Chapter 17
The G8/G20 and Global Health Governance: Extended Fragmentation or a New Hub of Coordination

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Readers' Guide

This chapter provides an overview of the current position and the possible future of Global Health Governance (GHG)—in terms of the connections and disconnections with the overall architecture of international organizations engaged in global governance. The main focus of this discussion is on the relationship between GHG and leadership summits, including both the "G8" and "G20." The discussion first notes that while GHG has become a central focus for international diplomacy it has become ever more fragmented as new actors and venues negotiate aspects of global health without apparent reference to a central agency or process. It then briefly reviews the growing role of foundations before focusing on the role of **G8** summitry in GHG. The final section and conclusion consider how the **G20** could provide a further venue for GHG.

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I. Kickbusch et al. (eds.), *Global Health Diplomacy: Concepts, Issues, Actors, Instruments, Fora and Cases*, DOI 10.1007/978-1-4614-5401-4_17,

Learning Points

- GHG has become more prominent in international diplomacy at all levels, but at the same time it has become fragmented between different agencies and fora.
- New actors have taken up GHG issues, these include private foundations and international political leaders meeting at **G8** summits.
- While **G8** meetings have increased focus on GHG issues and raised new forms of funding, it could be argued that rather than confirming the control of the GHG agenda by the existing agencies such as WHO, this has increased fragmentation.
- The **G20** is sometimes talked of as being a new global compact, being more inclusive than the **G8** and introducing North–South dialogue. The opportunity exists for **G20** to take forward GHG issues in a way that would coordinate action and reinforce the overall leadership of this issue by the WHO.

Introduction: The Fragmentation of GHG

What must be acknowledged at the outset is the paradoxical manner by which Global Health Governance (GHG) has risen on the global governance agenda as a central focus of concern but one which is fragmented by the many different agencies and processes designed to address it.

Intellectually, in many policy relevant ways, GHG has become a pivotal issue on the international stage. New centers have gown up around the world, for example, at the Geneva Graduate Institute, at Chatham House UK, at the US Council on Foreign Relations (CFR), and Center for Strategic and International Studies (CSIS). Rather than discounting health as a specialist technical/scientific subject, prominent academics from a range of disciplines have embraced the topic—and become more prominent by doing so. Research networks straddling regional divisions have flourished. Graduate students have grasped the topic with unexpected enthusiasm.

At international diplomatic levels health had traditionally been seen as an issue of concern only to technical officials in relevant departments—but not to senior diplomats; it was an issue, well down the agenda—below traditional areas of focus such as war and peace, commercial activity, and even competing social/environmental issues notably climate change (as subject which it must be remembered, brought the G5 to life at Gleneagles, as a staging post for the **G20**). This status is certainly changing—health is now a focus of negotiation and frontline activity (with a proliferation of health attaches/consular officials, etc.). As just one illustration of this trend of 2000 US embassy/diplomatic officials in Thailand one-half are said to work on health.

The reasons for this growing ascendancy are the trans-nationalization and securitization of health issues. The GHG agenda epitomizes the blurring of the divide

between domestic and international concerns. These trends are illustrated by the intensification of fears about pandemics such as SARS and Avian flu and threats of bio-terrorism in the mail, ports and airports and by the higher profile of issues such as AIDS—with levels of death rivaling those of the 1919 influenza.

GHG permeates a wide set of major debates and issues. It dominates the campaign for the MDGs. It adds to concerns about trade and migration (of doctors and nurses); Trade-Related Aspects of Intellectual Property (TRIPS), health concerns during emergencies—and questions about the availability of health-care facilities to migrants. All of these debates and issues cross or transcend national boundaries. All affect a commercial nexus, with huge economic disruptions/commercial losses—as in the SARS outbreak that cost 40–80 $billion. And all are issues that test social cohesion and solidarity.

Yet, if there is more attention, there is also increased fragmentation in GHG. Rather than coordination we see a great deal of messiness in the organizational/institutional architecture of GHG. Every international organization now undertakes GHG. These range from well-established bodies such as the WHO and UNICEF to civil society groups in the forefront of issues such as health as a human right and the right to affordable medicines, taking on Big Tobacco when national governments would not, and active in health and development diplomacy.

Yet these organizations are not only under-resourced but caught between issue and policy choices. These problems are reflected in, if not caused by, the fact that no International Commission on global health has grabbed international public attention in the same way that the Brandt, Palme, or the Brundtland Commissions grabbed attention in other subject areas and that there has not been one overarching rather than issue-specific UN world conference in the way that the environment/climate change, human rights, racism, and social development has done.

Moreover reforms to the GHG architecture have not been entirely successful. The World Bank has highlighted this, noting that the reforms have resulted in confusion with traditional institutions being increasingly marginalized. The WHO is also limited in the new era by its legal framework—in so far as it has had limited "interactions with the private sector and non-governmental organizations." There have been many calls for reform, but the WHO has not been able to move quickly enough to reverse its marginalization in the new GHG order (Reich and Takemi 2009).

