



Key arguments for increasing New Zealand's health development assistance in the Pacific

Nick Wilson, Osman Mansoor, and George Thomson

Overview

New Zealand is a relatively poor contributor of financial aid to developing countries – with a rank of 15th in the OECD. Given the poverty and poor health status within some Pacific Island Countries (PICs), there is an ethical imperative to do more. This imperative is strengthened by the need for the remediation of current and past harms to the health of Pacific peoples (eg, from New Zealand tobacco exports).

Development aid can also lead to direct and indirect health (and other) benefits for New Zealand. These benefits are most obvious for communicable disease control (eg, for tuberculosis, measles, pandemic influenza, and vector-borne diseases). These benefits will apply more broadly to any health intervention of relevance to the Pacific Island community in New Zealand (eg, diabetes prevention programmes). The reduction of poverty and population stabilisation in PICs may also enhance regional stability. Such stability would benefit New Zealand in terms of trade, reduced needs for peacekeeping, and a lowered risk of refugees arising from internal conflicts.

Introduction

The New Zealand Government has been contributing around \$NZ 250 million in overseas development aid each year, with this being recently boosted by \$NZ 20 million.¹ This sum is only around \$NZ 70 per person per year—which is equivalent to just a few hours work per year for a person on the average wage. In 2001, New Zealand ranked only 15th out of 22 OCED countries in terms of aid as a proportion of GDP.² This level was also less than half the United Nation's target of 0.7% of GDP and less than a quarter of the level provided by Denmark. Nevertheless, New Zealand has also been ranked fourth out of the world's 21 richest countries on a 'Commitment to Development Index' (with this index considering additional factors such as support for peacekeeping and trade policies).³

The major recipients of New Zealand development assistance are countries in the South Pacific (47% of the total assistance) and countries in East and South East Asia. New Zealand is the fifth largest donor in the Pacific region (after Japan, the European Union, Australia, and France).⁴ New Zealand's development assistance has recently been reviewed⁵ and a new semi-autonomous organisation 'NZ AID' (New Zealand Agency for International Development) has been established. The current major focus of development assistance is on poverty elimination, which includes health development.⁶

Various non-governmental organisations based in New Zealand also contribute to overseas development (eg, VSA, Oxfam, etc). Yet the impact of such organisations is generally small compared to official overseas development assistance.⁷ This article takes a public health perspective on the key arguments for increasing overall development assistance to the Pacific, particularly for health development.

Reason 1—Ethical reasons

There is a strong case on ethical grounds for rich countries to assist developing countries in alleviating poverty and disease.⁸ As noted in a recent review,⁵ the South Pacific region includes places with extreme poverty. In particular, the Solomon Islands, Papua New Guinea, and Vanuatu suffer from serious health problems, reflected in low life expectancy and high infant mortality. Infectious and vector-borne diseases are important contributors to the poor health outcomes (including malaria, diarrhoeal diseases and respiratory infections in many PICs). HIV/AIDS is spreading in the region and is of particular concern in Papua New Guinea. There are also problems with alcohol abuse, intentional and non-intentional injury, and increasing rates of diabetes and cardiovascular disease. Premature deaths from these conditions can result in families losing their principal income earners, which in turn exacerbates poverty. Similarly, chronic illness impairs workforce productivity and increases dependency levels.

Another ethical issue is remediation of current and past harms imposed on PICs by activity allowed by New Zealand Government policy. For example, one estimate is that New Zealand's cigarette exports cause around 75 premature deaths per year in nine Pacific countries.⁹ New Zealand also exports meat products high in saturated fat (eg, as 'mutton flaps') thus contributing to cardiovascular disease and diabetes in PICs (given the good evidence that saturated fat consumption is associated with these diseases).¹⁰

In the past, New Zealand has provided 'development funding' to the construction of a cigarette factory in Samoa in the 1980s.¹¹ This factory continues to supply cigarettes to Samoa and surrounding countries. Some of New Zealand's training of health professionals from the Pacific may also have contributed to a drain of nurses and doctors from Pacific Island Countries (PICs) to New Zealand or Australia.

There is a precedent for New Zealand concern for the consequences of its actions in the Pacific with a recent apology being by the Prime Minister to Samoa over New Zealand's 'inept' management of pandemic influenza.¹²

Reason 2—Shared communicable disease control benefits

Globalisation and extensive air travel allow for the rapid spread of communicable diseases between countries, and border controls have incomplete capacity to prevent their spread. In order for New Zealand to achieve or maintain control of these diseases, control is vital in neighbouring countries with frequent reciprocal travel. New Zealand faces three types of communicable disease risk from PICs: importation of diseases (and their subsequent spread in New Zealand); infection of New Zealand travellers who then require treatment by New Zealand health services; and infection in Pacific migrants who then both require treatment by health services and who can spread disease in New Zealand.

