



New Zealand's impact on health in the South Pacific: scope for improvement?

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Abstract

We examined how New Zealand activities impact on health in Pacific Island Countries and Territories (PICTs) in two domains: the provision of development assistance and the impact of trade. The available evidence suggests that New Zealand's official development assistance (ODA) is capably and strategically administered by its development agency, NZAID. However, New Zealand contributes comparatively little of its economic capacity to ODA; only 0.30% of gross national income, with a relatively small proportion spent in the health sector. Increasing this level of ODA and proportional spending on health is likely to be important for enhancing the long-term impact and credibility of the country's development assistance programme. New Zealand has a liberalised trade policy toward the PICTs which is likely to provide economic benefits. However, the country also exports health-damaging products to PICTs such as high-fat mutton flaps and tobacco. Permitting such exports may undermine non-communicable disease control strategies and are a significant area of policy incoherence given other support provided (e.g. for tobacco control). Overall there remains significant scope for New Zealand to contribute more effectively via aid and trade to health in the South Pacific.

As a South Pacific nation, New Zealand has strong historical, geographical, cultural, emigrant, and legal ties to nearby Pacific Island Countries and Territories (PICTs). These relationships, in conjunction with aid and trade programmes, inexorably link the practice and policy of New Zealand with health outcomes in the Pacific.

The PICTs are defined in this article as 22 island nations who are members of the Secretariat of the Pacific Community (SPC), with a combined total population of 9.15 million people.¹ The developing PICTs share regional commonalities of: narrow-based economies, limited national infrastructure, and aid dependence.

Governance, security, and education are variable throughout the region. Health indicators also vary widely between PICTs, but most experience high prevalence of non-communicable diseases (NCDs). NCD rates are high throughout the Pacific and obesity is endemic. In 10 of the PICTs, 50% of the population are overweight or obese; in a further 7 PICTs, 75% of the population are overweight.² Compounding NCDs, regional smoking rates are high—exceeding 50% in a number of PICTs.^{3,4}

Communicable disease burdens include relatively high rates of tuberculosis in many PICTs, concern around HIV/AIDS in Papua New Guinea (PNG) and with malaria in PNG, Solomon Islands and Vanuatu. All PICTs are at threat from pandemic influenza, especially if they cannot rapidly instigate rigorous border control measures as in the past.⁵

Health workforce shortages exacerbate the high burden of disease. Currently in the Pacific there are only 0.05—1.5 doctors per 1000 people.⁶ In contrast, the same ratio is 2.37 per 1000 in New Zealand.⁶ While there are two regional medical schools and a number of nursing colleges within the PICTs,⁷ these do not appear to be meeting health workforce needs. The small number of doctors in the Pacific must also contend with geographic limitations to provide care in a diverse, dispersed population. This context significantly worsens the effect of the low doctor to population ratio in rural and outlying areas.

There are many key areas where New Zealand policy and practice significantly impact on health in PICTs. These include the provision of development assistance, trade, health workforce migration, short-term natural disaster relief (e.g. after cyclones), conflict resolution, security assistance, and support for protecting key resources such as fisheries. New Zealand also contributes by providing leadership on global issues that may impact on PICTs (e.g. bans on nuclear weapons testing, nuclear weapons disarmament, and preventing global climate change).

This review focuses on just the first two of these areas (development assistance and trade) which arguably have the greatest health impact. Other future reviews can hopefully investigate these other important areas.

Methods

We undertook Medline searches from 1 January 1995 to 20 November 2007, using a wide range of search terms (including for the names of all PICTs and the word “Zealand”). We chose to focus on the impact of New Zealand since the instigation of NZAID in 2005 to avoid an undue focus on the shortcomings of its predecessor, New Zealand Overseas Development and Aid (NZODA), which have been covered in previous independent reports. Additional online searches covering this time period were conducted through the websites of the New Zealand Government’s development assistance organisation (NZAID), World Health Organization (WHO), and the SPC. Other sources were traced from the bibliographies of relevant documents.

To contextualise these sources, we considered key recent international documents on best practise in development.^{8,9} Our own work experience also allowed us to reflect on the quality of the available literature as all of us have worked in PICTs (10 different PICTs collectively) for a range of agencies.

