Burnet Institute
Medical Research. Practical Action.

Submission to the Inquiry into the strategic effectiveness and outcomes of Australia's aid program in the Indo Pacific and its role in supporting our regional interests.

Joint Standing Committee on Foreign Affairs, Defence and Trade

June 2018

Burnet Institute
Medical Research. Practical Action.

Summary of Submission from the Burnet Institute

Consistent with the Burnet Institute's vision, our submission focuses on health and equity and addresses aspects of the following three areas of interest of the Committee, which are interconnected:

- Australia's aid program in terms of strategic and development goals.
- The role Australia's aid program plays in building influence as a trusted development partner.
- Australia's aid program in fostering confidence, stability, sustainability, capacity, community-determined goals and best outcomes, particularly by utilising local procurement and smaller/local entities.

Our key conclusions include:

- The severe cuts in the Australian aid budget over the past five years have most likely resulted in Australia being regarded as an unreliable and unpredictable development partner, especially in Asia.
- The curtailment of existing aid programs and the lack of flexibility to launch new initiatives have affected the Australian aid program's ability to foster confidence, stability, sustainability, innovation, capacity and to attain community-determined goals and best outcomes. The health and education sectors have been disproportionately affected by aid budget cuts.
- The decline in investment in health by the Australian aid program is a barrier to achieving one of the prominent pillars of the aid program strategy -- *Gender equality and empowering women and girls* – given the high maternal mortality rates and high unmet need for family planning in some countries in the region.
- In contrast to Pacific Island countries, the poor in most Asian countries experience high levels of out-of-pocket expenses for health care. This puts them at high risk of catastrophic health expenditures that will worsen their poverty[1].
- The 2018-19 aid budget papers make little reference to Universal Health Coverage or the SDGs. This is unfortunate because the SDGs are, in many respects, a blueprint for the next phase of human development and Australia is a signatory to the relevant United Nations General Assembly resolution.
- We welcome the inclusion of research as one of the pillars of the recently launched DFAT-funded Regional Health Security Initiative.

Our key recommendations are:

- The Australian Government should reinstate – and seek bipartisan support for – the goal of the Australian aid budget reaching 0.5% of GNI by a set date, at least before 2025. This will help restore Australia's reputation in the Indo-Pacific region as a reliable and predictable development partner.
- The Australian Government should restore the proportion of the aid budget allocated to the education and health sectors to pre-2014/15 levels. At least 50% of the aid budget should be

[1] Health spending is taken to be catastrophic when a household must reduce its basic expenditure over a period of time to cope with health costs. A commonly used threshold proportion of household expenditure is 40%. Source: Ke Xu, David B Evans, Kei Kawabata, Riadh Zeramdini, Jan Klavus, Christopher J L Murray. Household catastrophic health expenditure: a multicountry analysis *Lancet* 2003; 362: 111–17. https://doi.org/10.1016/S0140-6736(03)13861-5

allocated to human development (including health, education, women's empowerment, social protection, and livelihoods).

- Each annual aid budget should include a headline funding amount for sexual and reproductive health that will enable monitoring of the $50 million per year pledged by Australia in 2012.
- To promote equity, the Australian aid program should consider restoring health sector support in countries such as Myanmar, Indonesia, The Philippines, Bangladesh, and Cambodia, that is focused on reducing out-of-pocket health care costs and the risk of catastrophic health expenditure.
- The Australian aid program should maintain a broad and flexible range of aid delivery modalities to achieve health equity both in the Indo-Pacific region and globally. These should include bilateral programs, multilateral organizations, global health partnerships and NGOs.
- We encourage more of the 'catalytic' research supported by the Regional Health Security Initiative in the broader development assistance program. Research makes development more effective and efficient if done well and can leverage other research funds, such as the NHMRC, the Medical Research Future Fund, the Bill and Melinda Gates Foundation, and the Wellcome Trust, especially as a direct adjunct to development efforts through implementation and operational research.
- In addition to the broader health and medical research recommended by the Burnet Institute in submissions to previous Parliamentary inquiries, cited in this submission, we urge the Australian aid program to support operational research that assesses the effectiveness of strategies to reduce health inequities and to increase community engagement with the health system.

About the Burnet Institute

Burnet Institute is unique in Australia in being both a medical research institute accredited by the National Health and Medical Research Council and a development NGO fully accredited by the Department of Foreign Affairs and Trade (DFAT). The Institute's vision is to achieve ***equity through better health.***

The Institute's recently developed mission statement for the next five years is *to achieve better health for vulnerable communities in Australia and internationally by accelerating the translation of research, discovery and evidence into sustainable health solutions.*

While our headquarters are in Melbourne, the Institute has offices in PNG and Myanmar, as well as public health and research programs in Cambodia, China, Fiji, India, Indonesia, Kenya, Laos, Solomon Islands, South Africa, Sri Lanka, Timor-Leste, and Zimbabwe. The Institute has more than 20 years of experience working with the Australian aid program as either technical partner or lead contractor in 13 bilateral health projects and through the Australian NGO Cooperation Program (ANCP) and dedicated NGO funding windows.

Underpinning our research and development focus are five multi-disciplinary programs which bring together our diverse staff skills to share their research and technical expertise across: (i) Disease Elimination (including malaria, tuberculosis, HIV and viral hepatitis); (ii) Maternal and Child Health, including Nutrition; (iii) Behaviour Change and Health Risk Reduction; (iv) Health Security; and (v) Healthy Ageing.

