%	-
Italy	118.5	7.8%	27.6	430%	-
Canada	25.0	1.7%	48.8	51%	23.8
High income non-G7 countries:					
Spain	15	1.0	14.9	100%	-
Netherlands	47.4	3.1%	9.5	501%	-
Switzerland	-	0.0%	18.3	0%	18.3
Belgium	11.1	0.7%	5.9	188%	-
Sweden	39.0	2.6%	5.8	672%	-
Austria	-	0.0%	4.8	0%	4.8
Denmark	16.0	1.1%	4.1	392%	-
Finland	-	0.0%	3.1	0%	3.1
Greece	-	0.0%	3.1	0%	3.1
Portugal	-	0.0%	2.7	0%	2.7
Ireland	12.1	0.8%	2.3	538%	-
Kuwait	-	0.0%	2.6	0%	-
Luxembourg	2.4	0.2%	0.4	539%	-
European Commission	262.8	17.3%	(Assumed equal to actual European Commission pledge)	100%	n/a
The non-high income countries that have pledged to the GF:	10.5	0.7%	n/a	n/a	n/a

Foundations:	-	0.0%	n/a	n/a	n/a
Corporations:	-	0.0%	n/a	n/a	n/a
Individuals, groups, events:	1.0	0.1%	n/a	n/a	n/a

Explanatory example: The GDP in 2000 of all 48 countries totaled $25,569 billion. The GDP of the US that year was $9,882 billion, or 38.7% of the total. Thus, if the 48 countries shared equitably the donation of $9 billion annually to the Global Fund (with the remaining $1 billion coming from the private sector), the US's contribution would be the $3.479 billion that is shown in the table.

Sources: Pledges: Global Fund Against HIV, Tuberculosis and Malaria <www.globalfundatm.org/files/Financial_contributions.html>, United Nations <www.un.org/News/ossg/aids.htm>. HDI: United Nations Development Programme <www.undp.org/hdr2001>. GDP: World Bank <www.worldbank.org/data/databytopic/GDP.pdf>. Pledges are as of 18 April 2002. Additional data plus future updates available at www.hdnet.org and www.aidspan.org.

The final column is based on private sources plus our own estimates, because the information is not published. We understand that total pledges are: 2002=$725m., 2003=$487m., 2004=$132m., 2005=$67m., 2006=$27m., plus $484m. for which the year(s) are not specified. We also understand that the pledges for 2002 (before adding shares of the EU pledge, when appropriate) include USA=$250m., UK=$60m., Netherlands=$40m., Canada=$37.5m., and Germany=$26.5m. For other countries and for the private sector, the 2002 portion is not known, so we have assumed it to be 33.8% of the total pledge, in order to bring the overall 2002 total to the known figure of $725 m. Further information received will be reflected in future versions of this table.

[a] The European Commission has pledged $106.9 million to the Global Fund. In the table, this sum has been added to the direct pledges to the Global Fund of the 15 EU countries, in proportion to their respective GDPs. Denmark, Portugal, Finland and Greece have not made any direct pledges, but, like the others, have been credited here with portions of the EC pledge.

[b] Non "high HDI" countries that have donated are Russia ($20m.), Nigeria ($10m.), Uganda ($2m.), Zimbabwe ($1m.), Andorra ($100,000), Niger ($50,000), Liberia ($25,000), Kenya ($8,273).

[c] Of the $101.15 m. pledged by the private sector as of 18 April 2002, $100 m. was from the Bill & Melinda Gates Foundation.

Source: Adapted from AIDSPAN (2004), "An Updated Analysis of the Equitable Contributions Framework regarding the Global Fund" <www.aidspan.org> (November 2004).

