



Globalisation and its impact on the South Pacific

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This issue of the *NZMJ* contains articles¹⁻³ that form part of the World Health Organization's (WHO's) International Joint Special Issue on scaling up training and education of health workers, a collaboration between over 20 health-related journals to publish on a common critically important theme, led by the journal *Human Resources for Health* (www.human-resources-health.com) and the WHO department of Human Resources for Health.

The *NZMJ* articles relate to Pacific healthcare worker issues, which New Zealand has considerable influence over. The New Zealand Government's international aid and development agency (NZAID) is responsible for delivering New Zealand's official development assistance and for advising government ministers on development assistance policy and operations. NZAID is a semi-autonomous body within the Ministry of Foreign Affairs and Trade (MFAT). In the 2008/09 financial year, the Pacific Regional Social Development Programme combines, for the first time, Pacific regional health and education programmes with an enhanced focus on gender and youth and the linkages between them.

The effects of globalisation on health and the environment can be both positive and negative. Hoyt and Brooks call it a "double-edged sword"⁴ while Woodward et al state the linkages between globalisation and health are complex.⁵ Moreover, globalisation has both direct and (less noticeable and often delayed or unforeseen) indirect effects on health and the environment.⁶

Climate change—caused by deforestation plus burning of fossil fuels that release greenhouse gases—is a "hot" topic these days and most experts now agree the phenomenon is real and is occurring.⁶ WHO experts at the recent *Climate Change Global Risks, Challenges and Decisions* conference in Copenhagen estimate around "150,000 deaths now occur in low-income countries each year due to climate change from four climate-sensitive health outcomes—crop failure and malnutrition, diarrhoeal disease, malaria, and flooding"—and that small island states, children, and the elderly are particularly vulnerable. They draw a direct correlation—climate change has adverse consequences for health: as carbon goes up health goes down (www.who.int/globalchange/climate/en/).

Likely longer-term negative effects on Pacific island states include raised sea levels due to melting of the polar ice caps, thus affecting low-lying atolls of the Pacific. This is already happening in Tuvalu where valuable land is being eroded into the sea and the entire population may be forced to evacuate in the not-too-distant future due to a recorded sea-level rise of 5.5 millimetres per year. Actually some people have already been evacuated.⁷

Moreover, a warmer and wetter climate is likely to exacerbate mosquito-spread arboviral diseases such as malaria and dengue fever. Indeed, recent outbreaks of dengue fever have been recorded in Far North Queensland and across the Pacific:

New Caledonia, Kiribati, Palau, Fiji, Samoa, and Tonga all reporting unusually high levels of the virus.⁸

The free movement of goods and passengers between islands also facilitates the spread of communicable diseases such as influenza. This was sadly illustrated in 1918 when the influenza pandemic reached Samoa via the trading vessel *SS Talune* that disembarked six ill passengers arriving from Auckland. Within a week, influenza had spread throughout the two main islands of Samoa and approximately 7500 people died (one-fifth of the population).⁹ It is therefore important that effective pandemic and disease control plans are in place, and the WHO has an important role to play here.

Global cooperation, vaccination campaigns, and global pandemic plans—as outlined in the International Health Regulations of the WHO—have led to numerous health successes such as the virtual elimination of smallpox, polio, and hydatids throughout much of the world and reduced incidences of other major infectious diseases.

For example, a joint study conducted in Samoa in 1964 by the WHO and UNICEF recorded a rate of filaria as high as 21%.¹⁰ The WHO in collaboration with Japan provided technical cooperation with volunteers to assist in filaria control. With this cooperation, the filaria detection rate dropped to 1.1%—a marked improvement in the health of the Samoan people.

Sexually transmitted diseases remain a serious problem, however, in some Melanesian countries (especially Papua New Guinea)¹¹ along with tuberculosis and arboviral illnesses in some Pacific Island countries.¹² They all rely on the policies, resources, and technical assistance provided by WHO to help combat these diseases.

