The G8 and Global Health Governance: The Case for a 2006 Eurasian HIV/AIDS Initiative

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Introduction

The Global Health Challenge and G8 Response

Since 1975, global health governance has been transformed by new physical challenges and by the poor performance of the old multilateral organizations in response.[2] During this time both the challenges for and the dominant conception of global health governance have become much more comprehensive and interconnected, shifting from the mere medical absence of disease to encompass socioeconomic well-being, resource availability, poverty reduction, and ecological integrity (Pannenborg 1979). This shift in conception was first pushed by the World Health Organization (WHO) at the apex of its strength in the 1970s through its ambitious human rights initiative of "Health for All." The WHO also drove the world from the historic concept of health as a national issue toward a more internationally focused and increasingly global approach.

Yet even with this great transformation toward global comprehensive interconnectedness in concept, the WHO has proven inadequate in addressing the major health challenges and crises of the twenty-first century world. The rapid spread of HIV/AIDS through the West and then the world was the first sign of the failure of the old multilateral and component regional regimes. Compounding the failure have been the cumulative body count from the chronic afflictions of malaria and tuberculosis, the re-emergence of old diseases such as polio once on the verge of extinction, the eruption of bioterrorism with the anthrax attacks on America after 9/11, the assault from severe acute respiratory syndrome (SARS) in 2002-03, and the subsequent spread of avian flu across continents and perhaps directly among humans themselves.

This failure has fuelled the search for a new generation of global health governance for a globalized world. In response, the Group of Eight (G8) major market democracies has taken up the challenge. Starting narrowly in the early 1980s 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. As the twenty-first century began, the G8 found it necessary to launch its own initiatives to deliver global health. It started in 2001 by creating the Global Fund to Fight AIDS, Tuberculosis and Malaria. It continued in 2001-02 with the development of the G8 Africa Action Plan, and with new attention and parallel institutions to combat bioterrorism after the shock of the September 11, 2001, assault on America and the subsequent anthrax attacks. At the 2003 Evian Summit, the G8's Health Action Plan directly tackled some of the world's most deadly diseases. At the 2004 Sea Island Summit, the G8 focused on specific interventions such as developing an HIV/AIDS vaccine and the eradication of polio. Gleneagles in 2005 continued this thrust. The 2006 St. Petersburg Summit is taking a great leap forward, making infectious disease one of its three priority themes and inspiring the first ever preparatory G8 meeting for ministers of health, heldin Moscow on April 28, 2006.

This increasingly ambitious G8 effort suggests that the G8 is emerging as an expansive and effective centre of global health governance, driven by new forces at work in the twenty-first century world. Understanding the course and causes of this emergence is an essential foundation for crafting timely, well tailored initiatives for St. Petersburg to confront the newest generation of

global health challenges. These include the immediate need for preventive action to stop a potential Eurasian HIV/AIDS pandemic that is now at the critical tipping point.

The Debate over the G8's Global Health Governance

Questions about the course and causes 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 the G8 can and should make. The debate ranges widely among 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, through to supporters who claim the G8 has already filled some gaps, has the potential to do much more, and is already delivering a new generation of health governance for a globalizing world.

In this debate, the first school of thought portrays the G8 as a great fundraising failure (Lewis 2005, Drohan 2005). Here the G8's proper role is narrowly conceived as raising massive amounts of new money to pass on, with few conditions attached, to 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 also note 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 the G8's easy acceptance of a dominant America's approach. Stephen Lewis (2005), an advocate employed by the UN as Special Envoy on HIV/AIDS in Africa, has referred to this placement 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 third cause is the "thinly disguised neo-colonial manipulation" that maintained the G8's "unbroken record of betraying their promises" through Gleneagles in 2005 (Lewis 2005: 31, 149).

A second school sees the G8 as having a much broader role, but still showing "fatal indifference" by 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 now known to be 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 sees the G8 as an informal institutional failure. It agrees there is more of a G8-wide than an American-inspired failure. But it 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). This view asserts that the G8's proper role goes beyond merely supporting the UN. 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.

In a shift from critics to supporters, a fourth school argues 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 the members of the G8 (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, gap filler and governor of last resort 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-making 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 [nongovernmental organizations] 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).

The Analysis

Despite the growing diversity and dynamism of the debate, there has been no full-scale analysis of the G8's actual performance in global health governance or of the forces that have propelled it to act in particular ways. Activists and analysts such as Lewis, Foster, and Labonte et al. understandably focus on the many problems that remain rather than on the efforts made or actions taken to provide solutions. They often ignore the G8 members' high compliance with the health commitments the G8 has made. 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 high-profile, crisis-oriented G8 can adequately address broader global health needs, especially through preventive action to stop emerging pandemics before they erupt. Nor do they examine the actual performance of the G8 in global health governance to see if its members can handle the requirements of a multifaceted disease containment regime. Savona and Oldani and Bayne highlight the G8's integration of private and public actors, but do not show how this generates 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, and how future initiatives might flow from what has worked in the past.

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 of performance that arise. Part 2 examines G8 diplomacy over global health issues at the most important individual summits, tracing the process by which G8 members — with different priorities and preferences — were pushed by outside pressures and internal institutional and individual incentives to produce a collective result. Part 3 addresses the major causes of these patterns of performance and diplomacy, 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). The conclusion employs this analysis as an evidence-based foundation for suggesting some initiatives that the G8 leaders could usefully take at their St. Petersburg Summit in 2006.

The Argument

This analysis shows that since the 1980s, and especially with the onset of rapid globalization in 1996, the G8 has emerged through several stages as an expansive, effective, high-performing centre of global health governance. In 1996 and 1997, under Franco-American leadership, the G8 summits started discussing and deciding on global health issues in a substantial way. In 2000-01, under Japanese and Italian leadership, the G8 more than doubled its health deliberations and decisions, delivered its decisions to a very high degree, and mobilized 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, especially when each has served as host. Effective action by this concert of equals has been driven by those deeper forces that the concert equality model of G8 governance highlights (Kirton 1989). 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 G8's newest member of Russia the G8's most infected partner, and then proliferated across an Africa whose concerns and leaders connected closely with the G8 at the summits since 2001. In the face of this rapidly expanding and equalizing G8 and global vulnerability, the old organizations of the UN system, led by the WHO, have proven increasingly ineffective in mobilizing their own members' resources on the scale required or in meeting the targets and timetables they have set. In contrast, the G8 countries have possessed the globally predominant and internally equal overall and specialized capabilities needed to combat the new diseases on a global scale. The G8's core common principles of open democracy, individual liberty and social advance have brought them closer to their newly democratic African partners and made 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 and act ambitiously at an unprecedented five summits in a row. Here they have met face to face with the same four core democratizing African partners and increasingly with the same democratizing "plus five" partners in the still constricted, cozy, leaders-dominated G8 club, to discuss global health in the comprehensive, interlinked, high-level way the world needs.

This analysis supports the case for the G8's 2006 St. Petersburg Summit taking an initiative to prevent a new HIV/AIDS pandemic erupting across Eurasia, starting in its Russian, Indian and Chinese core. With India just having become the country with the most HIV/AIDS-infected inhabitants in the world, there is a clear and present danger to human life, social cohesion and economic growth on a massive scale within the G8, across its plus-five partners of India, China, Brazil, Mexico and South Africa, and around the world. In response, the G8 offers the overall capacity required, the proven experience since 1985 in dealing with the critical stigmatized groups, a new emphasis on preventive action in related fields and important HIV/AIDS areas such as microbicides and vaccines, a tradition of having its annual host focus on geographic regions of greatest importance to it and a unique capacity for the comprehensive, coherent, creatively interconnected governance that this challenge demands. A low-cost, preventive program is well within the range of the financial resources the G8 has recently mobilized for global health, appropriate for the G8's increasingly institutionalized partnership with the democratizing plus-five partners that are on the front lines of the new and old pandemic and have

now proven, well-tailored techniques to transfer from the old south to the new eastern front. And at St. Petersburg there are many incentives for action on the part of the veterans — Russian host Vladimir Putin, America's George Bush, Britain's Tony Blair, France's Jacques Chirac, Japan's Junichiro Koizumi from Asia — and the newcomers — Germany's Angela Merkel, Italy's Romano Prodi and Canada's Stephen Harper. They could feasibly and usefully create a new G8 health leadership form aimed at preventing an HIV/AIDS pandemic in Eurasia, involving their plus-five and African partners, meeting at the ministerial and multi-stakeholder levels and starting with the analysis, pilot programs and largely voluntary funding needed to launch a full-scale initiative at the German-hosted G8 summit of 2007 and the Japanese-hosted summit in Asia in 2008.

1. The G8's Growing Health Governance, 1975-2005

Health as a G8 Policy Field

The new health paradigm that emerged in the 1970s expanded the dominant conception of health beyond disease or health care to include the socioeconomic determinants of health. In keeping with this broader conception, health in a G8 context should be conceived broadly as the human condition of being sound in body, mind, and spirit, and free from physical disease, infirmity, or pain. Health should also be considered in its relationship with the economy and society, as the heavy burden of HIV/AIDS in sub-Saharan Africa highlights, and in its connection with the environment, security and human rights.

In its G8 context, health can 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 objectives. 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), other diseases such as cancer, 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. Core health includes the use of health generating instruments, where health is specified as the welfare objective to be obtained, as in debt relief for the benefit of health systems in developing countries, information and communications technology (ICT) to improve healthcare facilities or for telemedicine or health education, or environmental issues that affect human health. Health-related issues deal with the specified ways in which health instruments affect outcomes on welfare objectives in other policy areas, such as economic development and growth.

This study analyzes the G8's health performance on both core health and health-related issues across the six basic functions of the G8's and other international institutions' global governance. These are: 1) managing domestic politics in member countries; 2) deliberating on specific global issues and thereby 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 member country compliance and implementing action; and 6) the development of global governance through creating or guiding G8-centred and other international institutions to which future tasks are delegated.