The Global Fund's First Replenishment 2006 — 2007
Pledges for 2006-07 (made on September 6, 2005)

Country	Pledge (USD m)
Australia	27.1
Austria	*
Belgium	26.2
Brazil	0.1
Canada	*[1]
China	4.0
Denmark	49.1
EC	**117.4**[2]
Finland	*
France	**684.8**
Germany	**200.0**
Greece	0.5
India	4.0
Ireland	39.1
Italy	**339.1**
Japan	**500.0**
Luxembourg	4.4
Mexico	*
Netherlands	117.4
Nigeria	10.0
Norway	43.1
Portugal	6.5
Russia	**15.0**
Saudi Arabia	2.5
Singapore	0.4
South Africa	4.0
Spain	70.0
Sweden	125.0
Switzerland	11.0
Thailand	2.0
Uganda	1.0
UK	**377.7**
USA	**600.0**
*	350.0
Total	**3,731.0**
G8 Average (excluding Canada)	**354.25**

The * are estimated to total USD 350 million, but have not been announced.
G8 Total = $2,834 billion of the $3.731 billion total.

[1] Canada will make its pledge at a later date.
[2] 2006 only.

Appendix I:
G7/8 Health Compliance Record

Year	G8 Research Group Analysis	Independent Analysis
1975	n/a	n/a
1976	n/a	n/a
1977	n/a	n/a
1978	n/a	n/a
1979	n/a	n/a
1980	n/a	n/a
1981	n/a	n/a
1982	n/a	n/a
1983	-	
1984	n/a	n/a
1985	n/a	n/a
1986	-	
1987	n/a	n/a
1988	n/a	n/a
1989	n/a	n/a
1990	n/a	n/a
1991	-	
1992	n/a	n/a
1993	-	
1994	n/a	n/a
1995	n/a	n/a
1996	-	
1997	-	
1998	-	
1999	-	
2000	+ 1.0	
2001	+ 0.75	
2002	-	+0.375
2003	+ 0.88	
2004	+0.50	
2005		+0.17 (Q1)

Notes:
No health commitments were included in the compliance study.
1. Health commitments are defined as core health.
2. 2005 is for the first quarter from July 9 to October 9, 2005, as assessed by Abby Slinger.

Appendix J:
G7/8-Inspired Health Institutions

Official-Level Institutions

International Ethics Committee on AIDS — est. 1987
"We take note of the creation of an International Ethics Committee on AIDS which met in Paris in May 1989, as decided at the Summit of Venice (June 1987). It assembled the Summit participants and the other members of the EC, together with the active participation of the World Health Organization." (*Communiqué*, Paris, July 1989)

Group of Experts on the Prevention and Treatment of AIDS — est. 1992

Global Fund to Fight AIDS, Malaria, and Tuberculosis — est. 2000
"At Okinawa last year, we pledged to make a quantum leap in the fight against infectious diseases and to break the vicious cycle between disease and poverty. To meet that commitment and to respond to the appeal of the UN General Assembly, we have launched with the UN Secretary-General a new Global Fund to fight HIV/AIDS, malaria and tuberculosis. We are determined to make the Fund operational before the end of the year. We have committed $1.3 billion. The Fund will be a public-private partnership and we call on other countries, the private sector, foundations, and academic institutions to join with their own contributions — financially, in kind and through shared expertise. We welcome the further commitments already made amounting to some $500 million." (*Communiqué*, Genoa, July 22 2001)

Global Health Security Laboratory Network — est. 2002
"We recognized that timely and effective collaboration among high-level laboratories is essential for global preparedness and response to biological incidents. We launched a new international network of high-level laboratories — the Global Health Security Laboratory Network — that is working to coordinate, standardize, and validate diagnostic capabilities, and contribute to global health surveillance and response to disease outbreaks." (Statement released by G8 Health Ministers, Mexico City, December 6, 2002)

Global Health Security Action Group (GHSAG) Laboratory Network — est. 2003
"Steps were taken to strengthen the coordination and collaboration among participating national high-level laboratories through the Global Health Security Action Group (GHSAG) Laboratory Network." (Statement released following the Fourth Ministerial Meeting on Health Security and Bioterrorism, Berlin, November 7, 2003)

