Generating Global Health Governance

from G8 to BRICS Summitry

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# Abstract

Global health challenges are great and growing as a globalized world rapidly approaches the due date for delivering the three United Nations Millennium Development Goals (MDGs) due for 2015. Yet the goals for children’s health, maternal health and HIV/AIDS, TB and malaria will not be met, and those shaping then post 2015 MDGs seemed destined to downgrade the place of health in the successor set. At the same time, new health challenges have arisen, from deadly infectious disease such as Ebola and swine flu and avian flu to the growing burden globally of the four main non-communicable diseases (NCD’s of heart attacks, cancer, diabetes and chronic respiratory disease. Yet despite special UN summits for HIV/AIDS in 2001 and NCDs in 2001, the UN system, its dedicated functional body, the World Health Organization (WHO), and the WHO’s regional affiliates remain unable to meet the need. Leadership in global health governance has thus been assumed by plurilateral summit institutions of established and emerging powers, notably the Group of Eight major market democracies first formed in 1975 and the BRICS of Brazil, Russia, India, China and South Africa first formed in 2009.

The G8 started narrowly by addressing malnutrition in 1979, nuclear health and safety in 1980-1981 and health research in 1983, largely diseases within the G8 countries. The G8 subsequently broadened its attention to focus on the major illnesses afflicting the world as a whole, with HIV/AIDS in the lead. At first the G8 worked to support the WHO and UN system in raising the money they needed but were unable to attract on their own. However, as the twenty-first century began, the G8 launched its own initiatives to promote global health. This phase began with the creation of the Global Fund to Fight AIDS, Malaria and Tuberculosis (GFATM) in 2001. It continued with the 2001-02 development of the G8 Africa Action Plan, and the Global Health Security Initiative (GHSI) to combat bioterrorism following the shock the September 11, 2001 and the anthrax attacks on America that autumn. At the 2003 Evian Summit, the G8’s Health Action Plan directly tackled some of the world’s most deadly diseases. By 2004, the G8 focused on specific interventions such as developing an HIV/AIDS vaccine and the eradication of polio. Gleneagles in 2005 promised affordable access to HIV/AIDS treatment to all afflicted by 2010. St. Petersburg in 2006 made infectious disease one of its three priority themes and had G8 Health ministers meet for the first time. In 2007 at Heiligendamm health remained high on the agenda. In 2008 the G8 countries focused on keeping the substantial health commitments they had already made, creating a follow-up mechanism to monitor progress on compliance with their health commitments. At the 2009 Maddelena summit, infectious disease appeared on the agenda and an accountability report came. At the 2010 Muskoka summit, the signature achievement was the Muskoka Initiative on Maternal, newborn and Child Health. Amidst the worst global recession since the 1930’s G8 leaders and their partners raised $7.3 billion in new money to advance MDG’s 4 and 5. At the UN summit in September this amount was multiplied to $40 billion, and an accountability commission was created to ensure that it did the job.

During these years, the G8 made an impressive array of ambitious health commitments to achieve by 2010 (Kirton 2009). It promised by 2010 to give affordable access to medicines to all HIV/AIDS suffers who need it, to cut malaria and tuberculosis in half, and to wipe polio off the face of the earth. To help fund the underlying health care systems in poor countries, it promised by 2010 to double aid to Africa as well. Given the close connections health has to climate change and biodiversity, its promise by 2010 to reduce greenhouse gas emissions and significantly reduce biodiversity loss matters much for health as well. Yet, just before the 2010 G8 summit, to be held in Huntsville on June 25-26, none of these commitments was confidently on track to be met by 2010, nor any of the three health MDG’s by 2015. And after the Muskoka Summit, G8 governance of health markedly declined.

This decline was not due to the emergence of a new, broader PSI, the Group of Twenty (G20) to take up the task of governing global health. For since its start at the ministers’ level in 1999 and the leaders level in 2008, the G8 has done very little to directly address health. Leadership in global health governance was thus left to another new PSI, the BRICS born at the ministerial level in 2006 and at the leaders level in 2009 (Kirton, Kulik and Bracht 2014). Since its first summit in Yekaterinburg, Russia, the annual BRICS summit has been a substantial global health governor, until its Durban Summit in 2013. The BRICS has focused on health issues common to the members as big emerging powers, and common to those of the emerging and developing world as a whole, such as access to affordable medicines, intellectual property and technology transfer. It has also led on NCDs, whereas the G8 and G20 have ignored these predominant threats to their own citizens health. Unlike the G8 and G20, the BRICS has created a ministerial-level institution for health backed by an official working group. Despite the decline at Durban, it there supported the need to achieve the MDGs, and the health linked issues of nutrition and food.

The causes of this G8 and BRICS health performance are partly accounted for by the model of systemic hub governance (Kirton 2013). Yet for both their continuing vulnerability to health shocks and the failure of multilateral organizations in response does not explain the recent decline, and the globally predominant health capabilities of the G7 suggested its leadership is needed if the global health challenge is to be met.

**References**

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