Domestic Political Management

On the first function of domestic political management, the G8's health performance has produced mixed results.[3] G8 leaders have not heralded their G8 health accomplishments in their annual national policy addresses. But they have increasingly received attention and approval for them in their national media news and editorial coverage at home. This trend culminated in 2005, when the virtually unanimous domestic media approval British prime minister Tony Blair received for his 2005 Gleneagles Summit was fuelled in part by its prominent attention to and action on African health (Kirton 2005b).

Prior to Gleneagles, the judgements of civil society groups about the G8's health governance were largely negative. Most campaign groups highlighted remaining needs rather than existing progress, and criticized the G8 as the new focal point, rather than the familiar UN bodies, for not doing nearly enough. Indeed, one reason why G8 leaders gave relatively little attention to health in 2002 was the strong criticism they received from NGOs (nongovernmental organizations) for what the leaders regarded for their major breakthrough on health at their summit in 2001 where they created and raised an initial US$1.2 billion for the Global Fund. The violent protests that erupted and the death of a protestor at this summit dominated the media coverage and drowned out any attention and approval for the leader's advances on health during the summit itself. Yet the reaction of civil society groups to the Gleneagles Summit action on African health shows that G8 leaders could secure domestic approval from this critical constituency when they produced credible, well-crafted agreements, such as the International Finance Facility for Immunization (IFFi) produced in 2005.

Deliberation

The G8's second function is deliberation. As an annual meeting of leaders, the G8 summits inherently reflect, legitimize, shape and create the agenda and priorities of both individual G8 leaders and the global community of the time. These agendas and priorities are often signalled publicly as leaders put a summary of their discussions and their personal representative agreements into the documents they collectively release during the summit itself. Since the subject of health first appeared on the G8's core agenda in 1982 there has been an increasing interest in the subject (see appendices A, B, C, D). This increase has been punctuated by six peaks, generally reflecting the sudden emergence of new diseases or threats such as AIDS, SARS and bioterrorism.

The first peak occurred with the introduction of health to the agenda at the French-hosted Versailles summit 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 to the role the G8 could play in improving health facilities represented a large percentage of the agenda because of the relatively small size of the communiqué (containing only 20 paragraphs overall).

The second peak occurred with the Venice Summit in 1987. Here the Italian host released the Chairman's Statement on AIDS, a separate four-paragraph statement calling for greater support of the WHO's programs (G7 1987). Although an oral statement on cancer had been made by the chair at London in 1984 and one on drugs at Bonn in 1985, 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. Here the threat of disease outbreaks from bioterrorism was highlighted as a result of the war with Iraq and the concern over Iraq's biological weapons program. Another driver was the review conference for the Biological Weapons Convention that took place in September 1991.

The fourth peak arose in 1996 and 1997 as the summits changed their focus from G8-centred health to full global health. The 1996 Lyon Summit produced substantially more paragraphs on health than any previous summit — nine of the 296 total. This text focused on the

need for reforming rather than reinforcing the old multilateral organizations, by restructuring the WHO to cope with HIV/AIDS and other infectious diseases. At 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 at Okinawa in 2000. Its documents contained the greatest percentage of paragraphs on core health subsets of any summit in G8 history. Okinawa focused on health in developing countries, committing to a "new global partnership" to reduce the prevalence of HIV, tuberculosis, and malaria. This became the Global Fund created at Genoa in 2001 (Zupi 2001). Despite the significance of the health issue area at Okinawa and Genoa, however, attention slipped subsequently until Evian in 2003.

The 2003 Evian Summit represented the sixth peak, pushed by the implications of the SARS outbreak of 2002-03 and a renewed initiative to eradicate polio. The summit saw the release of an entire collective document devoted to health, out of 15 in total. 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 overall 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 at 5.4 percent was the lowest it had been since 1998. The percentage peak of 2000 had been 14 percent, while 2003 had come in at 11.6 percent. Moreover, the G8's 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 2003 Iraq war's focus on weapons inspections and terrorism, biological weapons once again became a major component of the health-related agenda.

As Appendix D demonstrates, the G8's health agenda has been dominated, among a broad range of diseases, by HIV/AIDS from the very start. It was the only disease referred to in summit documentation in 1987, 1989, 1997 and 2004, and has almost always received twice as much attention as any other disease. It has been a favourite of American attention at the summits the U.S. hosted, under both Democratic and Republican party leadership, in 1997 and 2004. The summits hosted by France in 1989, 1996 and 2003 and by Canada in 2002 have given HIV/AIDS particular prominence as well.

Direction Setting

The third function is that of direction-setting. As a group composed of the world's eight most influential countries and the expanding European Union (EU), the G8 has a large role in setting the principles, norms, defining ideas, and epistemes that guide global governance. These principles are often highlighted in the chair's summary and introductory paragraphs or "chapeau" of the summit communiqués. These offer a reflection of the central thoughts and ideas that guide the leaders' meetings and discussions over the course of the summit and the directions they wish the global community to take.

The 2000 Okinawa summit had acknowledged for the first time in the body of the summit's documentation the link between health and development. 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, tuberculosis (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).

Health became a priority principle with the G8's move in 2002 to issue a chair's statement as the summit's defining capstone document and one reflecting only what the leaders actually discussed (see 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, TB and SARS, and healthcare reform within the G8. While there was a hint that health for the poor should trump trade values, there was no recognition of health itself for security or health as a human right (Labonte and Schrecker 2004, 226).

Decision Making

The G8's fourth function of decision making is fulfilled through the number, appropriateness, and ambition of the collective commitments its leaders publicly make at their annual summit. Commitments are discrete, specific, future-oriented, measurable, publicly encoded commitments, often with specified instruments, outcome targets, and timetables or deadlines attached. Health commitments represent 5.5 percent of the total commitments made at the summits from 1975 to 2005 (see Appendix F). The G8 has been a consistent producer of health commitments since 1996, when the G8 moved beyond merely discussing the issue to making clear commitments aimed at change in global health.

Prior to 1996, the single commitment on health appearing in each of the 1983, 1986, 1991 and 1993 summits accounted for a very small portion of the total summit decision-making output. Since Lyon in 1996, however, there was sustained and growing G8 decisional action on health. The summits of 2002 and 2003 produced the highest ratio of health commitments to date.

This progression from 1996 to the peaks of 2002 and 2003 was a slow development, both in the number of commitments made and in the significance of the commitments themselves. In the period leading up to Kananaskis and Evian, Nicholas Bayne noted the low ambition of the commitments. 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, both the number and the significance of the health commitments expanded, with a stand-alone health action plan included. 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 in 2001.

The decisional 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). They 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 leading the old international organizations or represented an independent initiative by the G8. No commitments called for the direct support of other institutions. The 12 commitments made at Sea Island therefore constitute a more directed focus on health issues and a desire to take control of these specific issues. They reflect a desire by the G8 to fill the gaps, whether technical or financial, in the specific areas it saw as lagging and to provide leadership when the older institutions were found lacking.

Delivery

The fifth function of delivery refers to the fulfillment by G8 members of their collective commitments through a broad range of behaviour in the year after they were made. Since 1998, G8 members' compliance with their health commitments has been quite high (see Appendix G). On the 22 measured health commitments from 1988 to 2005, the average compliance level has been +57%. From levels close to the overall summit compliance average in 1998 and 1999, compliance with health commitments soared to a near perfect +95% in 2000. They stayed at above average levels since, even with a noticeable dip in 2002 and 2005.

One form of commitment where compliance is important is that of new money mobilized. In the field of health, the centrepiece has been the Global Fund. 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, Tuberculosis and Malaria, which they had launched only the year before…the fund already needed replenishment but the leaders made no move to do this." Yet compliance with significant, non-financial commitments made to the Global Fund has been high, such as the promise made at Evian to participate actively in donor and support conferences. 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).

Moreover, although the summit commitments made to the Global Fund have not included concrete numerical financial targets, and while G8 donations have not always lived up to some NGOs' assertions of what an equitable contribution would be, the G8 nations have improved their donations to the fund significantly since 2002 (AIDSPAN 2002). Indeed, by 2004, the U.S. was at 117 percent of its recommended "equitable" contribution, the UK had reached 140 percent, and Italy led the way with 430 percent. Showing some improvement since 2002, Canada and Japan had 51 and 33 percent respectively. Most recently, at a pledging conference on September 6, 2005, US$3.7 billion was pledged to the Global Fund for 2006-07. The donors were 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 donations to the Global Fund had more than doubled from US$1.3 billion in 2001 to over US$2.8 billion in 2005.

The Development of Global Governance

The sixth function is the development of G8-centred and other international institutions for ongoing global governance in particular ways. Especially from 2002 onward, the G8 moved from supporting or directing the UN system to taking initiatives to build G8-centred instruments and institutions on its own (see Appendix H). The G7 established two institutions on AIDS 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. Its direct global health governance thus began with the subject of HIV/AIDS and with the creation of G8-centred institutions to move this agenda ahead.

With the establishment of the Global Fund in 2001, the G8 began a period of increased institutionalization. G7 members together with Mexico also began a parallel, non-G8 linked ministerial meeting, the Global Health Security Initiative (GHSI) in late 2001. Together these G8 and G8-parallel bodies have focused on health security and infectious disease. Three distinct areas of sustained institutionalization have arisen. 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, while the GHSI ministerial meetings

were established to deal with biological warfare and security, their post-SARS agenda has shifted attention to the containment of potential naturally occurring disease outbreaks.

At the ministerial level, there had not been a G8 meeting on health during the summit's first 31 years. The British had considered holding one in the fall of 2005 as part of their presidency. The Russians, as hosts in 2006, held the first G8 health ministers meeting on April 28, 2006, to help develop the St. Petersburg Summit's priority theme on infectious disease.

The Pattern of G8 Performance

The overall pattern of performance of the G8 in health across these six functions is consistent with the evaluation of the performance of the summits as a whole (see Appendix G). In Nicholas 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 (Bayne 2005). The University of Toronto's G8 Research Group gave A-level grades to both Denver and Okinawa on health.

