Russia's Global Health Governance Gap: A Strategy for Summit Success

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Abstract

Russia has a great and growing health challenge from non-communicable diseases (NCDs). But thus far there has been a large gap between its needs and the global health governance provided by the leading global institutions, which have focused overwhelmingly on infectious diseases led by HIV/AIDS, tuberculosis, and malaria, Russia's efforts to close the gap have met with little, if now slowly increasing success.

Within the G8, which Russia joined in 1998, Russia chose health as a priority for the first summit it hosted in 2006. Here it reoriented the G8's health agenda from infectious diseases in developing countries toward Russia's domestic concerns. But the G8 soon returned to its standard focus, determined largely by the United Nations three Millennium Development Goals (MDGs), on the leading infectious diseases and on maternal and child health. Russia's initiative in hosting the first G8 health ministers meeting in 2006 was not repeated by other G8 hosts. Russia also remains excluded from the G7-centred Global Health Security Initiative created in the wake of the anthrax attacks on the United States in the fall of 2001.

Within the G20, which Russia joined as a full founding member at both the ministerial level in 1999 and the summit level in 2008, the limited attention given to health has also focused on supporting the MDGs. The G20 summit in Seoul, Korea, in November 2010 did note NCDs as part of its new Seoul Development Consensus. But the subject was absent from the subsequent G20 summit at Cannes, France, on November 3-4, 2011.

The BRIC summit, which brought together the leaders of Brazil, Russia, India, China and Russia was co-founded and hosted in 2009, has recently addressed NCDs. Under the leadership of China, as host of the BRICS summit in 2011 – now with South Africa as a member – health first appeared on the BRICS agenda. It called for a meeting of BRICS health ministers , which also took up the issue of NCDs.

Russia's major leadership in global health governance came as part of the preparations for the UN's first High-Level Meeting (HLM) on NCDs in September 2011. In the lead up, Russia hosted the first global gathering of health ministers in Moscow, to integrate globally the regional consultations then underway as defined by the World Health Organization (WHO).

At the HLM, the limited participation of leaders and the absence of ambitious results mean Russia must now look elsewhere to mobilize global health governance on behalf of its core domestic challenge from NCDs. It can do so by constructing a strategy to bring NCDs onto the agenda of the plurilateral summits its hosts over the next few years – APEC in September 2012, G20 in 2013, and the G8 and BRICS in 2014. In this strategy its BRICS partners can serve as core allies, as China, Brazil, India and soon South Africa face the same domestic challenge of NCDs as Russia does.

Introduction

In 2008, the projected deaths in Russia due to non-communicable diseases (NCDs) were 572 per 100,000. The World Health Organization (WHO) has estimated that over the next 10 years, 19 million people will die as a result of one of these diseases (WHO, 2011). The global governance institutions, in which Russia is a member, have paid limited attention to NCDs despite their growing burden in recent years. The G8, a governor of global health since the late 1970s, has yet turn its focus away from infectious disease to NCDs. The G20 mentioned NCDs at its summit in Seoul in 2010, but failed to reiterate its attention the following year at Cannes. The summit of Brazil, Russia, India, China and South Africa (BRICS) and the subsequent meeting of BRICS health ministers in 2011 acknowledged the growing burden of NCDs in its member countries, paying particular attention in its final declaration. But it has not indicated that it is dedicated to take leadership on the issue.

Faced with the increasing burden of NCDs combined with the lack of action within the global governance institutions of the G8, G20, and BRICS and the lack of specific targets and timelines at the UN High Level Meeting in New York there is an opportunity for Russia, Brazil, India, China, and South Africa to use the experience they have gained in addressing domestic health challenges to lead the global community in implementing a strategy to combat NCDs. Here Russia is particularly well positioned to lead, given that it will host the summits of the Asia Pacific Economic Co-operation forum in 2012, the G20 in 2013, and the G8 and BRICS in 2013.

Russia's Great, Growing Health Challenge

If there was ever a time for Russia to take leadership in governing global health it is now. Russia has a great and growing health challenge that its constrained resources and increasing interconnectedness with the outside world it cannot solve alone. Its primary problem arises from its soaring burden of NCDs, its crumbling post-Soviet public healthcare system and its rapidly aging and declining population. These national health problems match poorly the dominant emphasis of the major global health governance institutions, which target infectious diseases led by HIV/AIDS, tuberculosis, malaria, and polio (Kirton, Guebert, Kulik, 2011).