Results

Health-related development assistance—New Zealand’s development assistance organisation was substantially restructured in 2002 with the formation of NZAID, a semi-autonomous body within the Ministry of Foreign Affairs and Trade. The previous aid administrative body, NZODA, had been heavily criticised in two independent reviews.

NZAID appears to have worked consistently to address the weaknesses of the previous NZODA programme. Since 2002, the official development assistance (ODA) programme has grown significantly in funding and strategic development. In the 2007/2008 financial year, New Zealand is budgeted to provide \$466.4 million in official development assistance, representing 0.30% of New Zealand’s Gross National Income (GNI).¹⁰ This allocation is set to rise to \$636.3 million in 2010/2011, equivalent to 0.35% of GNI.

New Zealand has focused its ODA programme on the Pacific region for many years and 51.7% of the 07/08 budget will be contributed to the Pacific. This contribution is

split between bilateral agreements with individual countries, regional programme contributions, and NZAID scholarships.

Bilateral programmes are direct arrangements with overseas governments on areas of development priority. Traditionally, spending on the health sector within bilateral Pacific arrangements has been small (<10% of the total programme).¹¹ There have been recent increases for some countries—e.g. for funding HIV/AIDS control in PNG taking the proportion spent on health up to 47% (for 2006/07).¹² However, for other countries the health proportion remains very low (e.g. 2% for the Solomon Islands¹³).

Within the regional programme, NZAID allocations to the health sector in the Pacific were 17.8% in 06/07.¹⁴ The NZAID regional health programmes are focused on three key areas; NCDs, communicable diseases and human resources for health. Additional support is provided to regional agencies acting in the health sector, such as SPC.

Sector spending on health is complicated by definitional difficulties. OECD Development Assistance Committee (DAC) data allows comparison between nations but probably underestimates actual sector spend. According to 2006 DAC figures, New Zealand targeted 5.0% of its ODA to health which was slightly less than the OECD average of 6.3%. This percentage differs from NZAID reports suggesting 8.5% of their total budget is health expenditure.¹⁵ Of ODA spending, 3.6% was on “basic health” which was also similar to the OECD average of 3.5%.¹⁶

NZAID also undertakes workforce development through the provision of tertiary scholarships for New Zealand universities and some regional training centres. Scholarship places and some direct funding are also provided to the Fiji School of Medicine.¹¹

Trade—New Zealand plays a dual role in trade with the South Pacific. It supports PICTs trade development initiatives through ODA contributions and also acts as a major trading partner. As the latter, New Zealand has a liberalised trade policy and an open market for PICT products. This support of Pacific trade has the potential for secondary improvement in health through economic development. However, New Zealand also has a direct impact on health through ongoing export of products to PICTs that are hazardous to health.

New Zealand is a major exporter of “mutton flaps” (scraps from butchered lamb and mutton) to the South Pacific. 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 good to the Pacific.¹⁷

Import data from Tonga indicates a three-fold mutton flap increase from 1976 to 1996.¹⁸ In 1992, mutton flaps accounted for 22% of food imports to Tonga.¹⁹ According to a 2002 SPC report, the PICTs represent a global market of US\$30 million for all low-grade meat cuts.²⁰

In much of the Pacific, mutton flaps have become a dietary staple and in Tonga are consumed an average of 2.3 times per week.²¹ The mean fat content of uncooked mutton flaps is 27.4%; considerably more than traditional island sources of protein.²²

Mutton flaps are relatively low cost and easily accessible for Pacific Peoples. One study suggests they are 15% to 50% cheaper than local sources of protein in Tonga.²¹ Surveys of food preference and nutritional knowledge indicate that cost, not

preference or poor nutritional information, is the primary determinant for consuming mutton flaps.²³ In some Pacific cultures, however, the consumption of mutton flaps has become a matter of social and ceremonial importance.²⁴

Many researchers have reported that excess consumption of imported food, especially imported fatty meats, has a causative relationship with endemic obesity in the Pacific.^{19,23,25}