Together these analyses show that the G8 became a global health governor at an early stage across a broad array of governance functions. In the mid 1980's the rising awareness of HIV/AIDS within G8 countries led to the Chairman's Statement on AIDS in 1987 and to the formation of the International Ethics Committee on AIDS. The Iraq wars of 1990-1 and 2003- led to increased attention to bioterrorism and biological weapons.

The post-1996 period has been defined by a more global focus and fully international health agenda, with the introduction of diseases, such as Ebola and cholera, primarily affecting the developing world. This period brought a dramatic improvement in the summits' performance, beginning with Lyon in 1996. Lyon made four commitments, when previously only single health commitments had been made. However, the pattern of health performance did not consistently improve from one summit to the next. A few summits stand out during this time of generally high health performance.

A major leap forward, inaugurating a twenty-first century takeoff, came a Okinawa in 2000. It was awarded a grade of A+ by the G8 Research Group for its performance in health. Okinawa was very strong in its health deliberations (with 30 mentions of health on the agenda), decision-making (11 health commitments), and compliance (an almost perfect score by all nations). Consistent with the focus on international health, Okinawa brought to the G8's agenda guinea worm and onchocerciasis (river blindness), diseases virtually unheard of within G8 countries.

Another jump came at Evian in 2003. Evian saw significant success in almost all functions. It had historic highs in deliberation, direction setting, decision making and developing global governance, and the second highest performance in delivery. Infectious diseases and their treatment (specifically AIDS in the developing world) was the major focus of the core health agenda, backed up by clean water and sanitation in the health-related agenda. Sea Island in 2004 and Gleneagles 2005 maintained this momentum, and brought new highs in money mobilized.

2. G8 Health Diplomacy at Key Summits

The G8's rise to relatively high performance in global health governance, and the diplomatic process and broader forces behind it, can be traced b looking in detail at some particularly important summits along the route.

Venice 1987

The G8's first direct treatment of AIDS came at the 1987 Venice Summit. It was codified in a separate, four-paragraph Chairman's Statement on AIDS released on June 10, 1987. The statement noted the 1994 London chair's oral statement on cancer and the 1985 Bonn chair's oral

statement on drugs.[4] It proceeded to establish several foundational principles for dealing with AIDS. It presciently declared the disease a priority as "one of the biggest potential health problems in the world." It called for intensified national efforts rendered more effective by international co-operation through "strengthening existing organizations," giving them "full political support," providing them with the "necessary financial, personnel and administrative resources" and identifying the WHO as "the best forum for drawing together international efforts on a world-wide level to combat AIDS." It focused on preventing AIDS from spreading further, "in accordance with the principles of human rights," through education campaigns, basic and clinical studies on prevention and treatment, joint action by researchers for a cure, vaccine development and consideration of ethical issues. It approvingly referenced specific initiatives by Britain (co-sponsoring an international ministerial conference on public education about AIDS), the European Community (on basic and clinical studies), the U.S. and France (joint action by researchers) and France's proposal for an international committee on the ethical issues raised by AIDS.

Taken together, the G8 thus started to address AIDS on a global scale by recognizing drug users as a vulnerable group, approving education and research, endorsing and encouraging co-operation among national efforts, and creating new G8-centred mechanisms at the officials level to follow up (even while affirming the centrality of the WHO).

Okinawa 2000

The twenty-first century takeoff in the G8's global health governance began at Okinawa in 2000, with its great leap forward in the deliberative, decision making and delivery domains. In the lead-up to Okinawa, the G8 system moved — at American urging — to real action on the global public commons, notably on the issues of climate change, infectious diseases and AIDS. The two health issues were dealt with on different if parallel tracks, due to the different international organizations involved. The WHO was responsible for infectious diseases and the UN for AIDS.

In a related domain, negotiations leading up to the ministerial meeting of the International Monetary Fund (IMF) in April 2000 had seen the AIDS issue injected into the difficult discussions on debt relief for the poorest. The draft of the G24 ministers statement had included a passage on HIV/AIDS, even though the IMF was widely regarded as irrelevant to this issue. At the meeting itself, ministers — in a highly unusual step — spontaneously demanded that the communiqué be altered to add malaria to the list. The fragmented nature of the old 1944-45 multilateral system was becoming clear.

For Okinawa, the Japanese host sought to secure summit approval for a collective effort on infectious diseases, including HIV/AIDS and secure major new financial resources from member countries to this end. To do so the Japanese offered a substantial national commitment, as did the United States. But the Europeans, Canadians and Russians resisted, preventing a collective G8 program from being agreed to that year. Their refusal to endorse collective G8 action at Okinawa made it easier for the Americans to proceed in a largely unilateral fashion when George W. Bush became president at the start of the following year.

Genoa 2001

For the 2001 Genoa Summit, the Italian hosts mounted an initiative to mobilize major action and money to combat AIDS, TB and malaria through concerted G8 action as a major summit achievement. Reacting to the reluctance at Okinawa of the Europeans, Canadians and Russians to offer money for this purpose, and to their own large national deficit and debt and the Maastricht legal obligations limiting their freedom to incur more, the Italians sought to avoid a straight increase in government pledges, in contrast to the U.S., whose new president Bush inherited a fiscal surplus that gave him far greater freedom to spend as he pleased. Yet with African leaders

coming to the summit along with the executive heads of the major multilateral organizations, and with a new plan for Africa coming with them, there were strong pressures for a forthcoming response.

The Italians sought to meet the need through two important innovations. The first was the creation of a new, differently designed G8-centred governance institution, the Global Fund to Fight AIDS, Tuberculosis and Malaria. In true G8 fashion, the concept was to sidestep the bloated UN bureaucracies with their slow-moving and skewed procedures, expensive overhead, equitable expenditure priority and lack of concern with results. They favoured a new body outside the UN. Like the G8, it would have no or very little bureaucracy, would allocate money in response to promising proposals and would cut off funds to programs that did not meet their performance benchmarks. Consistent with its foundation rather than with intergovernmental design, and akin to the 2000 Dot Force and the Renewable Energy Task Force and the 1996 Global Information Society, the Global Fund's multi-stakeholder membership included G8 and other national governments, international organizations and NGOs. Not surprisingly, the WHO tried hard to capture and control the new entity and its promised new money, and in fact ended up by serving as the secretariat for the fund.

To raise the needed new monies, the Italians first considered a program of voluntary private sector fundraising, by asking the world's 1,000 major multinational corporations to contribute US$1 million or more each. But when this concept failed to secure the consent of their summit partners, the Italians turned to a multi-stakeholder model of seeking contributions from several sources, with the familiar source of national governments securing by far the largest.

This worked. Yet with the U.S. contribution, the G8 raised US$1.2 billion for the new fund, a sum that grew to US$2 billion within the year. However, the public reaction proved highly negative. The UN General Assembly Special Session on AIDS, culminating on June 25, 2001, pointed to the need for a much larger amount if the problem were to be solved. Those associated with the UN, such as Stephen Lewis and Kofi Annan himself, as well as critics such as Jeffrey Sachs (who called for US$27 billion), pounced on the UN demand. They presumed that the sole purpose of the G8's new Global Fund was to raise monies for the UN right away, and condemned the US$1.2 billion as a failure, alluding to the underlying racism of the G8 leaders as the underlying cause. Not surprisingly the G8 leaders concluded they would have been better off, in terms of their first function of domestic political management, by having done nothing at all on AIDS and leaving it to the UN so they could devote their own time to pressing concerns elsewhere. This reaction was greatest for the greatest contributor, America's George Bush, attending the G8 summit with a hopeful attitude for the first time.

Kananaskis 2002

Not surprisingly, these very same G8 leaders, all meeting together again at Kananaskis the next year, resolved not even to try to raise so much as a dime for the Global Fund, lest they subject themselves to a new barrage of criticism that they offered far too little and were directly condemning Africans to death as a result. Their strategy worked, producing a summit success in domestic political management, if not one in money mobilized directly for fighting AIDS.

As a great global fundraiser, Kananaskis began before the Canadians assumed the chair, when they announced the new CA$500 million Canada Fund for Africa, to be spent on the agreed African priorities including its health needs. As part of their strategy, the Canadians encouraged the Americans and Europeans to pledge major new money for official development assistance (ODA), as they themselves did, at the UN's Conference on Financing for Development at Monterrey, Mexico, on March 15, 2002. At Kananaskis the G8 leaders agreed that up to half this money could be devoted to Africa should its leaders meet the conditions they had offered the G8. At Kananaskis they also added up to US$1 billion to top up the HIPC trust fund to relieve the

debt of the poorest, and thus free up these countries' own monies to meet their priority needs in education in health.

The failure of the Kananaskis G8 to raise any more money for the Global Fund flowed from several sources beyond the criticism inspired by the UN. One was the need to give the new fund time to get organized operationally and effectively to spend the US$2 billion already pledged. Another was the need for G8 leaders to prove to their skeptical taxpayers that new money would finally work, after 50 years of failure in Africa overall and a decade of failure in the fight against AIDS alone. With such evidence, the G8 sherpas were confident more money would flow, including US$2 billion from the United States. Yet another was the need for G8 leaders, under the new paradigm for African development, to respond as much as possible to the priorities of the African partners, who, led by South Africa's Thabo Mbeki, did not feature the fight against HIV/AIDS. Indeed, three months before the summit, during a trip to South Africa the host sherpa had witnessed a fascinating debate between Mbeki and Nelson Mandela about the appropriateness of the South African approach to AIDS. A further factor was the failure of the private sector to invest in the fund, notably the drug companies' reluctance to make medicines available at any cost.

Other factors were also relevant. There was a recognition of the many other needs in Africa beyond fighting AIDS that required funding as well. There was a desire to allow the UN agencies responsible for AIDS as well as bilateral agencies to do their work, without funnelling all funding and attention into the fund. Finally, when — one week before the summit — the U.S. announced US$0.5 billion to fight AIDS on its own, there was a feeling that it was better to have the additional money to deal with the problem rather than risk U.S. generosity by demanding that all flow through the fund.