Russia is registering catastrophic levels of mortality creating major gaps between itself and the rest of the western world. The main explanation for this gap is the surge of deaths due to NCDs, particularly cardiovascular disease. Currently, deaths from cardiovascular disease are three times higher in Russia than in Western Europe. Although Russia may be

rich in natural resources, this wealth is not a substitute for human capital. Russia's demographic decline will inevitably have a significant impact on its economic development and international security (Eberstadt 2011).

Russia does not stand alone as a net mortality society; three other G8 member countries – Germany, Japan, and Italy – are also experiencing rapid population decline. The defining difference between Russia and these three countries is that the latter possess continuing high-quality public health systems . Russia on the other hand, has yet to maintain its Soviet-era health system or to finance major public health campaigns that could mitigate the impacts of these diseases (Eberstadt 2011).

This, however, is not the first time that Russia has faced devastating health challenges. It has endured problems with its healthcare system since the collapse of the Soviet Union. Russia has also had a long, well-documented battle with infectious diseases, particularly HIV/AIDS but also tuberculosis, measles, and the avian influenza (Guebert 2011; Kirton and Mannell 2005). At the height of these challenges Russia was motivated by its domestic health problems to make contributions at the international level.

Russia's Global Health Governance Gap

Despite the growing burden of NCDs within Russia and within the countries it partners with in the G8, G20 and BRICS, there has been almost no attention paid to these diseases or to their economic and social costs in these comprehensive global governance forums. The G8, the primary forum in which Russia has displayed the clearest leadership in governing global health, has failed to address NCDs in its discussions or in its final summit documents. The G20 at its meeting in Seoul in November 2010 did recognize the link between development and NCDs but dropped the NCDs issue at its most recent summit in Cannes on November 3-4, 2011. More recently, at the BRICS summit in 2011 and then at the first health ministers' meeting in Beijing, China, on July 11, 2011, the members paid particular attention to NCDs in a way that the other forums failed to do. There is thus hope that Russia, following its ministerial meeting in Moscow to prepare for the UN HLM, will take the lead in collaboration with its partners in the BRICS forum.

The limited participation of leaders at the UN high level meeting in September 2011 and the absence of ambitious results mean Russia must still look beyond UN-based multilateral organizations to mobilize global health governance on behalf of its core domestic concerns.

Russia's G8 Health Governance

Russia's initial effort to exercise global health leadership came in the G8. Russia's struggle with domestic health care problems acted as a catalyst for it to become a global health leader within the G8. In 2006, Russia for the first time since its formal induction in 1998, hosted the G8 summit in St. Petersburg. Since the start of its preparations Russia, led by President Vladimir Putin, chose health as one of the summit's top priorities. This itself was another first, as health had never taken such a top spot on the club's agenda. This choice was fuelled by Russia's desire to demonstrate leadership within the global

community and improve its international reputation and by its desire to improve health at home (Panova 2005).

The G8 and its member countries have addressed global health since the late 1970s, first focusing on the challenges associated with hunger and malnutrition. The G8 made its first commitment in 1980 to give health and safety the highest priority when dealing with spent fuels and the disposal of nuclear waste. The G8's focus on health from that time up until the 1996 Lyon Summit was minimal. But the French-hosted summit marked a turning point in the club's focus as it turned to global issues in the face of the introduction of diseases such as Ebola and cholera in the developing world (Kirton, Shaw and Kulik 2011).

Since 2000, the G8 took a major leap forward in governing global health across a number of dimensions. There was an increase in: deliberation – the number of references to health in the club's official documents; decision making – the number it its collective health-related commitments; delivery – the fulfillment of and compliance with those commitments; and the development of global governance – the creation of health-related institutional bodies at both the international and ministerial level (Kirton and Mannell 2005).

Of all G8 summits, health was most prominent in St. Petersburg. That summit was successful in producing a substantial report on the fight against infectious diseases, which acknowledged their devastating effects on individual well-being, international economic development, and progress on the UN Millennium Development Goals (MDGs). The report also highlighted challenges associated with limited availability of vaccines and treatment, lack of essential healthcare services, and the shortage and migration of healthcare workers (Kirton forthcoming).