With limited resources and exports, expensive transport costs due to geographical isolation, and an increasing number of damaging cyclones (thought to be a side effect of global warming), many South Pacific countries rely on overseas development assistance to maintain their economies and a reasonable quality of life for their people. In the case of Independent Samoa, the top three contributors are Australia, New Zealand, and Japan. Assistance includes the building of education and health facilities, plus other important infrastructure such as port facilities and interisland ferries.

While stressing that New Zealand should contribute a higher proportion (currently 0.3%) of its gross national income to Pacific Island Countries and Territories (PICTs), Wyber et al,¹² in this issue of the *NZMJ*, point out the little-known fact (at least to us) that counter to its altruistic aid, New Zealand has been exporting what they term “health-damaging products” there, notably in the form of “mutton flaps” (fatty offcuts from the sheep meat carcass). Indeed, from July 2006 to July 2007, NZ\$73 million dollars of sheep meat was exported to the Pacific Islands, constituting New Zealand’s largest export to the Pacific. Similarly, byproducts (fatty turkey tails and necks) of predominantly US and Australia turkeys destined for Thanksgiving and Christmas dinner tables there have long found a willing market in the Pacific.²⁰ Add fatty chicken frames and backs and corned beef to that list.

Unfortunately many Pacific people are ill-equipped to consume such food in large quantities as they seem particularly susceptible to developing metabolic syndrome¹³ due to their evolved “thrifty gene” makeup. Rod Jackson (Professor of Epidemiology

at the University of Auckland) stated “[Pacific] people are literally eating themselves to death.”¹⁴ In addition, multinational fast food chains, which are particularly numerous in American Samoa,¹⁶ have contributed to the obesogenic environment. Not surprisingly, Pacific people have the world’s highest obesity rates (77% of adults in Nauru and 74% of women in Samoa, in 2002) coupled with high rates of diabetes, hypertension, and other “Western diseases” as a result of this obesity.¹³

With New Zealand’s best meat grades (along with other high-quality produce) going offshore to affluent consumers in Japan, Europe, and North America, the remainder for itself (thankfully generally lean recently¹⁵), and the unsellable unhealthy meat sent to the Pacific, one could term this practice “food inequality” and an unpleasant aspect of globalisation. Interestingly the process seems to happen the other way too, with New Zealand getting Japan's older vehicles—though not necessarily a negative.

Many Pacific consumers are not knowledgeable or motivated about the nutritional value or otherwise of mutton flaps and turkey tails, and taste and low cost is all-important, as shown by a survey conducted in Tonga and published in the WHO's flagship periodical, *Bulletin of the World Health Organization*, in 2001.¹⁷ In that survey of 430 Tongans, the most preferred and eaten food was imported chicken parts—while fish, surprisingly, was much lower down the list.

Thus, in the overall interests of the state and the health of its people, most public health experts argue that government regulation (while trying not to contravene world trade agreements such as GATT) is required instead of reliance on consumers making healthy food choices. Such an ideological debate is documented in the previous issue of the *NZMJ* which contains an editorial¹⁸ and letter¹⁹ advocating restrictions on the sale of junk food in New Zealand schools through the reintroduction of regulations introduced by the previous government.

Facing a health crisis and despite threatened trade action by New Zealand (later withdrawn), Fiji was the first island nation to ban the importation of low-grade fatty meat (1999)²⁰ followed more recently (2007) by Independent Samoa with its ban on US turkey tail meat as well as chicken backs.^{20,21}

The determinants of health are complex. Some activities done to improve one country's economic situation can have a negative effect on the health of another for instance. The WHO in promoting this series of articles is helping draw our attention to issues of workforce, training, and workforce migration while NZAID has previously recognised the complex nature of aid and health interaction.

The future health of Pacific people can’t be considered in isolation, as they are influenced by the aid we give and the effects of globalisation that New Zealand has at times espoused.

Competing interests: None known.

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