Substantively, the Kananaskis G8 dealt with AIDS as part of its debt relief and G8 Africa Action Plan. The latter focused on five broad areas, the third of which was education and health. Here the emphasis was on innovative leapfrogging methods and avoiding past mistakes, rather than more of the same. There was also a desire to reinforce the then fresh UN Millennium Development Goals (MDGs), including those on women's and children's health. Another was to spend the available from the fund and other sources on a broad range of purposes, including prevention, treatment, cure, education, research and healthcare infrastructure and systems. There was also an awareness that malaria killed more people than AIDS does, especially children under five, and that civil society was concerned about other African diseases.

Evian 2003

The 2003 Evian Summit, taking place amidst deep divisions among G8 members of the American-led invasion of Iraq that spring, saw an intensification of America's unilateral approach to health. In the lead-up to the summit, the U.S. announced the President's Emergency Plan for AIDS Relief (PEPFAR). It did so without even trying to use the U.S. contribution to lever new commitments from the G8 partners to create a much larger common pool.

The final preparations for Evian moved toward agreement that the summit would deal with health and produce language on polio and, as agreed a few days before it opened, on SARS. There was also to be follow-up on the Global Fund, not through pledges of new G8 money but by disbursing the money already committed. The U.S. sherpa, Gary Edson, was worried about the relationship of the fund to the WHO, which had been contracted to provide its administration. To raise more money for the fund, the G8 looked to reach out to contributors from beyond the G8.

By mid May, following a combined meeting of the sherpas and foreign affairs sous-sherpas (FASS) at Evian, it was agreed that the summit would release a document on health that would deal with AIDS and SARS. Any more money would come from countries beyond the G8. But the intra-G8 divisions, led on each side by G8 co-founders France and the U.S., continued to have an impact. One was positive: in response to the U.S. unilateral PEPFAR pledge of US$15 billion for

AIDS, French president Jacques Chirac announced an EU contribution, to the great surprise of the other EU members.

The other was negative. Having made a visible reconciliation with Chirac at the summit, U.S. president Bush left before the last day, flying off to the Middle East to promote his peace plan there. He was thus absent for the final day's discussion, scheduled to be on sustainable development. However, in a reflection of the summit's spontaneity, the leaders discussed AIDS instead. They focused on Bush's US$15 billion pledge in his speech to Congress and how the president's plan would work. Without anyone from the U.S. present to explain it, the other G8 leaders shared their interpretations. As they did so, they were driven to conclude that the US$15 billion was in matching funds with such stringent conditions for matching and releasing the monies that they might never be spent. Rather than concentrate on making new pledges of their own, the G8 leaders — without Bush and in light of prevailing mistrust of America — concluded his unilateral move was a massive public relations exercise and that they and the world had all been fooled.

3. Causes of the G8's Growing Health Governance

The G8's increasingly high performance in health was produced through the leadership of virtually all G8 countries as host, with each adding important components to the cumulative edifice. Behind this leadership of the individual agents lie the six forces highlighted by the concert equality model of G8 governance: the shared health vulnerability of G8 members; the increasingly poor health performance of the old international organizations; the equalizing capability of G8 members; health's close connection to the common democratic principles among the G8 members; their leaders' high political control and capital at home; and the constricted, controlled membership of and participation in the G8.

The Intensifying Equal Health Vulnerabilities of the G8 and the World

The first and most powerful force behind the G8's growing health governance was the increasingly equal vulnerability of each G8 member to a new generation of infectious disease. This came as the early AIDS assault on America rapidly spread to all G8 members, made the recently recruited Russia the leading source of new infections within the club, and proliferated throughout an Africa that became the dominant agenda priority and attending partner of the G8 summits since 2001.

This increasingly equal vulnerability to health threats, and thus common incentive to act, is seen first in the number of new infections of the primary new generation disease, HIV/AIDS, in each of the G8 countries (see Appendix J). These data show that the G8's growing health governance was a direct, rational response by G8 members to their physical vulnerability to 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). It was finally the provision of a global public good in response to a pandemic of global scope and scale in an increasingly globalized world in which people are increasingly mobile (see Appendix K)

The physical assault from AIDS began first in the United States, Canada, and France in the early 1980s starting with the discovery of the virus, under a different name, in 1981. 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 bearing 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 and one without a cure, vaccine for immuniziation or even medicines for effective treatment of the already ill.

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 for 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. It was the shock of this initial vulnerability, rapidly spreading equally among all G7 members, which 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 of HIV/AIDS on all G7 countries 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 such as cancer and heart disease, which accounted for significant deaths in G8 nations, received almost no attention at the summits.

By 2001, three new physical thresholds were crossed — 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 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 vulnerability from a new source, through the shock of SARS (see Appendix L). Although this 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 systems were vulnerable to diseases that developed in very poor countries, and that were half an old geographic 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 compounding sense of shock and panic, and relatively high levels of agenda attention after the first outbreak in 2002. The impact the awareness of SARS created for global collaboration was clearly felt at the summits.

In 2003, the year following the 2002 SARS outbreak, the G8 summit at Evian produced the highest performance on record in both health deliberation and commitments; two institutions were established, money was mobilized, and compliance was higher than average. The emerging health threats and the public concern surrounding them were thus largely responsible for introducing new health issues to the G8 agenda during this period. The shock of SARS 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.

In 2005 this lesson was driven home by a second shock – the attack of avian flu, originating in Asia, on the homelands of G8 members themselves (see Appendix M). Starting in the first quarter of Japan in 2004, the disease spread steadily to all G8 regions by the end of 2005. Although no human cases or fatalities were reported in G8 countries, by January 2005 the rising human death toll — in neighbouring Asia, in systemically important countries that were G20

members and twenty-first century G8 attendees, and on Turkey right next door to the EU — inspired the G8 to act quickly and preventively to this second Asian shock.

The Poor Performance of the Old International Health Organizations

The second cause of the G8's growing health governance was 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 G8's early lack of concern with health issues had flowed from its deference to the WHO, as the official formal and presumably functionally effective body for global health governance. All G8 summits from 1997 to 2003 with major health commitments included calls for support of the WHO's activities and references to the "important role" of the organization in combating the world's diseases (see Appendix F).

However, the vulnerability of the global healthcare system in the twenty-first century called for much stronger international collaboration than the WHO proved able to provide (Fidler 2002, 2003, Kickbusch 2003, Price-Smith 2001). Ilona Kickbusch (2000, 983) has emphasized how the old system was 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 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 was an inherent instability as the number of actors on the global health stage increased without the mechanisms necessary for increased collaboration. The result was that either emerging diseases went unnoticed or there was not the necessary cross-sector collaboration between national health systems and the pharmaceutical companies responsible for vaccine or antidote development, as was the case with river blindness.

The G8's adoption of issues such as river blindness sought to fill the gap in collaboration. 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 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 by the failure of the old international health organizations, notably the WHO and UN, to retain sufficient confidence from their members to lead these countries to invest the required resources there. As the financial reports from the WHO World Health Assembly documents show, from 1996 to 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. In sharp contrast, during this time G8 health performance grew strongly, culminating in the 2000-2001 launch of the Global Fund.

To be sure, with current infection rates of HIV/AIDS now exceeding 40 million worldwide, it is clear that no international institution has done enough of the right thing in response.Yet as the first line of defence, the WHO in particular received widespread criticism both from within the organization and from the larger international community. Moreover, those within the UN system also recognized that its internal failures in handling the crisis 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 as early as 1993, the UN itself had taken the Global Programme for AIDS, which was the WHO's largest program, out of the WHO's sole

control (Godlee 1994, 7). It created UNAIDS instead. Yet the UN itself also failed (Lewis 2005: 155).

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" (Italian Presidency, 2001).

This failure of WHO governance continued and was compounded. When the SARS crisis erupted in 2003, the WHO, with its deference to the sovereign prerogatives of closed countries such as China, to the extent possible, was slow to respond to protect the global community against this fast moving new disease. The WHO's "3 by 5" program, under which the WHO promised to have three million patients in treatment for AIDS by the end of the year 2005, was a striking failure, as only one third of the targeted three million were receiving treatment at that time (Lewis 2005: 154). Thus it was left to the G8 at Gleneagles to promise not partial but "universal treatment by 2010."

High G8 Health Capability

The third cause of growing G8 health governance was the globally predominant and internally equalizing capability of the countries in the G8 club. In sharp contrast to the limited capacity and poor performance of the old multilateral organizations, the G8 countries increasingly possessed the globally dominant share of the overall and specialized capabilities required to combat the new diseases, and shared these among G8 members in a way that enabled and required all to contribute in a materially meaningful way, if effective collection action were to take place.

The G8's global predominance is highlighted by a comparison of G8 healthcare spending and the healthcare capacity of the developing world. The G8 average for 2001 was an expenditure on health care of US$1,492 per capita (see Appendix N). In sharp contrast, according to the World Bank (2002) statistics, the average health expenditures per capita for developing countries was US$73.4, and for the poorest of the poor in sub-Saharan Africa only US$31.9. The Commission on Macroeconomics and Health predicts the financial need for health services in developing countries will reach US$27 billion by 2007. The disease burden of these countries has profound impacts on their economic capacity and therefore ability to improve their 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.

This disparity in healthcare budgets and the economic burden that resulted from the proliferation of disease in the developing world can partly explain the G8's focus on international health since 1996. This is where the greatest need met a great capability. The need itself became more apparent in recent years as AIDS took hold of Africa and other developing areas. The G8, through the Global Fund, came to provide more money to meet this global public need than the WHO itself. By 2004 the money committed to health at the summits combined was US$4.9 billion. Promises for official development assistance (ODA) on health outside the G8 structure accounted for US$6 billion (Commission on Macroeconomics and Health 2001). The G8 at Gleneagles promised to double ODA within five years, and inspired the additional $3.1 billion raised in the autumn replenishment of the Global Fund.

The equality among G8 members in health is evident in the way each took the leadership on a disease in which it had developed a specialized capacity over the years. France has been active on AIDS, a disease first discovered by a French scientist and closely followed by an American one. Britain had historic strengths in tropical medicine and led TB and malaria onto the G8 agenda. Canada was in the lead on polio and SARS. And Italy accepted stewardship in 2005 for developing a financial facility to ensure the development of vaccines.