Russia displayed progressive leadership by extending an invitation to the members of the Outreach Five – Brazil, China, India, Mexico and South Africa – as well as the WHO. Russia was also successful in hosting a summit that produced the highest number of health-related commitments in summit history. Russia complied with those commitments with a score of 80% (see Appendix A)

In complying with the G8's overall health commitments from 1983 to 2010, however, Russia has the second lowest performance of any of the nine members (including the European Union) of the Group. For the 54 G8 health commitments made from 1983 to 2010 where compliance has been assessed, the overall average is +.51 on a scale of -1.00 to +1.00, or about 75%. Russia's compliance score is only +.19, compared to Italy at +.14, Germany at +.40, Japan at +.43, France at +.52, the EU at +.54, the United Kingdom at +.68, the U.S. at +.74 and Canada at +.80. Only in 2005 and then in 2006 when it hosted did Russia's compliance with G8 health commitments rise. Russia complied fully with three health commitments and partially with two that the 2006 St. Petersburg summit made (see Appendix A).

While the G8 has not proven to be the forum for Russia, or any other member , to address NCDs it has provided the clearest case of Russia's global health leadership. Russia is set to host again in 2014 and thus has the opportunity to continue its trend in producing successful and substantial achievements in health. Three very similar conditions replicate the environment in 2006. First, Putin who was instrumental in putting health on the agenda in St. Petersburg, has announced that he will seek a presidential term in the election in March 2012 (Bourdreaux, Kolyandr and Cullison 2011). Second, Russia is faced with a health threat that will almost certainly cause severe demographic, economic and security challenges, this time from NCDs. And third, Russia has an opportunity to demonstrate international leadership by following up on its ministerial meeting on NCDs in Moscow in April 2011 as part of the preparations for the UN HLM.

Russia's G20 Health Governance

The G20, unlike the G8, has acknowledged the growing global burden of NCDs through the communiqué that was produced at the Seoul Summit in November 2010. This however, was the only reference to NCDs and one of the few references to health in the G20 summit's documents since its inception. The G20 has yet to establish itself as a forum that fosters dialogue on issues such as global health, or as a forum that Russia has utilized to lead on such issues (Guebert 2011).

The G20, comprised of the most powerful developed and emerging countries, was first created at the finance ministers' level in 1999. It emerged as the premier summit forum to respond to the onset of the global financial crisis in 2008 when the G8 failed to fully recognize the rising capabilities of the emerging economies. The G20's agenda quickly expanded after its first meeting in Washington to include issues like global market access, economic stability, and approaches to development beyond additional official development assistance (ODA) (Chand et al. 2010).

In its first four summits the G20 made little or no reference to health in its official documents. On a number of occasions the leaders reaffirmed the importance of their commitments to meeting the UN MDGs, half of which are dedicated to improving the health of people around the world. The Washington communiqué also acknowledged the importance of addressing issues like disease as a means of promoting economic development (see Appendix C).

Attention to health was again minimal at the Toronto Summit in June 2010. However, the G20 did briefly mention the importance of strengthening social safety nets like public health care. At Seoul later that year, in addition to recognizing the barrier that NCDs present in improving productivity and skills development, the leaders acknowledged the disproportionate impact of the financial crisis on low-income countries and its role in slowing progress on the MDGs (see Appendix C).

At the most recent summit in Cannes in November 2011, there was hope that health and NCDs in particular would find their way onto the agenda. They might do so as a reiteration of the club's commitment at Seoul but also building on the Russian-hosted

ministerial meeting in April and the UN HLM in September. The Cannes Summit did neither.

Although the G20 has yet to address health in a major way, it has many elements that lend itself well to becoming the next major forum to address this issue. Its reach extends beyond those networks accessible to the G8 and is not limited by bureaucracy in the way that formal institutions are, which could allow it to act much faster, especially in times of crisis. It represents 85% of the world's economy and two-thirds of the world's population, which gives it the representative legitimacy that the G8 is often criticized for lacking.

The G20 can be a key forum to respond to non-communicable diseases, as it has emphasized the interconnectedness of economic, development, and health issues from very early on. NCDs represent a major economic burden to every G20 member within the club. Russia is no exception and indeed is an acute case. Although Cannes did not advance a response to the prevention and control of NCDs, there is hope that Russia will provide leadership of the G20 as host for the very first time in 2013.