The Rise of New Challengers

Over the past decade new actors have gained prominence in the GHG arena these include private foundations and international political leaders meeting at **G8** and **G20** summits.

The rise of private foundations has generated some criticism and controversy. At the core of this issue is simply the unease about the amount of money and the dominant role played by Bill & Melinda Gates Foundation (Szlezák et al. 2010).

The Gates Foundation is now a larger international health donor than all governments, except for the USA and the UK (McCoy et al. 2009).

The rise of foundations has also had the effect of further fragmenting health governance. The Gates Foundation's decision to start the Global Alliance for Vaccines and Immunization outside of the United Nations is one telling example of this trend, with many resources increasingly being funneled into "smaller, independently governed initiatives that focus on 'quick fix,' high profile health problems" (Yamey 2002). This has raised the attention of traditional institutions like the WHO, where members have expressed concerns about their institution being sidelined with this new growth in private donors (Yamey 2002).

Beyond the institutional consequences, alarms have been raised over the question of what these changes will mean for the communities struggling with health emergencies. Sanders and Chopra raise just this point about GAVI and the Global Fund:

> On the other hand, these initiatives are causing a dangerous degree of fragmentation and overcrowding of the international health field, and at country level they can distort priorities, undermining country-led approaches and increasing opportunity costs for already overstretched ministries of health. Specific initiatives reinforce the notion that diseases are unfortunate, random occurrences, and allow us to turn a blind eye to the global political and economic conditions that underlie the desperate poverty in Africa.
>
> (Sanders and Chopra 2005, p. 757).

However, the positive contributions of both these challengers should not be underestimated. The Gates monetary contribution to vaccine research is impressive. And the Gates Foundation has demonstrated strong staying power. Nor has it been quiescent to western governments. The Gates Foundation has been outspoken on many issues, even chastising leaders—such as Stephen Harper for his abortion-related restriction on maternal health funding (Boseley 2010a).

Both Bill Clinton and Bill Gates have been outspoken in calling for the more efficient use of resources to deliver results in Africa. Unread reports and unneeded trips were cited as ways much present funding is wasted, when the international community's money should be paying for the services and goods that will help the individuals challenged with diseases and the risks of disease (Boseley 2010b).

The Gates Foundation has also moved into parallel issue areas that address some of the determinants of health. A prime example has been the Gates Foundation contribution of US $30 million to a new fund for poor farmers. By comparison the USA, Canada, South Korea, and Spain contributed a total of US $875 million. "Far short of the $22bn agreed to by the international community" at the **G8** summit in L'Aquilla (MacAskill 2010).

The **G8** has put the fight against infectious diseases on the highest political map over a long period. Infectious diseases have been central to most **G8** agendas since Okinawa in 2000, where the **G8** "acknowledged for the first time the link between health and poverty" (Kirton and Mannell 2005, p. 6).

The **G8**'s initial involvement in GHG took the form of raising money for UN and WHO initiatives—and the creation of the Global Fund—proposed by Japan at the 2000 Kyushu–Okinawa—to Fight AIDS, malaria, and tuberculosis in 2001 (Kirton

and Ditto Mannell 2005, p. 1). From this starting point, the **G8** moved to more independent initiatives. In 2001–2002 it created the **G8** Africa Action Plan as well as counter-bioterrorism institutions (Kirton and Mannell 2005, p. 1). Although the 2002 Global Fund requests saw little investment from member nations—USA 13 %, Japan 12 %, Italy 57 %, UK 44 %, Canada 41 % (Kirton and Mannell 2005, p. 9), 2004 saw a reversal—USA 117 %, UK 140 %, Italy 430 %, Canada 51 %, Japan 33 % (Kirton and Mannell 2005, p. 9).

By 2002–2003 three areas of sustained institutional reform could be credited to the **G8**: first, better international cooperation for the containment of disease outbreaks and HIV/AIDS, second, in the establishment of the Global Fund and the "creation of a Global HIV Vaccine Enterprise in 2004," and third the ministerial meetings that were established to deal with issues of biological warfare and security (Kirton and Mannell 2005, p. 10).

Between the 2003 Evian Summit and the 2005 Gleneagles meeting, the **G8** moved to target diseases that the UN and WHO had failed to combat effectively, with HIV/AIDS vaccine programs and Polio elimination (Kirton and Mannell 2005, p. 2). And at the 2008 **G8** summit in Toyako, the leaders reiterated the Heiligendamm Summit commitment to provide US $60 billion over 5 years and 100 million mosquito nets to combat malaria by then end of 2010—with the initiative led by Japan, reflecting a reversal of past hesitation to fully commit resources to such endeavors (Reich and Takemi 2009, p. 508.

