

Health and foreign policy: scope for Australian engagement?

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HEALTH AND FOREIGN POLICY — unlikely bedfellows? Perhaps... Current world interest in the ties between security, poverty, health, human rights, globalisation, and trade was an important backdrop to the symposium on Health and Foreign Policy: Scope for Australian Engagement, held in Sydney on 18–19 September 2003. Whether such a meeting would have taken place before the 2001 attack on the World Trade Center in New York is a moot point. Nevertheless, conference delegates were keen not to focus primarily on the “war on terror”, but rather, on “upstream” issues of social justice, equity, development, conflict prevention and human security. Opening addresses by the Honourable Professor Marie Bashir (Governor of New South Wales) and Kay Patterson (then Federal Minister for Health and Ageing) both stressed the imperatives for closer links between health and foreign policy.

The symposium was co-hosted by the School of Public Health and Community Medicine, the University of New South Wales (UNSW), and the Institute for International Health, University of Sydney. The Nuffield Trust, United Kingdom, supported student attendance and brought a dynamic team from the UK to engage Australian academics and policy makers. Nearly 140 people with backgrounds in aid and development, trade, the pharmaceutical industry, non-government organisations, health services, international relations, human rights, and public health met to formulate ideas for better links between these unlikely partners.

The symposium followed a key meeting in Canberra organised by the Nuffield Trust with the Australian Department of Health and Ageing, and attended by Australian and British policy makers in health, foreign policy and aid, academics, and Australian Foreign Minister Alexander Downer. Mr Downer stressed that, to deal effectively with issues such as the burden of ill health on economies, HIV/AIDS, sudden acute respiratory syndrome (SARS), and the availability of drugs for common diseases, “global health can no longer be the preserve of national health ministries... global health is a foreign policy issue”.² Governance and capacity building were identified as crucial to ensuring that

weak states can deliver health services, are supported to avoid collapse, and can tackle poverty.

Globalisation

At the Sydney symposium, Dr Kelley Lee (London School of Hygiene and Tropical Medicine) defined globalisation as:

a set of processes intensifying human interaction across economic, political, sociocultural, environmental and technological realms. These changes are evident across spatial, temporal and cognitive boundaries.

As examples, she highlighted the risk of emerging antimicrobial resistance and its accelerated spread as a result of global travel and international trade. Similarly, obesity and related health problems are reaching low- and middle-income countries, associated with rising consumerism and decreasing local food security.

Professor Ron Labonte (University of Saskatchewan) described the immense effect of globalisation on

health within and between nations, such as the impact of global trade in processed food. He also highlighted the limitations of departing from an “upstream” focus on determinants of health, health promotion and primary healthcare, to more “downstream” responses to disease.

Stuart Harris (Emeritus Professor of International Relations, Australian National University [ANU]) drew attention to the inevitability of some health considerations creeping into the foreign policy domain. The SARS epidemic revealed how emerging infections can rapidly, systematically and severely affect trade, tourism and perceptions of risk and safety. Global epidemics of HIV/AIDS, the unfinished agendas of tackling malaria, tuberculosis and child health problems, and the emerging problems of chronic disease, mental health and injuries and violence continue to pose significant challenges.

Professor Kalinga Tudor Silva (University of Sri Lanka) highlighted the links between growing globalisation and collective violence. There is mounting concern with how disease undermines economies and weakens states, with potential consequences of instability and violence. International governing structures no longer seem adequate to address such complex challenges.

Health and human rights

Chris Sidoti (Human Rights Council of Australia) and Elizabeth Reid (Gender Relations Centre, ANU) propelled health and human rights to the centre of the debate. While the right to health is not an absolute right, it is a right to be

“There can be no new consensus, no new order, no stability, without tackling the appalling poverty that afflicts nearly a half of the world’s population.”

— Tony Blair

(quoted by Sir Alastair Goodlad at the pre-symposium meeting in Canberra)¹

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“progressively realised”. It includes the right to control one’s body and the right to equality of healthcare access. Specific rights often articulated include access to quality maternal, child and reproductive healthcare, healthy workplaces and natural environments, disease prevention, treatment and control (including access to essential medicines), and access to safe and potable water, sanitation, and nutrition.

In 1990, the Commission on Health Research and Development (COHRED) described the 10/90 disequilibrium — only 10% of research and development spending is directed to the health problems of 90% of the world’s population. The Special Rapporteur of the Commission on Human Rights argues that the very neglected diseases and the 10/90 disequilibrium are human rights issues. Symposium discussions displayed solid commitment to ensuring better access to basic drugs in developing countries.

Delegates also learned and voiced concern that Australia has introduced restrictive policies, especially with respect to reproductive health. For example, partner organisations of the Australian Agency for International Development (AusAID) are prohibited from using funds for “activities that involve abortion training or services, or research, trials or activities which directly involve abortion drugs”.³ The Australian Government has also stopped funding to the World Health Organisation’s Human Reproductive Programme and the Population Council (Dianne Procter, Chief Executive Officer, Australian Reproductive Health Alliance, personal communication). These policies are more restrictive than domestic policies, are in tune with those of the United States, and appear to influence practice and values in recipient countries in ways that arguably conflict with international human rights law. Conference delegates pondered the ethics of applying stringent conditions in foreign assistance while not applying the same standards at home.

Humanitarian and development assistance

The generalised decline in development aid funding was seriously challenged. Despite the internationally accepted benchmark that 0.7% of gross national product (GNP) per capita be spent on international assistance, the US contributes about 0.1% and Australia 0.26%. The UK has recently and dramatically reversed its steady decline in development funding, as described by Dr Julian Lob-Levyt (Department for International Development, UK). The UK commitment to poverty eradication, a more humane globalisation and the United Nations Millennium Development Goals⁴ was widely applauded.

There has been a shift toward humanitarian relief funding directed at addressing instability and collective violence, but this emergency response has limitations, especially in influencing longer-term development. Professor Anthony Zwi (UNSW) elaborated several reasons for the decline in development aid: the end of the Cold War (as the value of propping up client states in the developing world is less apparent in our era), difficulty proving the direct benefits of

aid funding, critique of the role of the state, and generalised cynicism about internationalism.

That links exist between poverty, sociopolitical instability and inequity seems a logical notion. Yet, as Sue Ingram (Institute for International Health) pointed out, the evidence base for these links and for development assistance as a means to break them is not particularly strong, warranting further research and debate.⁵ Underlying concerns at the meeting were the rising trends in inequity in health and healthcare. There is disturbing evidence that health sector reform and macroeconomic structural adjustments within a globalising world may have contributed to increasing inequity within and between various countries. Examples include the 10/90 disequilibrium and the negative effect on the household economies of poor countries of having to pay more for healthcare.

Various conference delegates expressed concern with AusAID’s stated objective of primarily benefiting Australia,⁶ given potential and actual conflicts of interest between this objective and the development needs of the poorest nations. Delegates supported proposals endorsed by the Development Assistance Committee of the OECD. These proposals were to ensure that aid is less tied to the country providing assistance and more to the development and poverty eradication needs of the beneficiary country.

Towards an Australian global health coalition

The symposium ended with a call for a much more vigorous engagement by Australian stakeholders in shaping global health issues. All were challenged to rediscover pride in Australia’s contribution to global health, aid, development, and human rights and to put behind the period in which harsh approaches to refugees and asylum seekers had shamed Australia’s international reputation. The meeting concluded with a commitment to take this forward by establishing an Australian coalition on global health, which will promote new thinking and seek an aspirational, progressive content to Australia’s aid program.

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