Russia's BRICS Health Governance

Russia was the first country to host the BRIC summit at the leaders' level in 2009. However, it did not seem to be the forum Russia would choose to govern global health. The forum arose as a vehicle for the major emerging market economies, like the BRIC members to become more equal players in global affairs with a goal to improve the global economy. The first two summits, in Russia and Brazil, made no direct mention of health. There were however, references made to the health-related issues of development, agriculture, and poverty (BRICS 2010).

At the third leaders' meeting in China in April of 2011, the BRICS leaders — now with South Africa — made their first ever health commitment. It was to strengthen dialogue and cooperation in social protection, which included public health and the fight against HIV/AIDS (BRICS 2011). Here they also committed to hosting the first meeting of their health ministers, who would gather a few months later.

This meeting seemed to be an appropriate forum in which the BRICS countries could discuss non-communicable diseases. They acknowledged the challenges faced by all BRICS nations due to increasing rates of NCDs and the need to strengthen health systems and remove impediments to access to medicines, treatment, and technologies. At their meeting, BRICS health ministers agreed to meet again in conjunction with the UN HLM on NCDs in New York in September and to establish a technical working group (BRICS Health Ministers 2011).

Despite a slow start, the BRICS summit has arisen as a key forum to address global health and to address NCDs in a way that the other two global summit forums have failed to do. No official documents on health were released out at the most recent G20 summit in Cannes, halting momentum on the commitments made on NCDs at the G20 in Seoul, the BRICS in Beijing and the UN in New York. It is unclear how Russia will lead within

BRICS as it has not yet used the forum to govern global health, but it is set to host again in 2014 and there is hope that it will use its role as host of all three summits within the next few years to continue the momentum gained from its role as host of the ministerial meeting in April.

Russia's Leadership at the UN HLM on NCDs

In Moscow on April 28-29, 2011, Russia used the United Nations HLM process to assume leadership in addressing NCDs when it hosted the global ministerial meeting in the lead-up to the high level meeting. Russia collaborated with 90 ministers and 155 delegates to acknowledge the socioeconomic impact of these diseases, discuss international strategies on prevention and control, and advocate for a framework for strengthening health systems. The Moscow Declaration, the meeting's official concluding document outlined 48 commitments, focused mainly on integrating health into all sectors, strengthening health systems, and engaging in partnerships with private and civil society actors (UN 2011).

Russia's role as host of the ministerial meeting signaled that it might continue to dedicate itself to advocating for better NCD governance through global summitry. However, come the HLM in September, there was no head of state or government from Russia in attendance. There were also several issues that were left inadequately addressed. Absent from the agenda were any specific targets or timelines, which prove to be an important catalyst for global action and compliance in other forums like the G8 and G20. The HLM's outcome document also failed to include any references to TRIPS flexibilities that could allow greater access to low-cost generic medicines for developing countries. Also absent was the commitment by the leaders to invest any new money into combating NCDs either through prevention or treatment, or solid mechanisms for accountability and follow-up (Orbinski, Guebert and Koch 2011). Thus, gaps in leadership and governance were still evident as the UN's high level meeting came to a close. Russia and its BRICS allies, including Brazil, whose president Dilma Rousseff did attend the HLM, now have an opportunity to take the lead, particularly since disease burden only continues to get worse.

Emerging Economies and Governing Non-Communicable Diseases

By now the global health community is familiar with the statistics that NCDs account for 65% of deaths worldwide, 80% of which occur in low- and middle-income countries (LMICs). Russia is clearly not alone in its struggle with these diseases; in fact some of the most staggering figures come from its partners within BRICS who risk digressing from "emerging economy" status if they are not addressed.

In China NCDs account for 85% of deaths, well above the average for the rest of the world. China now has the largest population of people suffering from diabetes, and its rates are increasing faster than those in the United States and Europe. By 2040, it is suggested that China will have more people suffering from Alzheimer's than anywhere

else in the world. Part of this trend can be explained by the country's rapidly aging population. But China has also failed to address risk factors such as smoking, poor air quality, use of illegal substances and tainted food. China, like Russia, has long overlooked its public healthcare system in pursuit of economic growth, which has subsequently caused rapid declines in the health of its population (Huang 2011).

In India, the story is similar . It has high rates of diabetes and increasing rates of cardiovascular disease, which are striking people in the most productive years of their life. High rates of tobacco use and obesity as well as occupational hazards and poor living conditions have contributed to the rising burden of these diseases. India's healthcare system has made improvements in dealing with infectious diseases as well as maternal and child health, but health promotion and chronic disease prevention have yet to be properly addressed (Reddy et al. 2005).