Technical Working Group on Pandemic Influenza Preparedness — est. 2003
"Furthermore, we recognize that preparedness for and response to bioterrorism have much in common with preparedness for and response to naturally occurring global health threats such as pandemic influenza. Much work needs to be done to enhance preparedness by member countries and globally by addressing critical issues for an effective pandemic response. To this end we have agreed to the Terms of Reference for

the Technical Working Group on Pandemic Influenza Preparedness. The Technical Working Group will focus on critical gaps related to the rapid development, evaluation and availability of pandemic influenza vaccines; and, the optimal use of antiviral drugs. This group will carry out its work in conjunction with the WHO and other appropriate international organizations." (Statement released following the Fourth Ministerial Meeting on Health Security and Bioterrorism, Berlin, November 7, 2003)

Global HIV Vaccine Enterprise — est. 2004
"We believe the time is right for the major scientific and other stakeholders — both public and private sector, in developed and developing countries — to come together in a more organized fashion. This concept has been proposed by an international group of scientists. Published as a "Policy Forum" in *Science* magazine. Klausner, RD, Fauci AS, et al: "The need for a global HIV vaccine enterprise." *Science* 300:2036, 2003. We endorse this concept and call for the establishment of a Global HIV Vaccine Enterprise — a virtual consortium to accelerate HIV vaccine development by enhancing coordination, information sharing, and collaboration globally." (*G8 Action to Endorse and Establish a Global Vaccine Enterprise*, Sea Island, July 2004)

G8 Global Health Security Initiative Ministerial Meetings

Ottawa on November 7, 2001

Mexico in attendance. It issued a six-paragraph public Statement at its conclusion, which reacted to the events of September 11th, 2001 and emphasized the importance of global security against biological, chemical and radio-nuclear terrorism.

London on March 14, 2002

Mexico in attendance. It yielded a seventeen-paragraph statement on biological, chemical and radio-nuclear terrorism. The focus of the document is support of initiatives and actions of the World Health Organization.

Mexico City on December 6, 2002

Mexico in attendance. An eighteen-paragraph statement on global disease security was issued. The focus of the document was on smallpox and risk management for a potential outbreak of the disease.

Berlin on November 6-7, 2003

Mexico and the Director General of the World Health Organization were in attendance. An eighteen-paragraph statement was issued on global health security, smallpox outbreak risk mitigation, bioterrorism, chemical and nuclear attacks, and pandemic influenza. This was the first time naturally occurring health threats were mentioned in a publicly release health ministerial document.

Paris on December 10, 2004

Mexico in attendance was in attendance, Italy was in absentia. A twenty-paragraph statement was issued on the Global Health Security Laboratory Network, Exercise Global Mercury, smallpox, the Working Group on Chemical Events, pandemic influenza preparedness, emerging infectious disease outbreaks, and the importance of strengthening national and international efforts on public health emergency response.

Fall 2005, Rome: TBD

G8 Global Health Ministerial Commitments

Statement of G7 Health Ministers' Meeting
Ottawa, November 7, 2001

Commitments = 14

2001-1. We affirm our resolve as a group of Health Ministers/Secretaries representing diverse nations to, individually and collectively, take concerted actions to ensure the health and security of our citizens, and to enhance our respective capacities to deal with public health incidents.

2001-2. We are committed to working aggressively to strengthen our readiness and response by increasing collaboration amongst governments, in partnerships with international organizations, such as the World Health Organization (WHO).

Recognizing the wide range of issues that are part of any health security plan, our objectives for the partnership, within the framework of existing international agreements are:

2001-3. To explore joint cooperation in procuring vaccines and antibiotics;

2001-4. To engage in a constructive dialogue regarding the development of rapid testing, research in variations of vaccines, and our respective regulatory frameworks for the development of vaccines and in particular smallpox vaccines;

2001-5. To further support the World Health Organization's disease surveillance network and WHO's efforts to develop a coordinated strategy for disease outbreak containment;

2001-6. To share emergency preparedness and response plans, including contact lists, and consider joint training and planning;

2001-7. To agree on a process for international collaboration on risk assessment and management and a common language for risk communication;

2001-8. To improve linkages among laboratories, including level four laboratories, in those countries which have them;

2001-9. To undertake close cooperation on preparedness and response to radio-nuclear and chemical events; and

2001-10. To share surveillance data from national public health laboratories and information on real or threatened contamination of food and water supplies along with information on risk mitigation strategies to ensure safe food supplies.