The **G8** summit has continued to emphasize global health in its agenda and declarations though as shown in Box 1 this has been variable and may have reduced in recent years.

Box 1 Percentage of Total Paragraphs in G8 Summit Documents Related to Health

2000—17.9 %	2006—38.3 %
2001—20.5 %	2007—12.9 %
2002—13.1 %	2008—9.1 %
2003—34.7 %	2009—6 %
2004—6.5 %	
2005—14.6 %	

(**G8** Information Centre) (2010)

Observers have generally seen the **G8** in a positive light as being able to "think and act outside the existing global health bureaucracies and stakeholders" (Reich and Takemi 2009, p. 512). In terms of the GHG agenda the **G8** has similarly been credited with the broadening of GHG to include "neglected tropical diseases," whereas the old standard had been to focus on just the larger diseases, like HIV/

AIDS (Liese et al. 2010, p. 71). The **G8** Research Group has been even more glowing in its praise: "the **G8** has been a relatively effective centre of GHG, from its pioneering decision-making start in 1980 through to the present. The **G8**'s performance is distinguished by the large number of commitments it has made, above all at the summits in 2006 (with 61) and 2007 (with 43). Moreover, its members have complied with these commitments to a substantial degree, at an average solid B level of 77 %" (Guebert and Kirton 2009, pp. 1–2).

But rather than confirming the centralized control of the GHG agenda by the existing agencies such as WHO, it could be argued that the **G8** has increased fragmentation. The **G8** has built up a constituency around it, a host of NGOs and other civil society groups attend. Some gain considerable access to both the media center and to state officials. Stephen Lewis argued that the **G8** should be a mobilizing agency for the UN—especially the WHO.

While this constituency is not uncritical, some see it as failing short of delivering its commitments. Laurie Garrett argued that more people died of the diseases covered by the Global Fund than ever in history. Others suggest the **G8** has been captured by specific interests. Traditionally, the finger has been pointed at material interests, with GAVI, which is partly funded by **G8** contributions, "over-reliant on private sector funding and hi-tech vaccines" which are unsustainable and non-transparent (Sunder 2003).

More recently the criticism has turned towards more ideological concerns, as showcased by the controversy over maternal health at the 2010 summit. As one critic stated: "Beside endangering the lives of women in the poorest countries, this reluctance to embrace family planning as part of a **G8** initiative is toe-curlingly embarrassing for all those countries, like the UK and now the USA as well, that wholeheartedly support it. Let's hope international development ministers are hitting the phone to Canada even now" (Boseley 2010a).

Moving into the G20 Era

Against this background, there appears to be some logic in the calls for the **G20** to move more decisively into the domain of GHG as the **G8** has done. This logic is not without flaws, like the **G8** the **G20** is an example of exclusive executive multilateralism. This develops a distinctive form of **summit diplomacy** sometimes known as **forum diplomacy**. Top leaders and bureaucrats get to work together and to know and trust one another. When its club dynamics grows and some collective identity emerges behavior changes. Of course this is more difficult at the **G20** which inevitably has more of the atmosphere of a public concert than a private club. But while this may not achieve the same level of discourse as a **G8** meeting, there are offsetting advantages. As opposed to the **G8** the **G20** allows key voices from the global South to be heard in global and regional decision-making, and in so doing it injects both a catalytic element and degree of equality.

Putting GHG on the agenda of the **G20** could also prove valuable for this summit meeting. In terms of its mode of operation, the **G20** process has done remarkably well in mobilizing a collective response to the global financial crisis, largely addressing failures in regulation of the private sector. Among the **G20**'s successes:

- It has cut through the traditional boundaries of North–South and has mobilized both national and international fiscal stimulus packages.
- It has prevented a repeat of 1930s-style protectionism.
- It has served as a platform to build a new regulatory regime through the Financial Stability Board, invoking mechanisms for benchmarking and peer pressure.
- It has negotiated policy trade-offs and facilitated compromises, including IMF quota reform for the emerging economies in exchange for moving the sensitive issue of global imbalances onto the institutional agenda.
- It has allowed—although far from complete—the promise of a coordinated exit strategy from expansionary fiscal activity.

These achievements deserve praise. Yet, if the **G20** is to move to the hub of global economic governance—as advertised at the September 2009 Pittsburgh G20—it must be more than a crisis committee. It must do more than correct private wrongs. It must support global public goods.

As the economic crisis subsides, a much longer list of tasks and responsibilities begins to emerge. While systemically important, remedies undertaken to address private greed in global commerce—through better regulation and institutional reform—do not provide succor for the poor in the countries affected by the reverberating crisis and unrepresented in the **G20**. This is an opportunity that should not be missed for a number of reasons. One is simply the importance of the GHG agenda. To paraphrase the D–G of the WHO Dr Chan: health did not make the crisis—but it bears the brunt of the crisis.