In Brazil, 72% of deaths are due to NCDs, with neuropsychiatric disorders being the largest contributor. Unhealthy diet and physical inactivity are contributing to high rates of diabetes and hypertension. However, the Brazil case is slightly more optimistic. The successful implementation of anti-smoking and NCD prevention policies has meant that NCD mortality has been declining by 1-8% per year. Brazil has also invested in the expansion of primary health care, which integrates health into all sectors and promotes the inclusion of individuals and communities (Reddy 2005).

The growing global burden of NCDs threatens the strong economic growth experienced by the BRICS countries in recent years. The ongoing costs associated with the loss of productivity, disease surveillance, and the production and distribution of medicines will inevitably lead to higher levels of poverty and inequality. However, the emerging economies of Brazil, Russia, India, China, and South Africa have offered innovative solutions for their domestic health challenges that they can use to provide leadership in governing global health.

Russia's Global Health Allies and Assets Within the BRICS

In the 21st century, Brazil, Russia, China, India and South Africa have become increasingly involved and influential at the centre of global health governance through their contribution in the G8 as the outreach five, the G20 and the BRICS summits. These countries have moved beyond second-tier status within the G8 to full and equal members of the G20 and founding members of BRICS. In struggling with their own domestic health problems, the emerging economies now have valuable lessons for the global community for governing global health (Chand et al. 2010).

Brazil has a well-known successful program for treating and preventing HIV/AIDS, which provides a leading example of an approach to epidemics by a middle-income country fraught with social inequality. Its program for universal access to treatment has caused a dramatic decrease in morbidity and mortality from AIDS (Berkman et al. 2005).

India is known to have a strong pharmaceutical industry that has produced and provided low-cost treatments to prevent epidemics in countries in Africa. The Serum Institute of

India agreed to reduce the price of a vaccine that protects against five fatal diseases and distribute it to some of the poorest countries in the world through the Global Alliance for Vaccines and Immunisation (GAVI) (Chan 2011).

South Africa has become the centre of research and development, epidemiology, and pharmaceutical production within Africa. It has successfully battled the pharmaceutical industry to circumvent patent protections and allow for access to low-cost medicines (Barnard 2002). South Africa is likely to expand its domestic production of antiretrovirals (ARVs) and is considered a promising leader in addressing health challenges within Africa.

Since the shocking outbreak of severe acute respiratory syndrome (SARS), the Chinese government has invested significant resources in improving its ability to control infectious diseases. China has created monitoring and reporting mechanisms at the district level to ensure that mistakes made during SARS are not repeated (Blumenthal and Hsiao 2005). The Chinese government has also committed to giving its large rural populations priority in access to affordable care, which is supported by its scientific capacity to produce innovative solutions (Chan 2011).

Russia's Global Health Strategy as Summit Host, 2012-14

Russia has already demonstrated its willingness to lead on global health governance, particularly through its role as host of the 2006 St. Petersburg Summit and the 2011 Moscow Ministerial Meeting on NCDs. In the coming years, as Russia prepares to host a set of summits –APEC in 2012, the G20 in 2013, and the G8 and BRICS in 2014 – it can use its partnership with the emerging economies to take action against the NCDs that burden BRICS countries and the rest of the world.

The inadequate action taken by the major global health governance institutions on addressing non-communicable diseases has presented an opportunity for Russia and the other BRICS members to take leadership on the issue. The ongoing costs associated with the loss of productivity, disease surveillance, and the production and distribution of medicines will inevitably lead to higher levels of poverty and inequality. However, the emerging economies of Brazil, Russia, India, China and South Africa have offered innovative solutions for their domestic health challenges that can be used to provide leadership in governing health globally.

Although there are many differences among the big four NCDs of cancer, diabetes, cardiovascular disease and chronic respiratory disease, they share a similar property with HIV/AIDS in that they are chronic. The BRICS countries have all struggled with the onset and spread of HIV/AIDS in recent years, which has required their health systems to scale up to be able to treat this disease. Brazil has led the BRICS countries in its battle with pharmaceutical companies to obtain low-cost access to ARVs to fight against HIV/AIDS, which will be important moving forward on NCDs as access to medicines and treatment is an essential component to disease control and prevention (Rabkin, El-Sadr, 2011).