The G8's Common Principles of Open Democratic Health

The fourth cause of the G8's growing health governance was the institution's shared common principles of open democracy and social advance. These core values fuelled the functionally appropriate, multi-stakeholder approaches (including business and non-profit organizations) most appropriate to combat the new generation of disease. They brought bring the G8 members ideologically closer to their new African partners now embracing democratic development.

Providing high-quality health care was also a principle shared by all G8 members. This shared social purpose led to higher performance in deliberation and decision making, as all members saw the 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 represented a relatively equal preference in country budgets, with an average of 9.15 percent (2001) (see Appendix N). They thus saw how public heath was vital to the G8's seminal mission of social advance. The shock of SARS in 2003 showed them how a lack of transparency in countries that did not have open democracy proliferated deadly disease in a globalized age.

Far less relevant as a unifying force was the G8's seminal value of "individual liberty," as not all G8 members accepted at home an internationally asserted human right to health. The value of individual liberty was important at the G8's 1987 start in explicitly governing how the G8 would approach the prevention and treatment of HIV/AIDS. But it never extended in full-blown fashion to a human right to health as a guide to G8 action in this field.

G8 Leaders High Political Control and Capital at Home

The fifth cause of growing G8 health governance was the fact that since 2001 the high political control at home by the popularly elected G8 leaders allowed the same seven individuals to come to an unprecedented five summits in a row. This encouraged a sustained, iterative and expanding treatment of health more than half a decade (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 — meaning that leaders with a fresh mandate and in firm control of their party, legislature and public opinion have maximum political control. In the case of health, however, it is longevity alone, and the experience, self confidence and iteration that came with it, that drove high performance.

In 1998 the newly elected Tony Blair as G8 hosted did bring the Rollback Malaria initiative to the summit, but Birmingham did little to further G8 health governance as a whole. In general, the peaks in G8 health performance came 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 came as Clinton attended his last summit, and the unelected Japanese prime minister Mori hosted his first. The summit's success can be attributed in part to Clinton's desire for a legacy and to an all-encompassing effort domestically and internationally to push forward the agenda items he had previously been holding off. The 2002 Kananaskis Summit's high deliberation and decision-making performance coincided with the leadership of Jean Chrétien, attending the summit for the tenth time and hosting it for the second. The Sea Island Summit's focused deliberation and decreased decision making came as host George Bush was entering 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.

The Constricted Participation of the G8 Leaders' Club

The sixth cause of the G8's growing performance in global health governance was the fact that the G8 summit-driven institutional system allowed the same G8 leaders to meet face to face on an annual basis with themselves and the same four core African partners and, increasingly, the systemically significant plus-five participants in the still-constricted G8 club, and reach out to other stakeholders at the ministerial and official level below (Hajnal 1999). The club allowed leads to be leaders, by acting on the spontaneous, interconnected, comprehensive, creative way that only leaders can.

Constricted participation and the spontaneous innovation among leaders it allowed was responsible for placing health on the G8's agenda in the early years. In the 1980's it was Margaret Thatcher's informal, personal conversation with Ronald Reagan at the summit that led the leaders to take up the issue of drugs, which led directly to the G7's attention to HIV/AIDS. The move to a more restricted format in 1998, when heads only started to meet at the summit, helped Tony Blair as host have the summit broaden the G8's attention from AIDS to malaria and TB.

The G8's highly selective, tightly controlled and well-targeted expansion of participation also directly fuelled the increase in its health governance performance in both breadth and depth. The inclusion of Russia as a full and then permanent member starting in 1997 coincided with the G8's rapidly growing health agenda and action since that time. The dramatic increase in the number of HIV/AIDS cases in Russia during this time, together with Russia's growing inclusion and experience as a full member, sustained the G8's growing attention to health, even if Russian was long reluctant or unable to highlight the problem in its national agenda at home. The peak of G8 health 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. Most directly, the presence at the summit every year since 2001 of the same four leaders of Africa's major democratic powers has fuelled the "twenty-first century" take-off in G8 health governance, particularly in its concentration on those diseases that destroy Africa most. The plus-five partners of India, China, Brazil, Mexico and South Africa, attending on an expanding basis in 2003, 2004 and 2005 helped reinforce the G8's extension to the Asian-incubated diseases of SARS and avian flu and other poverty-driven illnesses. The attendance of the executive heads of the most relevant multilateral organizations — in 1996, 2001, 2003, 2003 and 2005 — had a reinforcing effect.

A further consequential component of constricted participation has been the G8's growing responsiveness to civil society and mobilization of the multi-stakeholder model in the health field. At Birmingham in 1998 and Cologne in 1999 outside NGO pressure from the Jubilee 2000 coalition pushed G8 leaders to do more for debt relief to free up resources to devote to developing countries' health and education. At Genoa, the G8 pioneered the use of public-private partnerships (PPPs) in their major form with the creation of the Global Fund that included G8 and other governments, international institutions and civil society actors from many spheres. By Genoa, in regard to health and other issues, the G8 had demonstrated its progress in "involving both private firms and non-profit bodies in summit preparation and follow-up" (Bayne 2002).

Driving the importance of multi-stakeholder participation in G8 health governance were the increasing variety and numbers of actors participating in global health governance; NGOs made their voices heard across the international arena and showed considerable power of persuasion in influencing public opinion and public policy. Most notably, the Médecins Sans Frontières campaign for access to essential medicines played a significant role in altering policy on drug access. Elsewhere 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) also demonstrated their influence as non-state actors in

affecting public policy. The lobbying of the U.S. government by pharmaceutical companies was a major impediment to progress in providing access to antiretroviral drugs for developing countries. Private foundations, led by the Bill and Melinda Gates Foundation, became major financial sponsors of the new initiatives on global health.

Conclusion: Past Performance, Future Possibilities

Past Performance

With the onset of rapid globalization in 1996, the G8 emerged as an increasingly expansive and effective, high-performing centre of global health governance. This emergence 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 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 was driven by skilful G8 summit diplomacy and by those deeper causes that the concert equality model of G8 governance highlights. The most powerful cause was 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 growing demand bred by the rapid proliferation of vulnerability, the old organizations of the UN system, led by the WHO, proved increasingly ineffective in supplying the required response. In contrast, the G8 countries alone possessed 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 brought them close to their newly democratic African partners and made 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 allowed the same seven individuals to come to an unprecedented five summits in a row. Here they met face-to-face each year with the same four core African partners and later the global plus-five powers in the still constricted and cozy leaders-dominated G8 club.

Driving this twenty-first century takeoff in G8 health governance were the complexities that globalization brought to the health field. The paradigm of health changed, moving toward a conception that included a breadth of socioeconomic, ecological, political-security and human rights factors as causes, consequences, conditions and targets of health. There arose more players on the field, with health NGOs and MNCs looking to have their say in the decision-making process. In this era of frequent air travel, the stakes became higher than ever as an infectious disease could travel from one continent to another in hours. And it could spread in far more pervasive and uncontrollable ways as migratory birds moved around the world. The G8, as an informal international institution led by an annual summit where the world's most powerful leaders could comprehensively, swiftly, spontaneity and creatively address all policy areas across international and domestic domains, and make the complex connections among them in policy

that mapped those in the physical world, was well designed to generate the desired global health governance for this new world.

In their annual summits, the G8 first brought health issues to the table in order to discuss the new realities presented by globalization and assist the WHO in its efforts to contain the world's diseases. The rising panic over HIV/AIDS and the apparent threat it posed to the U.S. and Europe drove the G8's initial concern. Other health issues subsequently came onto the G8's agenda out of public panic over infectious disease, such as SARS, bioterrorism, and avian flu. The six peaks in agenda attention reflect the contribution health crises had in stimulating and steering the G8's focus. At the Denver Summit in 1997 the G8 moved away from dealing with health sporadically whenever there was a crisis and began more sustained governance, with a growing performance in the deliberative, decision-making and delivery domains. Evian in 2003 was the highest performer in all these functions, with an entire collective document devoted to health.

This sustained period of attention and activity on diseases that did not primarily directly affect the G8 countries themselves was driven by the weakness of the WHO. Its manifest failures in the face of the new fast moving global pandemics opened the door for other global institutions, especially those that could facilitate collaboration between the many participants now consequentially involved in the global health system. The flexibility of the G8 to expand the participants included in its deliberations to NGOs, MNCs, and the existing international health organizations was a great asset in its ability to achieve its health goals. This was seen most clearly in the G8's effective leadership in creating the Global Fund, which came to enjoy substantial financial and political support worldwide.

Future Challenges

This impressive past performance by the G8 now confronts the stark realities of the growing global body count from preventable infectious disease, the huge gaps in healthcare funding, systems and practices in developing countries and the large capacity the G8 possesses for closing these gaps in many ways. The need for new G8 leadership is underscored by the striking contrast between the world's two major summits that took place in the summer of 2005.

On July 6-8, the G8 leaders met at their annual summit with their African and systemically significant plus-five partners at Gleneagles. There they came to conclusions 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 for their first summit in half a decade. There they issued a document that in its priority passages noted the value or existence of health not at all (UN General Assembly 2005). In its overall documentary output the Gleneagles G8 devoted 15 paragraphs to health, but the New York UN leaders only 10. Diseases such as polio made the G8 but not the UN list. The UN's World Summit did make more commitments on health than the Gleneagles G8. But the UN leaders mobilized no new money to meet them, whereas the Gleneagles G8 leaders raised more money for global health than ever before.

There are thus good grounds for looking to the G8 as the primary global health governance platform on which to build and innovate in the years ahead. And the current G8 seems prepared to act. One driver is the position of Russia, the G8's 2006 host, as the most vulnerable G8 partner to HIV/AIDS and a broad range of health threats, especially with its rapidly declining population that took centrestage as a problem in its president's 2006 National Policy Address. Another is the rapid spread of avian flu from its Asian incubator into Russia, Europe, the Middle East and Africa, and the probable outbreak of human-to-human transmission in its Indonesian epicentre. And a third is the human, economic, social and security devastation to Russia, China, India, their Eurasian neighbours and the global community, if low-cost, well-tailored and targeted action, based on the proven performance of G8-fosted programs, is not taken now.