2001-11. To urgently take this process forward, each of us will designate a senior official to be the point person to ensure that this Plan is translated into concrete actions. Officials from each country will meet without delay to flesh out specific measures of this Plan. In addition, these senior officials constitute a network of rapid communication/reaction in case of crisis.

2001-12. To ensure follow up, Canada will serve as the coordinating partner to take the lead in establishing networks, linkages and collaboration agreed upon today, and to facilitate arrangements for a second ministerial meeting.

2001-13. Ministers/Secretaries/Commissioner also agreed to broaden this forum as appropriate to include other governments.

2001-14. Canada will also coordinate the early designation of senior officials, the ongoing sharing of best practices and development of specific proposals for ministerial consideration, including cooperation on pharmaceuticals and stockpiling issues.

Health Ministers Meeting
London, March 14, 2002

Commitments = 19

2002-1. We will engage with other countries on specific issues and make the most of any opportunity to share information on our efforts with other countries, such as at the meeting of the World Health Assembly in May 2002.

2002-2. We remain committed to working together to strengthen our readiness and response to protect public health and security.

2002-3. We agreed to meet again in Mexico to take stock of where we are and to consider what further actions may be appropriate.

2002-4. We fully endorse the World Health Organisation Executive Board's resolution adopted in January, 2002 on the deliberate use of biological and chemical agents, and radio-nuclear attacks. This resolution "urges member states to share expertise, supplies, and resources in order to rapidly contain the event and mitigate its effects". Efforts will be undertaken to urge all countries to adopt the resolution at the World Health Assembly, May 13-18, 2002.

2002-5. Ministers have agreed that an exercise will be held which will test and build on current response plans and protocols for international assistance and collaboration.

2002-6. The United Kingdom has offered to host a meeting on modelling, one output of which will be to provide a basis for planning the exercise.

2002-7. Canada will draw together a steering committee to plan this exercise.

2002-8. Ministers reaffirmed their commitment to the World Health Organisation strategy on search and containment as a strategy for smallpox outbreak control.

2002-9. The UK has offered to convene and carry forward future joint working on risk and in particular the "incident scale."

2002-10. We have asked the Global Health Security Action Group to validate the framework against chemical, radio-nuclear and biological incidents, and to assess how this can complement current international arrangements in place.

2002-11. The United States will host, in collaboration with the WHO, a training the trainer session on smallpox outbreak containment.

2002-12. We also intend to share plans on preparedness and response to chemical events and

2002-13. Japan will look at the possibility of hosting a meeting of laboratory directors and experts.

2002-14. A meeting of Directors of high level laboratories was held in Lyon, France on March 12, 2002 which will lead to improved linkages among the laboratories in our countries and, therefore, our response to biological threats. This meeting will be followed by a meeting in Canada to seek common agreement on standards and cooperation among laboratories in participating countries, as well as assistance to other countries.

2002-15. France and the WHO will organise a meeting on approaches and best practices in providing assistance to other countries with regards to health security and public health emergencies.

2002-16. Germany will host in collaboration with the WHO and the EU, a meeting to review and define or redefine best practices in vaccine production for smallpox and other potential pathogens.

We intend to further support the WHO's global public health surveillance and response, including public health events of international importance by:

2002-17 . providing support for existing networks and WHO coordinating response;

2002-18. helping WHO to strengthen coordination activities to support national laboratory work;

2002-19. considering seconding technical experts and technical and/or financial assistance.

Health Ministers Launch Initiatives to Improve Health Security Globally
Mexico City, December 6, 2002
Commitments = 10

We agreed on the following actions as instrumental to preparing and responding to such an incident, and mitigating its consequences.
2002-20. We, therefore, intend to pursue, to the extent possible, the means to increase the WHO reserve and encourage others to do the same.

2002-21. This smallpox emergency response exercise will be held in mid 2003, and link the multiple locations involved via communication networks.