Another key element that went into the scaling up of healthcare systems in response to HIV/AIDS is the continuity of care. Both HIV/AIDS and NCDs require the coordination of services from primary care to the tertiary level over a number of years. Sustaining a continuous relationship with healthcare professionals over time can lead to fewer hospitalizations by focusing on education and prevention and identifying problems early on (Rabkin, El-Sadr, 2011). The strengthening of healthcare systems to respond to the spread of HIV/AIDS also focused on community- and family-based care. This approach to health care emphasizes greater coordination between paediatric and adult care, the linkage of family medical records, and family member outreach. Community- and family-based care can be effective in managing risk factors within families and in recognizing the disproportionate impact of NCDS on certain communities (Rabkin, El-Sadr, 2011).

Together, with the lessons learned from recent struggle with infectious diseases and their desire to demonstrate leadership within global summitry, Russia in partnership with its BRICS allies can take the lead in producing innovative solutions and strategies for combating NCDs. With the upcoming summits hosted by Russia, there is no better time for Russia to prove itself capable of this role as social and economic costs continue to rise due to these diseases action.

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Appendix A: G8 Health Compliance (N=54)

Caroline Bracht
November 16, 2011

	Health	Canada	France	Germany	Italy	Japan	Russia	UK	US	EU	Average Score
1	**1983-23**	1			1				1		**1.00**
2	**1997-26**	1	1					1	1		**1.00**
3	**1997-55**	-1	-1	1	-1	0		1	1		**0.00**
4	**1998-23**	1	1	0	-1	0	-1	1	1	1	**0.33**
5	**1998-24**	1	1	-1	-1	-1	-1	1	1	1	**0.11**
6	**1999-38**	1	1	-1	1	1	0	1	1		**0.63**
7	**1999-39**	0	0	0	0	0	0	0	0		**0.00**
8	**2000-36**	1	1	1	1	1		1	1	1	**1.00**
9	**2000-23**	1		0	0	1	0		0	1	**0.43**
10	**2000-37**	1	1	1	1	1		1	1	1	**1.00**
11	**2000-38**	1	1	1	1	1		1	1	1	**1.00**
12	**2000-76**	1	1	1	0	1	-1	1	1	1	**0.67**
13	**2001-26**	1	1	1	1	0	1	1	0		**0.75**
14	**2001-28**	1	1	1	1	1	1	1	1	1	**1.00**
15	**2002-11**	0	0	0	0	0	0	0	0		**0.00**
16	**2002-109**	1	1						1		**1.00**
17	**2002-110**	0		0		0		0	0	0	**0.00**
18	**2002-116**	1	1	1	1	1	-1	-1	1		**0.50**
19	**2002-117**	1	0	0	0	1	0	1	0		**0.38**
20	**2002-118**	1	1	1	1	1	1	1	1	1	**1.00**
21	**2002-119**	1	0	0	1	0	0	0	0		**0.25**
22	**2002-124**	1	0	0	-1	0	0	1	1	1	**0.33**
23	**2003-xx**	1	1	1	1	1		1	1		**1.00**
24	**2003-3**	1	1	1	1	1	1	1	1	1	**1.00**
25	**2003-10**	1	1	0	1	1	1	1	1	1	**0.89**
26	**2003-13**	1	1	1	1	1	1	1	1	1	**1.00**
27	**2003-14**	1	1	0	1	1	0	1	1	1	**0.78**
28	**2003-115**	1	0	0	0	0		0	0	0	**0.13**
29	**2004-(b)1**	1	1	1	1	-1	-1	1	1	1	**0.56**
30	**2004-(c)3**	1	-1	1	-1	0	1	1	1	1	**0.44**
31	**2005-5**	-1				1	1		0		**0.25**
32	**2005-38**	0	1	0		1		-1	0	1	**0.29**
33	**2005-40**	1	1	1	1	1	1	1	1	1	**1.00**
34	**2005-42**	0	0	0	-1	1	1	0	1	1	**0.33**
35	**2005-44**	1	-1	1	-1	-1	-1	1	1	1	**0.11**
36	**2005-46**	1	0	0	0	1	1	1	1	1	**0.67**
37	**2006-27**	1	1	-1	1	-1	1	1	1		**0.50**
38	**2006-31**	1	1	0	0	1	1	0	1	0	**0.56**
39	**2006-36**	1	0	0	0	0	0	0	1	0	**0.22**
40	**2006-43**	1	0	1	-1	0	1	1	1	0	**0.44**
41	**2006-247**	0	0	0	0	0	0	1	0		**0.13**
42	**2007-227**	1	1	1	0	1	0	1	1	0	**0.67**