There are a number of examples of communicable disease spread from PICs to New Zealand—including typhoid,¹³ Ross River fever,¹⁴ and acute haemorrhagic conjunctivitis.¹⁵ Dengue fever poses both risks to travellers from New Zealand,¹⁶ and there is also a potential risk of it becoming established in this country.¹⁷ Migrants from PICs to New Zealand also have relatively high rates of tuberculosis (30% of all cases in Auckland were born in PICs).¹⁸ Infectious agents in imported food from PICs

have also caused health problems in New Zealand.¹⁹ Indeed, the 1997 measles epidemic may also have been started by an importation from the Pacific. Other diseases in which there is a potential risk of spread (from PICs to New Zealand or vice versa) include: HIV, pertussis, rubella, pandemic influenza, and SARS (severe acute respiratory syndrome). Indeed, the global response to SARS particularly highlights the importance of nation states cooperating on communicable disease control issues.

Fortunately, many communicable disease control interventions in developing countries are highly cost-effective. Tuberculosis control strategies in developing countries are estimated to save a disability-adjusted life year (DALY) for only \$US 3–5²⁰ (and \$US 12 per year of life saved).²¹ There is extensive international data on the cost-effectiveness of malaria control (eg, \$US 13 and \$US 43 per year of life saved in Guinea,²¹ and \$US 69 per DALY in Brazil).²² In Melanesian countries, malaria poses a major and continuing threat and there is evidence from the Solomon Islands that permethrin-impregnated bednets are an effective low-cost control strategy.²³

Immunisation programmes are also generally considered to be extremely cost-effective in developing countries (eg, \$US 12 – \$17 per DALY for the Expanded Program on Immunization).²⁰ A hepatitis B immunisation programme (part-funded by the New Zealand Government) was found to be successful in protecting infants from chronic infection in the Pacific—at an estimated cost of around \$US 190 per premature death prevented.²⁴ Even newer vaccines such as Hib vaccine appears to be cost-saving in some settings,²⁵ and in the Pacific, Fiji has used this vaccine to substantially reduce Hib disease rates.²⁶ Given this evidence, it is not surprising that improving immunisation cover is an indicator for one of the United Nations Millennium Development Goals (ie, Goal 4 to ‘reduce child mortality’).²⁷

Reason 3—Shared non-communicable disease control benefits

New Zealand shares with PICs such problems as high rates of rheumatic heart disease, obesity, diabetes, and tobacco use among its citizens (particularly among Maori and Pacific peoples).²⁸ Indeed, the increasing prevalence of adult obesity and type 2 diabetes are particularly major problems for both New Zealand and PICs. As Auckland has the largest single concentration of Pacific peoples in the world, many lessons learnt in the process of addressing these health problems (in both Auckland and in PICs) can be shared to the benefit of all. Examples might include the sharing of lessons in public health legislative frameworks, tobacco control policies, culturally-appropriate nutritional interventions, physical activity promotion programmes, and diabetes control programmes (eg, as per a programme run in Otara, Auckland).²⁹

If future immigration from PICs occurs at high rates, then improved control of chronic diseases in these countries might ultimately lower health costs for New Zealand. — This may especially be the case for low-lying island nations (eg, Tuvalu, Kiribati) that could be de-populated by rising sea levels attributable to global climate change (particularly as seawater invades below-ground freshwater supplies).

Reason 4 —Enhanced regional stability

There are several areas of instability in the Pacific. Furthermore, some small states may also be at risk of exploitation by terrorist organisations and crime syndicates (eg, for money laundering, human smuggling, and drug trafficking).³⁰ New Zealand has

been involved in a number of successful stability-promoting initiatives, including peace-keeping activities in both the Pacific and South East Asian region (eg, Bougainville and East Timor), providing police training (eg, Solomon Islands), and supporting constitutional reform (eg, Fiji). Such actions appear to be well worthwhile, but can be supplemented with actions to reduce poverty and improve health. For example, improving the health status of the workforce may contribute to stronger economic development and therefore reduce the risk of state instability. Family planning programmes can assist in lowering population pressures in island nations that have limited natural resources. Family planning is also a very cost-effective way to improve child and maternal health (at \$US 20-30 per DALY²⁰). Child health programmes may also contribute to population control, since as child survival improves, maternal fertility tends to decline.³¹

A more stable South Pacific would facilitate mutual economic development (including more trade and tourism) and reduce New Zealand requirements for expensive peacekeeping operations. It would also lower the long-term risk of New Zealand having to accept refugees from local conflicts. Similarly, enhanced stability may increase the resilience of PICs to the impacts of climate change and, therefore, future numbers of environmental refugees.

Summary

There are both ethical and self-interest reasons for New Zealand to enhance its health development assistance to neighbouring Pacific Island Countries (PICs). Many of the relevant health-related interventions are highly cost-effective and are likely to result in health gains in both PICs and New Zealand.

Nick Wilson

Senior Lecturer (public health)
Wellington School of Medicine & Health Sciences
Wellington

Osman Mansoor

Public Health Physician, Wellington

George Thomson

Research Fellow
Wellington School of Medicine & Health Sciences
Wellington

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