2002-22. We also welcomed the report from Germany on best practices in vaccine production for smallpox and other potential pathogens, and agreed to make this report widely available through the websites of WHO and the Paul-Ehrlich-Institut.

We confirmed that:

2002-23. the WHO and USA will co-host a pilot train-the-trainers session on smallpox outbreak containment in Geneva, Switzerland in March, 2003. Training modules developed from this session will be shared with other countries.

2002-24. the WHO and Italy will hold a meeting on strategies in isolation techniques for patients with smallpox and other highly contagious viral infections in Rome in March, 2003.

2002-25. The Global Health Security Laboratory Network will meet to validate smallpox diagnostic tests at the Centers for Disease Control and Prevention in Atlanta in Spring 2003.

2002-26. We also approved a proposal to develop agreed principles for a common approach to risk management and communication for CBRN incidents. The technical working group on risk management and communication led by the United Kingdom will carry forward this work.

2002-27. We have established a working group on chemical incidents that will develop an action plan.

2002-28. We agreed to establish a technical working group on influenza pandemic, which will be co-chaired by the US and the UK, to address existing gaps and research and development needs. This work should be carried out in conjunction with the WHO and other appropriate international organizations.

2002-29. We reaffirmed our commitment to engage and share information with other countries and regional networks as necessary.

Fourth Ministerial Meeting on Health Security and Bioterrorism
Berlin, November 7, 2003
Commitments = 13

2003-1. We have endorsed the final evaluation report on *Exercise Global Mercury*, and have asked our officials to undertake the necessary work from the lessons learned during this exercise in order to improve international communications capabilities of our public health professionals to deal with an actual public health emergency.

2003-2. We endorsed progress made on developing a set of principles for risk management and communications in the event of a chemical, biological and radio-nuclear incident. We have asked our officials to further develop and refine their work and to bring forward a set of principles for our consideration at the 5th Ministerial meeting.

2003-3. Italy has completed a report on strategies for isolation techniques for patients with smallpox and other highly contagious viral agents based on a meeting of experts, and we have decided that this report should be shared with other countries. We agreed to continue our collaboration in this area.

2003-4. Our countries have successfully evaluated and shared information on the effectiveness of our respective smallpox detection assays at a smallpox practical laboratory workshop hosted by the United States. We are pleased to report that all countries performed to an acceptable standard. We agreed to continue our collaboration in this area.

2003-5. We reaffirmed our commitment to strengthening the WHO smallpox vaccine reserve. The form of support for this global vaccine reserve is at the discretion of each member of the Global Health Security Initiative. Ongoing work on the logistical management of the reserve is underway in cooperation with WHO.

Steps were taken to strengthen the coordination and collaboration among participating national high-level laboratories through the Global Health Security Action Group (GHSAG) Laboratory Network:

2003-6. We are addressing the challenges related to the issue of transporting diagnostic specimens and reference materials across international borders, and have agreed to work together to that end.

2003-7. The UK will host an anthrax testing workshop in March 2004.

2003-8. To underscore our commitment to improve public health security globally, we decided to undertake work in new areas concerning radio-nuclear threats, field epidemiology practices, and collaboration on research.

2003-9. Led by the European Commission, we will pursue better collaboration on research in order to, for example, facilitate the exchange of information, the identification of common interests and research gaps, and to consider opportunities for joint research.

2003-10. We have called for concrete progress in these areas for our 5 th Ministerial meeting.

2003-11. Much work needs to be done to enhance preparedness by member countries and globally by addressing critical issues for an effective pandemic response. To this end we have agreed to the Terms of Reference for the Technical Working Group on Pandemic Influenza Preparedness.

2003-12. The Technical Working Group will focus on critical gaps related to the rapid development, evaluation and availability of pandemic influenza vaccines; and, the optimal use of antiviral drugs. This group will carry out its work in conjunction with the WHO and other appropriate international organizations.

2003-13. While membership in the Global Health Security Initiative remains the same, we will initiate steps to more fully share with other countries appropriately designated information and outcomes from the Global Health Security Initiative, including the possibility of periodic information sessions determined by the World Health Organization at the World Health Assembly.