In response to such forces, President Vladimir Putin as host decided from the start, for the first time in G8 history, to include infectious disease as one of the three priority subjects for the

summit (Panova 2005, Savostiyanov 2005). In preparing for St. Petersburg, the Russians began with a wide ranging, ambitious program for the control of infectious diseases, including AIDS, TB, malaria, polio, emerging diseases, and avian flu. The program embraced G8 measures to strengthen global information and analysis monitoring networks for infectious diseases, a G8 plan of action to control avian flu and prevent a global flu pandemic, the prevention and mitigation of the epidemiological consequences of natural disasters (such as the shocks of the hurricanes that ravaged a vulnerable America in the summer of 2005, as well as the Asian tsunami and Pakistani earthquake), and scientific exchanges to study infectious disease agents, including those involved in bioterrorism.

Proposals for Progress on the Built-In Agenda

To further the G8's growing performance as the centre of global health governance, there are several initiatives that the G8 at the St. Petersburg and subsequent summits could usefully take. These embrace both the next stages of the old or built in agenda, and bold new initiatives for timely, well tailored, low cost immediate action to prevent the next generation of already looming threats.

The first task, from the old agenda, is to mobilize more money to combat HIV/AIDS and other infectious disease. Here the first target is to "fund the Fund" to complete the US$7 billion dollar funding package the Global Fund requires for 2006-2007, by doubling the funds committed at the pledging session held shortly after the Gleneagles summit took place. Doing so would fulfil the commitment made by the G8 leaders at Gleneagles to "work to meet the financing needs for HIV/AIDS, including through the replenishment this year of the Global Fund to Fight AIDS, TB and Malaria; and actively working with local stakeholders to implement the '3 Ones' principles in all countries."

The second task is to devote resources to ensure that the WHO's failed "three by five" program is reached within the next few years.

The third task is commit to the resource and actions required to ensure that the G8's promise to eliminate polio is fulfilled within the next few years. Here the Gleneagles G8 leaders had optimistically promised to support "the Polio Eradication Initiative for the post eradication period in 2006-08 through continuing or increasing our own contributions toward the $829 million target and mobilizing the support of others."

The fourth task is ensure that the first-ever meeting of G8 health ministers, held by the Russians in April 2006, becomes a permanent, perhaps annual G8-centred ministerial institution, and that it quickly embrace a broad range of other relevant stakeholders as well.

And the fifth task is to endure that the St. Petersburg G8's work on bio-terrorism takes place in a way that is fully integrated with that of the highly effective Global Health Security Initiative.

Proposals for Progress on a Eurasian HIV/AIDS Extension

This built-in agenda is very big and badly in needed of a new political impetus to move it ahead. But there are still good grounds for going beyond it to mount an extended initiative, aimed at Eurasia and preventing the coming HIV/AIDS pandemic there.

The first reason is the clear case for the imminent probability and great cost of the looming pandemic and the high value of low-cost preventive action now. The case has been highlighted by the announcement by UNAIDS that India has overtaken South Africa as the country containing the most people living with the HIV virus (UNAIDS 2006).

The second reason is the G8's increasing interest and effectiveness in moving into preventive rather than reactive behaviour. As a modern international concert, the G8 is, in its essence as a global governance centre, a conservative creature designed primarily to protect the order produced by the already privileged members it contains. But from the start it has had a core

proactive mission, grounded in promoting social advance around the world. To be sure, on the HIV/AIDS pandemic of the 1980s and 1990s its preventive performance was poor. Its reactive performance has been disappointing in many ways to this day. But beginning in 1985 in the related field of sustainable development and in 1999 in the field of conflict prevention, it has started to move with some effectiveness into the preventive realm.

The third reason is the G8's considerable accumulated capacity and proven practice from its work on AIDS for almost two decades now. Thus in Eurasia it could begin in 2006 where it began within the G7 in 1987, with drug users and other critical, vulnerable stigmatized groups. While much of the African experience is not easily transposable to the very different conditions in Eurasia, the G8 and its plus-five partners can draw on a much more diverse wealth of experience from within its many participants from most regions of the world. And useful lessons can be learned from what has failed everywhere, as well as from what has worked in particular venues.

The fourth reason is the G8's long tradition of adding new initiatives directed at those regions physically or politically close to the host country. In 1993 and 2000, Japan privileged Asia. More recently, Italy in 2001, Canada in 2002 and Britain in 2005 selected Africa, with sub-Saharan Africa at the core and its health problems an important part. In 2004 the U.S. chose the broader Middle East and North Africa, again with health on the agenda there. For 2006 Russia had initially considered focusing on poverty reduction in the neighbouring CIS states and inviting the leaders of the member countries to come to St. Petersburg to participate in the G8 summit. But it was dissuaded by its summit partners from including such substantially non-democratic group. A Eurasia-oriented health initiative would thus represent Russia's regional addition and assist poor people in Russia's CIS and other neighbours as well.

The fifth reason is the G8's desire for coherence, creative linkage and integration across its wide agenda, in the innovative way that leaders are uniquely well positioned to produce. Here G8 foreign ministers or their representatives will meet in Moscow on June 28 to discuss Afghanistan, its drug production and use, and drug trading routes into the G8. This already places drugs and drug users on the G8 St. Petersburg agenda, in somewhat the same way that it first arrived in 1985. The infectious disease threat to vulnerable drug users, in the G8 and poorer neighbouring countries, is a natural extension of this file. Similarly, G8 leaders will be importantly considering the prospects for continuing vibrant growth in China, India, Brazil and elsewhere as part of their energy demand and world economy discussions. Assessing the threat to growth in these countries from a coming AIDS pandemic would be a natural and valuable extension of their discussions there.

Given these reasons, the question for the G8 leaders at St. Petersburg is less whether than how much and how to act to address the coming Eurasian AIDS pandemic. Here there are several guidelines, based on the summit's past performance about how best to proceed.

The first step is to get started by putting it on the agenda as a priority subject. This involves adding to the summit documents a dedicated passage on Eurasian AIDS and referring to it in other sections, rather than requiring the leaders to discuss the subject themselves.

The second step is to identify basic principles for addressing the problem in Eurasia. This could include a focus first on the value of rapid preventive programs, aimed at vulnerable populations, encouraging education to overcome stigmatization and involving many stakeholders, including legislators, NGOs and international organizations and those living with AIDS.

The third step is to institutionalize the effort by creating an inclusive G8 plus health leadership forum that would have preventive action in Eurasia as its priority task. It should include all G8 members, the now regularly participating plus-five partners of India, China, Brazil, Mexico and South Africa, the leaders of Nigeria, Senegal and Algeria who have been to most of the summits of the past half decade, and the executive heads of the international organizations that have attended G8 summits before (Kirton 2001). Its regional focus on Eurasia would build on and broaden the G8's repertoire of recently created regionally focused institutions, notably those

bred by the Broader Middle East and North Africa Initiative and by the G8 African Action Plan. Its composition would allow for a direct transfer from the plus-five, broader Middle East, African and intra-G8 experience to Eurasia of those paradigms, programs and practices proven to work.

The forum could operate at the ministerial level, under the dual chair from the start of Russia as the representative and host of the G8, and a plus-five or African partner. A strong candidate is India as the outreach partner with the earliest experience of participating in G7/8 summits and as the country with the largest number of HIV/AIDS infections in the world. It could also be constructed on a multi-stakeholder model, along the lines of the G8-created Global Fund, the Dot Force, the Renewable Energy Task Force and the Global Information Society before.

The work of such a body could begin, following the precedent of the Africa Commission created to prepare for the 2005 Gleneagles Summit, with a comprehensive analysis and action plan based on what is known about the problem, what needs to be done and what has been proven to work. It could extend immediately to pilot projects in locations covering all critical sub-regions and key subjects in Eurasia. A premium would be placed in the first year on practical low cost projects, with a view to making a case for much larger programs and resources at the German-hosted G8 summit in 2007, and the Japanese-hosted summit in Asia itself in 2008.

To help fund the pilot projects for the first phase of this low-cost initiative in its inaugural year, consideration could be given to an adapted version of the voluntary corporate fundraising program devised but not adopted by the Italians in 2001 for financing the Global Fund. That funding formula was inappropriate for raising the relatively large sums then required from the world's major multinational corporations. They had limited commercial interest in sub-Saharan Africa, and in the then relatively new principles and practices of corporate social responsibility through multi-stakeholder partnerships. In the current case, the initial funding needs are much more modest. The model of multi-stakeholder private-public partnerships has proven its value in the global health field. And corporate social responsibility has become an accepted practice for most of the world's major firms. Moreover, virtually all of the world's major multinational firms already have — or will soon develop — direct foreign investments, portfolio investments, markets and suppliers in China, India, Russia and their neighbours. They thus have an immediate commercial incentive to assist in protecting the health of their employees, customers and their families there.