The GGH agenda also deserves to get onto the **G20** leaders agenda on its own merits. More out of convenience rather than commitment, GHG has fewer constraints than other areas for getting onto the agenda of the **G20**—as it did for the **G8.** There aren't the competitiveness problems for **G20** countries embracing the GHG agenda that are associated with climate change, for example. There is a perception that if China, India—or for that matter the USA—do more to cut emissions they will hurt their own industries

Building national and global health infrastructure will help competitiveness—Canada's state health system, for instance, adds to the competitiveness of the Canadian auto sector in comparison with the USA. In the same way the redirection of the Chinese stimulus package to health infrastructure should add to Chinese competitiveness. Improved health in turn leads to increased capabilities—a prerequisite to accelerated economic growth. A third major benefit—although there is sensitiveness—is that health goes beyond some of the sovereignty taboos that we find in other areas. That is to say, it blends the Westphalia understanding of national independence with a modern understanding of interdependence without compromising either.

On traditional security issues—lack of communication remains rife—as witnessed by the remarks of the retiring US admiral of the Pacific fleet that he didn't know how to communicate to his Chinese counterpart. Health operates in a very different more benign context and learning trajectory. China—as other countries—learnt a lot from the SARS episode—that withholding information did it more harm than good in terms of reputation. Information about outbreak will get out—so it might as well be managed effectively.

Although China was criticized by some individuals—during the H1N1—it was not trying to pretend there was not a problem. Increasingly it will not be simply a question of upgrading China's health system at home, but measuring the impact of China's global reach in terms of health diplomacy—Chinese supply of vaccines to Africa, for example. But there is still need to be more done in the immediate future to build trust—a key public good in itself.

The opportunities of the **G20** for GHG were appreciated even before the **G20**—came into being. As early as 2004, at least one WHO official (Evans 2004) made a number of strong points:

- **G20** could serve as forum for raising awareness of health crises in areas or countries not receiving proper attention, such as Eastern Europe.
- **G20** could also work on "unfinished agendas," such as infant mortality rates and maternal health.
- The **G20** leaders have the capacity to "catalyze the action necessary to get these MDGs on track."
- **G20**'s global reach exceeds the **G8**'s and, consequently, it may be able to better assess "global preparedness" in the international health sector to deal with new problems.
- **G20** can name and shame ("label the laggards") on topics like preventable deaths in childbirth.
- **G20** would be better positioned to deal with medical brain-drain of impoverished nations than the **G8**.

There are of course risks in trying to raise health issues at the **G20**. Health issues could create tensions along older North–South fault lines—as witnessed by the case of virus sharing with Indonesia (see Chap. 6, Box 6) or on the level of donations and contributions. Yet the best way to deal with these tensions may be to embed them in the **G20** process, with meetings not just among state officials but engaging non-state actors.

To develop such an expanded mandate for **G20** in global health there it would be desirable for the D–G of WHO to attend at least one summit each year (assuming there are two meetings each year). This could match the attendance of the heads of IMF, WB OECD, and other relevant UN organizations at the **G20**. The **G20** could also provide regular access for regional groups—including ASEAN and the African Union—as this could build international/regional linkages on GHG.

Conclusion: The G20 as an Opportunity for GHG

There is always of course going to be competition for the form and scope of GHG—and the mode of diplomacy that goes with it. In such a competitive and fragmented atmosphere it is easy to opt for the status quo. Yet the **G20** does seem to be a special opportunity that should not be missed, allowing GHG a hub that it needs. Moreover, in practical terms there are signs of moves in this direction. The focus on the notion of a "global safety net" put forward by South Korea as hosts of the November 2010 **G20** is compatible with this development. So is the prominent place accorded to Bill Gates in the context of the Business **G20** to be held in conjunction with the leaders' summit.

The **G20** is sometimes talked of as being a new global compact—albeit an incomplete one—that allows a sense of mutuality to be reinforced. We should grab the opportunity to redefine and elevate the sense of urgency with which we deal with global health, what (Fidler 2004) calls scaling up political commitment.

Questions

1. Why have global health issues become so prominent in diplomacy?
2. Is the agenda and mechanism for GHG coordinated?
3. Why have global foundations entered the global health arena?
4. What advantages and disadvantages do **G8** meetings have in addressing GHG?
5. It appears that **G8** meetings have worked well with civil society organizations and foundations why can't the WHO operate in the same way?
6. What are the advantages and disadvantages of the **G20** in addressing GHG?
7. If the **G20** takes up GHG will this displace the functions of the UN?
8. Will **G8** continue to play a role in GHG or will they be displaced by **G20**?
9. How should the WHO respond to these emerging players in GHG?

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