New Zealand also exports tobacco to the Pacific Islands, worth NZ\$2.8 million in 2006.²⁶ In 2000, this export market represented 87.3 million cigarettes, causing an estimated 75 premature deaths in the Pacific.²⁷ Yet NZAID is simultaneously working with the PICTs to implement the WHO Framework Convention on Tobacco Control (FCTC).²⁸⁻³⁰

Discussion

This article briefly considers the direct effects of New Zealand's impact on the health of PICTs in just two domains and for only a 12-year period. Our analysis is limited by the general reliance on published data and website reports which are probably only a small fraction of the information held by stakeholders. Systematic key informant interviews could have provided additional contextual information, but this method was beyond the scope of this project which had no external funding support. Nevertheless, the work presented here may stimulate discussions around how New Zealand can further develop its contribution to health in the South Pacific.

The importance of health in development—There are five core arguments for New Zealand to focus on health aspects of development in the Pacific. Firstly, health is a human right and providing good health should be a goal of all responsible members of the international community.⁸ Secondly, the increasing burden of NCDs in the Pacific is, in part, a predictable consequence of New Zealand's development assistance policy which encompasses economic development as an expressed goal.

Countries in transition show a characteristic increase in NCDs when economic development produces import-driven changes in diet and lifestyle.^{31,32} Therefore, New Zealand should consider funding programmes to combat the rise in NCDs in parallel with economic development programmes. Thirdly, NZAID aims to work in partnership with PICT governments and leaders, as per the Paris Declaration on Aid Effectiveness and similar guidelines.³³

The PICTs have clearly expressed that they consider health is a regional priority, via the Healthy Islands Plan.³⁴ As a development partner, New Zealand should therefore consider facilitating the articulated priorities of the PICTs.

There are two further pragmatic reasons for New Zealand to focus on health in the Pacific. Firstly to respond to growing data that prioritisation of health in development programmes has significant economic benefits. The overwhelming message of the UN's Commission on Macroeconomics and Health was that health was under-recognised as an essential prerequisite for global development.⁸ In addition, New Zealand should logically attempt to improve Pacific health to limit the demands on its own domestic health service. Reports suggest that New Zealand health services may have been strained by the demand from immigrants and visitors from the Pacific with NCD conditions.^{35,36}

Secondly, improved Pacific health is also likely to reduce the risk of the spread of infectious diseases to New Zealand.³⁷ Of particular concern is HIV/AIDS which is threatening to spread further throughout PICTs and has the potential to contribute to the disease burden in New Zealand.

Tuberculosis has a similar risk of international transmission. Over the 2000–2004 period, 14% (249/1722 with known birth country) of tuberculosis cases notified in New Zealand were born in Pacific countries.³⁸ The requirement for New Zealand to help strengthen surveillance and response capacity in the Pacific is now supported by the new International Health Regulations 2005 (IHR 2005).

The IHR 2005 came into force in June 2007 for all 193 World Health Organization member states including New Zealand. This international law includes obligations to assist with assessing and building capacity, and responding to public health risks and public health emergencies of international concern.³⁹ One specific area where New Zealand could assist capacity building would be in supporting PICTs in pandemic influenza planning.

Health-related development assistance—The UN, with broad international support, identified a global target of 0.7% of GDP for ODA donations from all donor countries in 1971. Achieving this goal by 2015 was reiterated by the Millennium Declaration in 2002, to which New Zealand is a signatory. However, New Zealand's ODA contribution as a proportion of GNI peaked at 0.52% in 1975 and currently stands at 0.30%; the only planned increase is to 0.35% by 2010/2011.^{10,40} This level is significantly below the OECD average country contribution of 0.47% of GNI in 2005.³³

Current ODA is also much less than the estimated minimum ODA:GDP ratio to meet Millennium Development Goals (MDGs) (0.44% by 2006 and 0.54% by 2015).⁴¹ The New Zealand Government has made repeated public commitments to reaching the 0.7% ODA:GDP goal and to the MDGs. However, New Zealand is now one of only two OECD countries without interim targets or a timeline for achieving this goal.⁴²

There is significant pressure on the New Zealand Government to commit to a timetable of ongoing increases in ODA. For instance, an opinion survey in 2004 indicated that 61% of New Zealanders were in favour of increasing aid to the 0.7% of GNI threshold.⁴³ The New Zealand NGO community, under the banner of Centre for International Development, has launched a campaign to advocate for a timeline to reach 0.7% ODA:GNI.⁴²

The formation of NZAID as an ODA distribution group in 2002 represented a national commitment to excellence in aid delivery. The organisation has been widely lauded for its achievements and it seems illogical and unethical not to provide NZAID with increased ODA funds to expand their commendable development programmes.