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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			

* Announcement of the Global Fund

Notes:

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: Healthcare 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

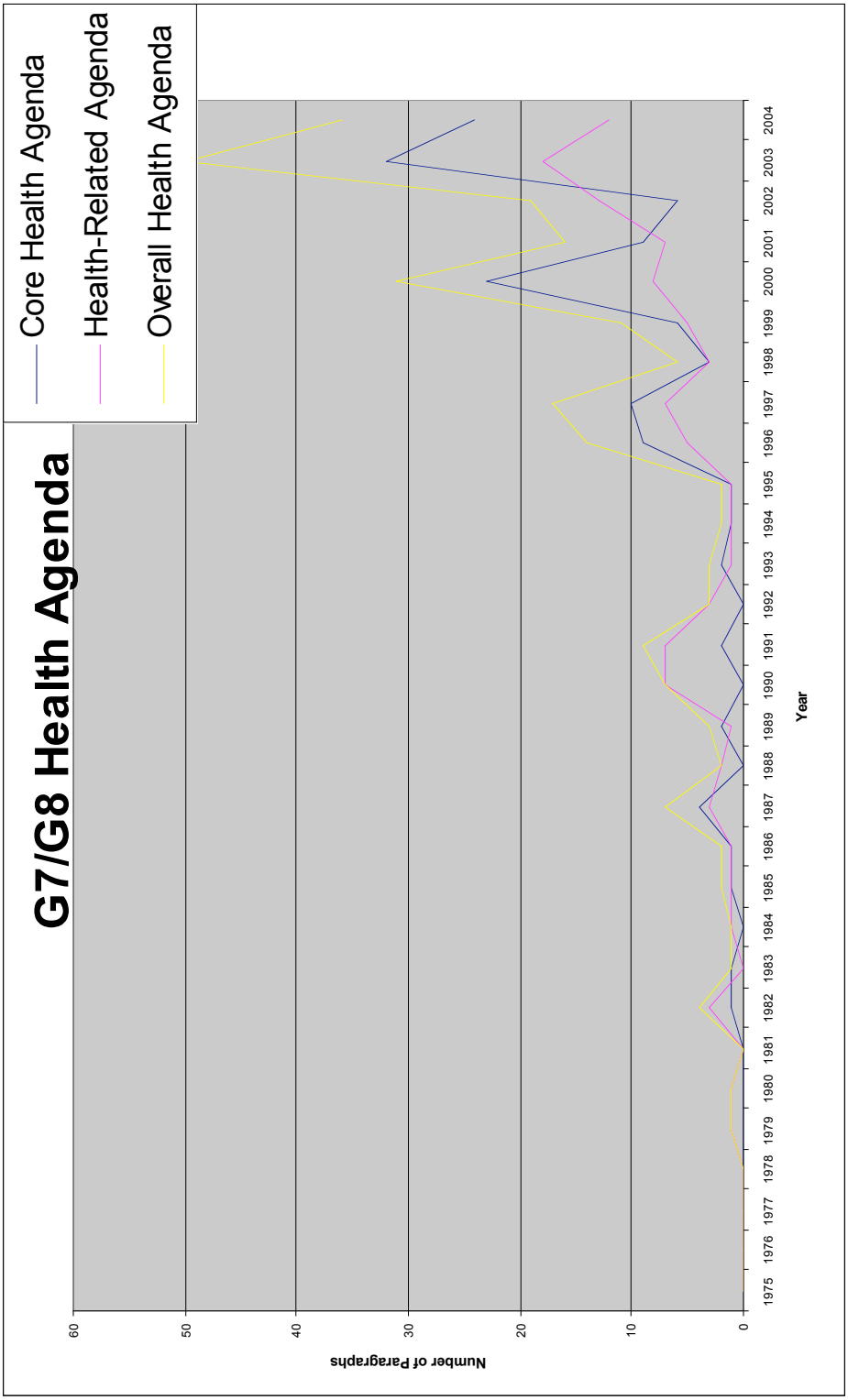
MOB: Mobilization of resources

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															
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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. A reference 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 (IO): 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 (IO):** 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:
G7/8 Health Compliance Record 1998-2005
(Cases = 22)

Commitment	Issue	Score
1998-23	HIV/AIDS	+0.33
1998-24	HIV/AIDS	+0.11
1998-46	Aging	+0.33
1999-32	Disease	0.00
1999-38	HIV/AIDS	+0.63
2000-23	Infectious disease	+1.00
2000-36	HIV/AIDS	+1.00
2000-37	TB	+1.00
2000-38	Malaria	+1.00
2000-73	Aging	+0.86
2000-S108	Biotechnology	+0.86
2001-26	Global Fund	+0.75
2001 Annual Average		*75%*
2002-11	Polio	0
2002-117	Medicine	+0.38
2002-119	Global Fund	+0.25
2002 Annual Average		*21%*
2003-10	Global Fund	+0.88
2003-13	Polio	+1.00
2003-14	SARS	+0.78
2003 Annual Average		*89%*
2004(10)-1	HIV/AIDS	+0.56
2004(11)-3	Polio	+0.44
2004 Annual Average		*50%*
2005*	Global Fund/3 Ones	+0.33
2005*	Polio	+0.11
2005 Annual Average		*22%*
Average		+0.57

* Preliminary final scores

Average Scores by Issue, 1998-2005

HIV/AIDS(5)	53%
Global Fund (4)	55%
Polio (4)	39%

Appendix H:
G7/8-Centred 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, Tubercuolosis and Malaria — est. 2001
"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 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 Parallel Institutions
8 Global Health Security Initiative Ministerial Meetings, 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 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)

Appendix I:
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	-	0	NDA
1997	TBC	17	0	7	0	-	0	A
1998	TBC	6	0	4	0	+26%	0	B+
1999	TBC	11	0	3	0	+32%	0	NDA
2000	TBC	30	0	11	0	**+87%**[b]	0	**A+**
2001	TBC	15	0	3	$1.3 billion	+75%[b]	1*	NDA
2002	TBC	19	2	19	0	+21%[c]	1	B-
2003	TBC	**50**	**6**	**21**	$500 mill	+89%[a]	**2**	NDA
2004	TBC	36	5	12	$3.3 billion	+50%	1	NDA
2005	TBC	22	1	18	**$24 billion**	+22%		

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, Tuberculosis and Malaria
[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 to health in summit chapeau/chair's summary

Appendix J:
New Cases of AIDS Per Year, G8 Countries

	G8 ave.	U.S.[5]	JAP[6]	GER[7]	FRA[8]	UK[9]	ITA	CDA	RUS[10]
1979								1[11]	
1980				0	4		0	5	0
1981		339		1	8		0	9	0
1982		1,201		9	31		1	26	0
1983		3,153		40	92		8	68	0
1984		6,368		116	236		37	167	0
1985	2,254	12,044	6	311	583	-	198	381	1[12]
1986	3,726	19,414	5	573	1,259	-	458	647	-
1987	5,736	29,105	14	1,038	2,252	-	1,030	977	-
1988	7,238	36,126	14	1,268	3,054	-	1,775	1,190	-
1989	8,803	43,499	21	1,589	3,809	-	2,482	1,420	-
1990	8,758	49,546	31	1,553	4,320	1,241	3,134	1,478	103
1991	10,553	60,573	35	1,767	4,657	1,393	3,827	1,622	81
1992	13,480	79,657	51	1,811	5,183	1,579	4,261	1,817	87
1993	**13,688**	**79,879**	85	1,900	5,514	1,788	4,818	**1,889**	106
1994	12,875	73,086	135	**1,913**	**5,737**	**1,851**	5,522	1,882	156
1995	11,653	69,984	169	1,695	5,253	1,771	**5,659**	1,773	198
1996	10,618	61,124	234	1,358	3,941	1,443	4,997	1,230	1,526
1997	8,251	49,379	250	773	2,168	1,078	3,292	815	1,804
1998	6,959	43,225	231	442	1,335	792	1,926	762	8,067
1999	8,024	41,356	300	-	1,808	756	3,220	701	19,846
2000	6,376	39,513	327	736[13]	1,717	830	2,026	481[14]	59,340
2001	6,404	39,206	332	693	1,679	728	1,797	395	**88, 422[15]**
2002	7,373	40,267	308	655	-	877	1,753	380	
2003	6,602	41,831	336	353	686[16]	908	1,759[17]	349	39, 699[18]
2004	9,169	42,514	385	-	2,697	813	-	237	-

Notes:

(1) This chart does not include HIV statistics. In most G8 countries (the epidemic is unclear in France and Italy) HIV prevalence is currently rising rapidly.
<www.unaids.org/epi2005/doc/EPIupdate2005_pdf_en/epi-update2005_en.pdf>.

(2) Bolded number is the peak of AIDS infections in that country.

(3) Calculation of average does not include Russia, for which there is only HIV data, not AIDS data.

Appendix K:
Global HIV/AIDS Cases

Year	New Infections	Cumulative Infections (AIDS)	Cumulative No. People Living with HIV/AIDS	Annual Deaths	Cumulative Deaths	Number in Treatment
1970-1980	100,000-300,000 est.					
198319	3,064			1,292		
198420		8,569			3,711	
1985		20,303				
1986		38,401				
1987		71,751				
1988						
1989		142,00021	5-10m			
1990		307,00022	8-10m			
1991		450,00023	9-11m			
1992						
1993						
1994		985,119				
1995	4.7m est.	1,291,810				
199624	3m est.		23m est.		6.4m est.	
1997				2.3 m est.		
1998	5.8m est.					
1999			33 m est.	2.6 m est.		
2000	5.3 m		36.1 m	3 m	21.8 m	
2001	5 m	35m	40 m	3 m		
2002	5 million		42 million	3.1 m		
2003	5 m	38m	40 m	3 m		
2004						
2005	4.9m	40.3m		3.1m	25+m	1m

Sources: Avert.org <www.avert.org/historyi.htm>; World Health Organization <www.who.int/hiv/epiupdates/en>.