43	**2007-229**	1	1	1	1	1	1	1	1	1	**1.00**
44	**2007-233**	1	1	0	-1	0	-1	1	1	1	**0.33**
45	**2007-244**	1	1	0	0	1		1	1	0	**0.63**
46	**2007-246**	1	1	1	1	1	1	1	1	1	**1.00**
47	**2007-264**	1	1	1	0	0	1	1	1	0	**0.67**
48	**2008-118**	1	1	1	1	0	0	1	1	-1	**0.56**
49	**2008-127**	0	-1	-1	-1	0	-1	1	1	-1	**-0.33**
50	**2009-147**	1	1	0	-1	1	0	1	1	1	**0.56**
51	**2009-151**	1	0	0	0	1	0	1	0	-1	**0.22**
52	**2010-11**	1	-1	1	-1	-1	-1	-1	-1	-1	**-0.56**
53	**2010-14**	1	0	0	-1	1	0	-1	1	1	**0.22**
54	**2010-18**	1	0	1	-1	-1	0	1	1	-1	**0.11**
	Country Average	**0.80**	**0.52**	**0.40**	**0.14**	**0.43**	**0.19**	**0.68**	**0.74**	**0.54**	**0.51**

Appendix B: G8 Conclusions on Health, 1975-2011

John Kirton, Zaria Shaw and Julia Kulik
G8 Research Group, June 21, 2011

Summary of Conclusions on Health in G8 Summit Documents

Year	# of Words	% of Total Words	# of Paragraphs	% of Totals Paragraphs	# of Documents	% of Total Documents	# of Dedicated Documents
1975	0	0	0	0	0	0	0
1976	0	0	0	0	0	0	0
1977	0	0	0	0	0	0	0
1978	0	0	0	0	0	0	0
1979	15	0.7	1	2.6	1	50	0
1980	116	2.9	2	4.1	1	20	0
1981	59	1.8	1	1.9	1	33.3	0
1982	0	0	0	0	0	0	0
1983	21	.97	1	2.7	1	50	0
1984	12	.36	1	2	1	20	0
1985	59	1.8	2	4.7	2	100	0
1986	74	2	2	6.2	1	25	0
1987	719	14	7	9.5	3	42.8	0
1988	195	4	3	4.6	2	66.6	0
1989	272	3.8	7	5.8	1	9	0
1990	146	1.9	10	8.1	1	25	0
1991	300	3.7	6	10.7	1	20	0
1992	34	.45	1	.59	1	25	0
1993	62	1.8	1	2.3	1	50	0
1994	0	0	0	0	0	0	0
1995	0	0	0	0	0	0	0
1996	825	5.3	16	7	2	50	0
1997	1400	10.7	16	11.4	2	40	0
1998	404	6.6	3	4.6	1	25	0
1999	589	5.8	8	9.3	2	66.6	0
2000	1996	14.6	26	17.9	2	40	0
2001	1520	24.4	15	20.5	2	28.5	0
2002	1482	12.3	19	13.1	2	25	0
2003	3753	22.2	58	34.7	3	23	2
2004	1507	3.9	22	6.5	3	14.2	2
2005	2197	9.8	31	14.6	4	20	0
2006	7072	23	94	38.3	7	41.1	1
2007	4263	16.4	36	12.9	4	33.3	0
2008	2008	11.9	16	9.1	3	27.2	1
2009	2338	14	20	6	6	46.1	0
2010	2772	26.1	29	29.5	1	33.3	0
2011	756	4.1	12	5.6	2	40	0
Average	999.08	6.79	12.59	8.29	1.73	29.46	0.16

Notes:
Data are drawn from all official English-language documents released by the G8 leaders as a group. Charts are excluded.
"# of Words" is the number of health-related subjects for the year specified, excluding document titles and references. Words are calculated by paragraph because the paragraph is the unit of analysis.
"% of Total Words" refers to the total number of words in all documents for the year specified.
"# of Paragraphs" is the number of paragraphs containing references to health for the year specified. Each point is recorded as a separate paragraph.