New Zealand spends a modest proportion of its small ODA allocation on the health sector. Evidence, ethics, and pragmatism suggest that focusing on health is critical for development. In their 2005 health policy, NZAID foreshadowed increased spending in the health sector: “It is envisaged that the proportion of NZAID's overall expenditure on health will increase considerably within the next five years from the current level of approximately 8.5% of total ODA”.¹⁵

Health has also been identified as a high priority sector in the NZAID Multilateral Engagement Strategy through to 2010.⁴⁴ This move towards increased health focused funding is important in the ongoing strategic evolution of New Zealand's development assistance activities.

Trade—New Zealand has a liberalised trade policy with PICTs and allows duty free and unrestricted access to all products of Pacific Island origin.⁴³ Although this is probably a positive contribution to development overall, the export of health-harming products is undermining this benefit.

Concern over high fat food imports and increasing obesity in the Pacific has been raised by numerous authors.^{19,23,25,45} It is also recognised that the cost of these products is a key determinant in their consumption.^{21,23} Thus, the effects of public health promotion alone are likely to be limited and economic intervention must be considered a primary NCD preventative policy.^{19,23,46}

Some Pacific nations have attempted to reduce high fat imports under domestic law. Fiji banned mutton flap imports in 2000 and New Zealand responded by threatening to refer the issue to the World Trade Organisation (WTO).⁴⁷ New Zealand later withdrew plans to approach the WTO and the ban still stands.²⁴ Tonga considered imposing mutton flap import quotas but withdrew the proposal in view of WTO concerns.⁴⁸ The legality of trade bans and tariffs in the health sector are complex and subject to considerable international debate.⁴⁸ However, for the New Zealand Government to actively resist the attempts of PICTs to address the critical health burden of NCDs is inconsistent with promoting health in the region.

Tobacco exports to PICTs represent further incoherence in New Zealand policy from a health and development perspective. We suggest therefore that New Zealand halt tobacco exports to PICTs and encourage other nations to follow this lead. This action would fit with the spirit of the Framework Convention on Tobacco Control (ratified by New Zealand 2004) and greatly improve congruence with NZAID health programmes.^{27,49} Similar concerns may apply to the exports of alcohol, soft drinks, and various processed foods that are high in fat, sugar, and salt.

Conclusion and recommendations

The PICTs are fragile states, dependent on aid for the foreseeable future. Thus, bilateral donors such as New Zealand have a significant role to play in supporting the development of a stable and healthy South Pacific region. As globalisation and interdependence between nations intensify, the importance of this role will probably continue to increase.

The first priority for New Zealand should be developing a timeline for reaching an ODA contribution of 0.7% of GNI, as supported by reviews of NZAID, the NGO sector, and the New Zealand public. The DAC average country effort (0.47%) could serve an appropriate medium-term goal. New Zealand's continued affirmation of the 0.7% goal without any tangible planning is a significant threat to its international credibility and to the success of NZAID development programmes.

NZAID should increase the proportion of ODA spent in the health sector, as alluded to in its health policy. The evidence for an increased focus on health is soundly based in pragmatism, economics, and ethics. An increased emphasis on prevention and

primary care would better meet regional health priorities than previous tertiary health interventions.

New Zealand's liberalised trade policy is an important contribution to economic stability in the Pacific region. However, this benefit is significantly undermined by its export of health-damaging products. New Zealand should consider removing its opposition to PICTs using domestic law to limit the sale of imported mutton flaps into their countries. Continued export of tobacco is particularly inappropriate and should be stopped immediately. Consideration could also be given to possible controls on the trade in alcohol and processed foods that are high in fat, sugar, and salt (e.g. restrictions, or at least improved labelling around risks to health).

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