Fifth Ministerial Meeting on Health Security and Bioterrorism
Paris, December 10, 2004
Commitments = 8

2004-1. We commit to a collaborative and complementary approach in continuing our work with other international organizations, in particular the World Health Organization.

2004-2. Tests of this [Emergency Contact] Network conducted to date indicate that a protocol for immediate contact among our health ministries and organizations is an essential component for rapid international communications in emergencies, and will be kept current through emergency communication drills.

2004-3. We are committed to improvements in the interoperability of our communication capabilities.

2004-4. We are committed to working with the WHO on pandemic influenza preparedness, and acknowledge the importance of enhancing WHO surveillance and outbreak response activities.

2004-5. We agreed that France and Germany would lead a process of collaboration with WHO to identify approaches for enhancing capacity in developing countries.

2004-6. Considering that field epidemiology, including outbreak investigation, provides the necessary action to assess and deal with public health emergencies, we thanked Mexico for hosting a workshop in June 2004 as a first step to improve the capability to respond to such incidents of international concern. We agreed to continue work on this issue in order to develop a common approach for addressing such emergencies and welcomed the offer by Mexico to host the Second Workshop on Best Practices and Coordination in Field Epidemiology and Outbreak Investigation.

2004-7. Today we called for development of an international tabletop exercise that will provide us with lessons learned and recommendations for future steps.

2004-8. In response to our commitment to share more fully appropriately designated information and outcomes with other countries, we have endorsed the creation of a public Global Health Security Initiative website. This website will be operational by the Summer 2005.

Appendix K:
Pattern of G8 Health Performance

	Domestic Political	Deliberative	Directional	Decisional: total com't	Decisional: money	Delivery	Dev'l Global Gov	G8RG score
1975	TBC	0	0	0	0	-	0	-
1976	TBC	0	0	0	0	-	0	-
1977	TBC	0	0	0	0	-	0	-
1978	TBC	0	0	0	0	-	0	-
1979	TBC	1	0	0	0	-	0	-
1980	TBC	1	0	0	0	-	0	-
1981	TBC	0	0	0	0	-	0	-
1982	TBC	4	0	0	0	-	0	-
1983	TBC	1	0	1	0	-	0	NDA
1984	TBC	1	0	0	0	-	0	-
1985	TBC	2	0	0	0	-	0	-
1986	TBC	2	0	1	0	-	0	NDA
1987	TBC	7	0	0	0	-	1	-
1988	TBC	2	0	0	0	-	0	-
1989	TBC	3	0	0	0	-	0	-
1990	TBC	7	0	0	0	-	0	-
1991	TBC	9	0	1	0	-	0	NDA
1992	TBC	3	0	0	0	-	1	-
1993	TBC	3	0	1	0	-	0	NDA
1994	TBC	2	0	0	0	-	0	-
1995	TBC	2	0	0	0	-	0	-
1996	TBC	14	0	4	0	TBC	0	NDA
1997	TBC	17	0	7	0	TBC	0	A
1998	TBC	6	0	4	0	TBC	0	B+
1999	TBC	11	0	3	0	TBC	0	NDA
2000	TBC	30	0	11	0	**+1.00**[b]	0	**A+**
2001	TBC	15	0	3	$1.3 billion	+0.75 [b]	1*	NDA
2002	TBC	19	2	19	0	+0.38[c]	1	B-
2003	TBC	**50**	**6**	**21**	$500 mill	+0.88[a]	**2**	NDA
2004	TBC	36	5	12	$3.3 billion	+0.50	1	NDA
2005	TBC	22	1	18	**$24.billion**			

Notes:
No significant references to health were made by the G8 in that year
TBC: To Be Completed
NDA: No Data Available
* The establishment of the Global Fund to Fight AIDS, Malaria and Tuberculosis
[a] Interim Report Data
[b] Compliance report completed by the University of Toronto G8 Research Group
[c] Compliance completed by Jenevieve Mannell
Peak scores are in bold
Directional = references in Summit chapeau / Chair's summary