"% of Total Paragraphs" refers to the total number of paragraphs in all documents for the year specified.
"# of Documents" is the number of documents that contain health-related subjects and excludes dedicated documents.
"% of Total Documents" refers to the total number of documents for the year specified.
"# of Dedicated Documents" is the number of documents for the year that contain a health-related subject in the title.

Appendix C: G20 Leaders Conclusions on Health, 2008-2011

Zaria Shaw and Sarah Jane Vassallo
G20 Research Group, November 24, 2011

Summary of Conclusions on Health in G20 Leaders Documents

Year	# of Words	% of Total Words	# of Paragraphs	% of Total Paragraphs	# of Documents	% of Total Documents	# of Dedicated Documents
2008 Washington	118	3.2	2	2.8	1	100	0
2009 London	59	0.9	2	2.1	1	33.3	0
2009 Pittsburgh	284	3.0	5	4.5	1	100	0
2010 Toronto	139	1.2	2	1.4	1	50	0
2010 Seoul	643	4.1	10	4.6	4	80	0
2011 Cannes	470	2.9	6	3.0	3	100	0
Average	285.5	2.5	4.5	3.0	1.8	77.2	0

Notes:
Data are drawn from all official English-language documents released by the G20 leaders as a group. Charts are excluded.
"# of Words" is the number of health-related subjects for the year specified, excluding document titles and references. Words are calculated by paragraph because the paragraph is the unit of analysis.
"% of Total Words" refers to the total number of words in all documents for the year specified.
"# of Paragraphs" is the number of paragraphs containing references to health for the year specified. Each point is recorded as a separate paragraph.
"% of Total Paragraphs" refers to the total number of paragraphs in all documents for the year specified.
"# of Documents" is the number of documents that contain health subjects and excludes dedicated documents.
"% of Total Documents" refers to the total number of documents for the year specified.
"# of Dedicated Documents" is the number of documents for the year that contain a health-related subject in the title.

Introduction

This report catalogues all G20 final statements, referred to as "conclusions," related to the issue area of health. It refers to all official statements and annexes released by the leaders, as a group, at each G20 leaders' summit since their beginning in 2008 to present, 2011.

Definition of Issue Area

Health is defined as the human condition of being sound in mind, body and spirit, and being free from physical disease or pain. This definition becomes more complex when health is considered in terms of its economic effect, as is the case with the heavy burden of HIV/AIDS in sub-Saharan Africa. The G20 are working to support the health-related Millennium Development Goals and to ensure more equitable, affordable and available healthcare for populations worldwide.

Of further interest: the G20 Research Group's Conclusions on Development.

Appendix D: BRICS Leaders Conclusions on Health,

2009-2011

Maria Marchyshyn, BRICS Information Centre
November 23, 2011

Summary of Conclusions on Health in BRICS Leaders Documents

Year	# of Words	% of Total Words	# of Paragraphs	% of Total Paragraphs	# of Documents	% of Total Documents	# of Dedicated Documents
2009 Yekaterinburg	1	0.1%	1	5.9%	1	100%	0
2010 Brasilia	4	0.2%	2	5.9%	1	100%	0
2011 Sanya	9	0.3%	7	20%	1	100%	0
Average	**5**	**0.2%**	**3**	**10.6%**	**1**	**100%**	**0**

Notes:
Data are drawn from all official English-language documents released by the BRICS leaders as a group. Charts are excluded.
"# of Words" is the number of health-related subjects for the year specified, excluding document titles and references. Words are calculated by paragraph because the paragraph is the unit of analysis.
"% of Total Words" refers to the percentage of health-related subjects to the total number of words in all documents for the year specified.
"# of Paragraphs" is the number of paragraphs containing references to health for the year specified. Each point is recorded as a separate paragraph.
"% of Total Paragraphs" refers to the percentage of paragraphs containing references to health to the total number of paragraphs in all documents for the year specified.
"# of Documents" is the number of documents that contain health subjects and excludes dedicated documents.
"% of Total Documents" refers to the percentage of documents containing health subjects to the total number of documents for the year specified.
"# of Dedicated Documents" is the number of documents for the year that contain a health subject in the title.

The first informal meeting of the BRIC leaders took place during the G8 Hokkaido-Toyako Summit in Japan in 2008, however, no official declaration or communiqué was issued.
South Africa was invited to join the BRIC countries at the Sanya summit in 2011 when the grouping became known as BRICS.