Appendix L:
Cumulative (Probable) Cases of SARS Worldwide

Country	February 2003	March 31, 2003	April 30, 2003	May 31, 2003	June 30, 2003	July 11, 2003	Final Data (December 31, 2003)
Asian Countries							
Vietnam	1:0	54:4	63:5	63:5	63:5	63:5	63:5
Hong Kong, China		530:13	1,589:157	1,739:278	1,755:298	1,755:298	1,755:299
Singapore		91:2	201:24	206:31	206:32	206:32	238:33
Thailand		5:1	7:2	8:2	9:2	9:2	9:2
Taiwan, China		10:0	78:1	676:81	678:84	671:84	346:37
Macao, China			1:0	1:0	1:0	1:0	1:0
Malaysia			6:2	5:2	5:2	5:2	5:2
Mongolia			6:0	9:0	9:0	9:0	9:0
Philippines			4:2	12:2	14:2	14:2	14:2
ROKorea			1:0	3:0	3:0	3:0	3:0
G8 Countries							
Canada		44:4	148:20	188:30	252:37	250:38	251:43
Germany		5:0	7:0	10:0	10:0	10:0	9:0
UK		3:0	6:0	4:0	4:0	4:0	4:0
Ireland		2:0	1:0	1:0	1:0	1:0	1:0
USA		59:0	52:0	66:0	73:0	75:0	27:0
Italy		2:0	9:0	9:0	5:0	4:0	4:0
France		1:0	5:0	7:0	7:0	7:1	7:1
Japan			2:0				
Russia				1:0	1:0	1:0	1:0
EU Countries							
Spain			1:0	1:0	1:0	1:0	1:0
Sweden			3:0	3:0	3:0	3:0	5:0
Finland				1:0	1:0	1:0	
G20 Countries							
Australia			4:0	6:0	5:0	5:0	6:0
Brazil			2:0	2:0	3:0	1:0	
China		806:34	3,460:159	5,328:332	5,327:348	5,327:348	5,327:349
India				3:0	3:0	-	3:0
Indonesia			2:0	2:0	2:0	2:0	2:0
South Africa			1:0	1:1	1:1	1:1	1:1
Other European Countries							
Romania		3:0	1:0	1:0	1:0	1:0	1:0
Switzerland		3:0	1:0	1:0	1:0	1:0	1:0
Bulgaria			1:0				
Other Countries							
Kuwait			1:0	1:0	1:0	1:0	1:0
Columbia				1:0	1:0	1:0	
New Zealand				1:0	1:0	1:0	1:0
TOTAL		1,622:58	5,663:372	8,360:764	8,447:811	8,437:813	8,098:774

Reported cases: reported deaths
Source: www.who.int

Appendix M:
Confirmed Cases (Cumulative) of H5N1 Bird Flu

Country	1996-2003	2003-2004	2004-Q1	2004-Q2	2005-Q1	July	Aug	Sept	Oct	Nov	Dec
Other Asia											
Thailand		Y[25]:0:0	Y:12:8	Y[26]:17:12[27]	Y:0:0				Y:18:12	Y:21:13	Y:22:14
Vietnam			Y:23:16	Y:27:20	Y:33:20		Y:64:21			Y:66:22	
Cambodia			Y:0:0	Y:0:0	Y:4:4						
Lao PDR			Y:0:0	Y:0:0							
Malaysia				Y:0:0							
Mongolia							Y:0:0				
Other Europe											
Kazakhstan							Y:0:0				
Romania									Y:0:0		
Croatia									Y:0:0		
Turkey									Y:0:0		
G12											
Hong Kong	Y:18:6	0:20:7									
China	Y:0:0		Y:0:0	Y:0:0	Y:0:0		Y:0:0		Y:0:0	Y:3:2	Y:7:3
South Korea		Y:0:0									
Indonesia			Y:0:0	Y:0:0		Y:1:0		Y:4:0	Y:5:0	Y:11:7	Y:16:11
G8											
Japan			Y:0:0								
Russia						Y:0:0					
UK									Y[28]0:0		
Canada										Y[29]:0:0	
EU											
Brussels				Y[30]:0:0							
Middle East											
Iraq											
TOTAL											

Country	Jan 2006	Feb	Mar	April	May	Total human cases: deaths
Other Asia						
Thailand						22:13
Vietnam						66:22
Cambodia			Y:1:1	Y:6:6		6:6
Lao PDR						0
Malaysia						0
Mongolia						0
Other Europe						
Kazakhstan						0
Romania						0
Croatia						0
Turkey	Y:21:4					21:4
Azerbaijan		Y:0:0	Y:7:5	Y:8:5		8:5
Bulgaria		Y:0:0				0
Slovenia	Y:10:7	Y:0:0				0
G12						
Hong Kong	Y:19:14					20:7
China		Y:14:8	Y:16:11	Y:18:12		18:21
South Korea						0
Indonesia		Y:27:20	Y:29:22	Y:32:24	Y:48:36	48:36
India		Y:0:0				0
G8						
Japan						0
Russia						0
UK						0
Canada	N:1:1					0
Italy		Y:0:0				0
Germany		Y[31]:0:0	Y[32]:0:0			0
France		Y:0:0				0
EU						
Brussels						0
Greece		Y:0:0				0
Austria		Y:0:0				0
Sweden			Y:0:0			0
Middle East						
Iraq		Y:2:2				2:2
Iran		Y:0:0				0
Egypt		Y:0:0	Y:5:2	Y:12:4	Y:14:6	14:6
Afghanistan			Y:0:0			0
Africa						
Nigeria		Y:0:0	Y:0:0			0
Niger		Y:0:0				0
Djibouti					Y:1:0	1:0
TOTAL						226:122

Notes:
Mortality rate from H5N1 cases in humans is approximately 54%.
1. Ratio used is birds infected : human cases : human deaths
2. 2004-Q1 = January – June; 2004-Q1 = July – December; 2005-Q1 = January – June

3. + means that the country announced an initial human infection, and then subsequently announced “more” infections in humans, without a specific number.
4. Total human cases : deaths is all cases that have been confirmed by laboratory tests, and does not account for all “suspected” or “probable” human H5N1 infections.
5. Y = yes, a poultry outbreak has occurred.

Source: <www.who.int/csr/disease/avian_influenza/updates/en>

Appendix N:
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
2002a	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."[33]

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%

Notes

[1] Paper prepared for presentation at the International Parliamentary Conference in Conjunction with Russia's G8 Presidency, on "HIV/AIDS in Eurasia and the Role of the G8," sponsored by the Transatlantic Partners Against AIDS, at the State Duma of the Federal Assembly of the Russian Federation, Moscow, Russia, June 8, 2006. I am grateful to Jenevieve Mannell and Laura Sunderland for their important contributions to this paper. Version of June 8, 2006.

[2] This study is based in part in its analytical sections on a 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 members of the G8 Research Group.

[3] Domestic political management can be measured by media attention and approval, civil society reaction, legislative reaction, public opinion results, national policy address attention and re-election results.

[4] In 1984, 74-year-old U.S. president Ronald Reagan had a benign polyp discovered. On July 12, 1985, a second polyp was removed, while later another was discovered, requiring surgery to remove the right side of the colon. In 1987, two more polyps were discovered and removed. On July 31, Reagan reportedly had a cancerous lesion removed from his nose. It is not known how these personal experiences affected the summit, although Margaret Thatcher was adept at securing recognition of Reagan's personal concerns. The G7's 1985 statement on drugs arose spontaneously at the summit when Thatcher asked Reagan about his wife, Nancy, and was told of her work on the U.S. national "Just Say No" campaign on drugs; she then suggested that the summit collectively endorse such efforts. Reagan's son and wife became aware of AIDS, then known as GRID (gay-related immune disease), in the early 1980s, when both had many friends in the gay community. Nationally, Reagan was regarded as developing into an AIDS-aware present.

[5] Statistics from <www.avert.org/usastaty.htm>.

[6] Statistics from <idsc.nih.go.jp/iasr/iasr-ge1.html>.

[7] Statistics from <www-aids.med.unibo.it/eustat/>.

[8] Statistics from <www-aids.med.unibo.it/eustat/>.

[9] Statistics from <www.avert.org/statsyr.htm>.

[10] Russian statistics are based on HIV positive testing, not AIDS cases. Because the epidemic is relatively new in this country, AIDS statistics have not been generated.

[11] Statistics from <www.phac-aspc.gc.ca/publicat/aids-sida/aic04-00/pdf/aic0400e.pdf>.

[12] From 1985-2000, statistics from <www.ilo.ru/aids/docs/dec02/cis/Russia-eng.pdf>.

[13] From 2000 on, statistics from <epp.eurostat.cec.eu.int/cache/ITY_OFFPUB/KS-NK-04-018/EN/KS-NK-04-018-EN.PDF>

[14] From 200 onward, statistics from <www.avert.org/canstatr.htm>.

[15] From 2001-onward, statistics from <www.unaids.ru/index.php?id=hiv-aids1&nm=2

[16] From <epp.eurostat.cec.eu.int/cache/ITY_OFFPUB/KS-NK-04-018/EN/KS-NK-04-018-EN.PDF>.

[17] From <epp.eurostat.cec.eu.int/cache/ITY_OFFPUB/KS-NK-04-018/EN/KS-NK-04-018-EN.PDF>.

[18] The apparent decline in HIV prevalence in Russia "appears not to have represented an actual slowing of the epidemic; it reflected changes in HIV testing policy, the smaller number of tests carried out in population groups with high-risk behaviour (especially drug injectors and prisoners), and shortages of test kits (Pokrovskiy, 2005)." <www.unaids.org/epi2005/doc/EPIupdate2005_pdf_en/epi-update2005_en.pdf>.

[19] Data for USA only.

[20] Data for USA and Europe only.

[21] Number of reported AIDS cases, WHO estimated that actual number (beyond those reported) was over 400,000.

[22] Number of reported AIDS cases, WHO estimated that actual number (beyond those reported) was closer to 1 million.

[23] Number of reported AIDS cases, WHO estimated that actual number (beyond those reported) was 1.5 million.

[24] UNAIDS became operational on January 1, 1996, and with it new methodologies for reporting and estimating cases were used.
[25] First cases of large mammal (non-human) infection in leopards and tigers fed on chickens.
[26] Outbreak and death in 147 tigers in Thai zoo.
[27] First case of human-to-human transmission.
[28] H5N1 confirmed in imported parrot, held in quarantine and died.
[29] Two outbreaks in birds in Canada (in Manitoba and B.C.). H5N1 virus confirmed, but not the same virulent strain as in Asia. (www.cbc.ca/story/canada/national/2005/11/20/avian-flu051120.html)
[30] Two eagles imported (illegally) into Brussels from Thailand infected with H5N1.
[31] H5N1 confirmed in Germany in both poultry and three domestic cats (Baltic island of Ruegen).
[32] H5N1 confirmed in Germany in a second mammalian species, a stone marten, in the same area where the infected domestic cats were located (Baltic island of Ruegen).
[33] World Health Organization, "Countries," Accessed Nov 4, 2005. <www.who.int/countries/en/>.