Appendix L:
New Cases of HIV/AIDS per year

	G8 ave.[a]	U.S.	JAP	GER	FRA	UK	ITA	CDA	RUS
1979								1	
1980				0	4	0	0	3	0
1981		323		1	8	5	0	8	0
1982		1170		9	31	28	1	26	0
1983		3076		40	92	114	8	63	0
1984		6247		116	236	419	37	160	0
1985	2303	11794	6	311	583	2847	198	384	0
1986	3598	19064	5	573	1259	3178	458	649	1
1987	5273	28599	14	1038	2252	2985	1030	991	27
1988	6389	35508	14	1268	3054	1941	1775	1165	52
1989	7742	42768	21	1589	3809	2142	2482	1380	298
1990	8823	48732	31	1553	4320	2545	3134	1446	141
1991	10612	59760	35	1767	4657	2718	3827	1518	115
1992	13517	78705	51	1918	5195	2741	4257	1750	115
1993	14030	78954	85	4404	5522	2619	4802	1823	119
1994	13197	72266	135	4372	5763	2566	5505	1773	198
1995	12880	69307	169	4093	5295	2652	5651	2990	239
1996	11423	60613	234	4582	4011	2686	5045	2792	1566
1997	8464	49062	250	3078	2276	2729	3374	2518	4432
1998	7523	43225	231	3125	1926	2812	2435	2342	4115
1999	9318	41314	300	2609	1808	3071	3220	2245	19980
2000	14107	41239	327	2414	1717	3824	2026	2124	59184
2001	17824	41227	430	2046	1679	4975	1797	2185	88253
2002		42136		2581	2004	5704	1753	2499	50529
2003		43171				7217	1104		
2004				1979	2697	7275		2529	

Notes: Does not include HIV statistics
Peak years are in bold
[a] Calculation of average does not include Russia for the years prior to 1997, when it became a member of the G8.
Sources: U.S. Centers for Disease Control; HIV/AIDS Surveillance Report, U.S. HIV and AIDS cases reported through December 2002. End of year edition Vol. 14; 3. Health Protection Agency and the Scottish Centre for Infection and Environmental Health, 03/03, Quarterly Surveillance Tables, No. 60; World Health Organization Regional Office for Europe <www.who.dk/Informationsources/Data?20010827_1>; Health Canada, HIV/AIDS in Canada, Surveillance Report to June 30, 2003, Canadian data prior to 1995 does not include HIV cases DNA; <www.avert.org>.

Appendix M:
Annual Health Care Spending Per Capita
($US at average exchange rates)

	G7/8	U.S.	JAP	GER	FRA	UK	ITA	CDA	RUS
1997	1,400	1,784	1,803	2,073	1,728	1,253	1,133	1,305	122
1998	1,406	1,824	1,715	2,075	1,754	1,349	1,154	1,297	77
1999	1,468	1,895	2,056	2,043	1,738	1,442	1,155	1,372	46
2000	1,467	2,005	2,245	1,807	1,568	1,444	1,114	1,490	66
2001	1,492	2,168	2,046	1,807	1,603	1,508	1,193	1,533	78
2002[a]	2,460	5,274	2,113	2,817	2,736	1,160	2,116	2,931	535

Based on data available from the World Health Organization

[a] "**Definition:** Total health expenditure per capita is the per capita amount of the sum of Public Health Expenditure (PHE) and Private Expenditure on Health (PvtHE). The international dollar is a common currency unit that takes into account differences in the relative purchasing power of various currencies. Figures expressed in international dollars are calculated using purchasing power parities (PPP), which are rates of currency conversion constructed to account for differences in price level between countries."[3]

Percent of GDP spent on health — World Bank (2001): World Development Database Indicators

US	Germany	France	Canada	Japan	UK	Italy	Russia
13.9%	10.8%	9.6%	9.5%	8.0%	7.6%	8.4%	5.4%

[3] World Health Organization, "Countries," Accessed Nov 4, 2005. <www.who.int/countries/en/>.