Burnet Institute
Medical Research. Practical Action.

The Institute has an annual turnover of approximately $45 million, of which more than one-half supports our overseas research and development programs.

Response to selected terms of reference

1. Australia's aid program in terms of strategic and development goals
2. The role Australia's aid program plays in building influence as a trusted development partner
3. Australia's aid program in fostering confidence, stability, sustainability, capacity, community-determined goals and best outcomes, particularly by utilising local procurement and smaller/local entities

Our submission addresses aspects of these three areas of interest of the Committee, which are interconnected. If the aid program's strategic and development goals reflect the priorities of partner countries then it has the potential to play an important role in building influence as a trusted development partner. However, its full potential will only be realised if the aid program is predictable, consistent, evidence-based, and implemented in a way that engages national institutions and communities, respects their views, and helps build their capacity. This in turn will foster confidence, stability, sustainability, and address community-determined priorities. Reflecting the Institute's vision, this submission focuses on Health and Equity.

Aid program strategy

Australia's aid strategy acknowledges that the world has changed and that the aid program needs to adapt to those changes. We agree. It is hard to argue against the key objectives of the aid strategy: *promoting prosperity, reducing poverty, and enhancing stability;* nor is it unreasonable that the overall goal is to promote Australia's national interests by contributing to sustainable economic growth and poverty reduction.

While the written strategy appears sound, its application over the past five years starkly indicates a lack of *commitment* by the Australian Government to achieving the aid program goals. While the Australian aid program was once one of the most generous in the world, there has been a decrease in the aid budget of 30% since 2013. This takes aid expenditure as a proportion of Gross National Income (GNI) down to an all-time low of 0.22% in FY 2018-19 and will continue to fall to 0.19% by 2021-22, which is comparable to Spain, Portugal and Slovenia.

The cuts in the aid program budget have meant that some existing programs were abandoned or had their budgets severely curtailed. This translates as Australia being an unreliable development partner and adversely affects the ability of the aid program to foster confidence, stability and sustainability. Another outcome of the aid budget cuts is the difficulty of launching new initiatives in response to the Sustainable Development Goals (SDG) and promoting innovative approaches to solving development problems.

Human development pillar

While a number of submissions to this Inquiry will decry the drastic cuts to the aid program budget, we wish to highlight the fact that these cuts have disproportionately affected what the aid

Burnet Institute
Medical Research. Practical Action.

strategy terms "human development", including health and education. For example, between the 2014/15 and 2015/16 budgets, the largest cut in absolute terms was to education, which fell by $286 million or 27%[2]. The health sector budget fell by $221 million or 28%. The health and education sectors are crucial for long-term development, economic growth, gender equality and regional stability. Funding for health, water and sanitation decreased 20% in the 2018-19 budget. We assume most of this change is to account for the re-profiling of the new Indo-Pacific Health Security Initiative – which we welcome – now classified under Indo-Pacific Sectoral Programs.

Numerous studies have demonstrated the positive relationship between investment in health and education and economic growth. The World Bank has identified a number of mechanisms whereby improved population health leads to higher economic growth[3]. The first is the role of health in labour productivity. Healthy workers lose less time from work due to ill health and are more productive when working. The second is the effect of health on education. Childhood health and nutrition can have a direct effect on cognitive development and the ability to learn as well as on school attendance. In addition, because adult mortality and sickness can lower the prospective returns to investments in schooling, improving adult health can raise the incentives to invest in the education of their children. The third is the effect of health on savings. A longer prospective life span can increase the incentives to save for retirement, generating higher levels of savings and wealth, and a healthy workforce can increase the incentives for business investment. In addition, unanticipated health care costs can compel families to sell productive assets, forcing them into long-term poverty.

In the 2014-15 aid budget there were major cuts nearly across the board in Southeast Asia; Indonesia, Vietnam, Myanmar, the Philippines and Laos all experienced 40% cuts. In the 2018-19 budget, funding for South-East and East Asia declined by $70.8 million to $1027.2 million; except for Vietnam and The Philippines, all other countries will see a further cut in total Australian ODA. The shift in the Australian aid program's focus from Asia to the small island states of the Pacific ignores the fact that a number of so-called middle-income Asian countries continue to have large numbers of people mired in poverty.

Per capita GNI does not always reflect the burden of poverty. For example, Indonesia had a per capita GNI of US$3,570 in 2016; however, 11% of the population lived below the poverty line, equivalent to 28 million people. This is more than twice the number of people living in poverty in Myanmar, which has a per capita GNI of US$1,275. In both these examples, aid investments in health and education focused on the poor may have a major impact on poverty alleviation in addition to improving health in its own right. The Australian aid program no longer invests in health in Myanmar (except through ANCP) and health is no longer a major priority of the aid program in Indonesia.

Those living in poverty are at high risk of catastrophic expenditure on unanticipated medical events (defined as more than 40% of their household expenditure). The risk is highest in countries where out-of-pocket expenditure on health care is a high proportion of total health expenditure.

The following infographic shows that when countries reach a per capita GNI/GDP of US$5,000, development assistance for health tends to disappear and government spending on health increases; however, out-of-pocket expenditure on health continues to be high, thus elevating the risk of

[2] Stephen Howes. Health and education bear the brunt of the last budget's aid cuts; governance spared. DevPolicy Blog. 3 May 2016.
[3] Bloom, David E.; Canning, David. 2008. **Population Health and Economic Growth**. Commission on Growth and Development Working Paper No. 24. World Bank, Washington, DC.

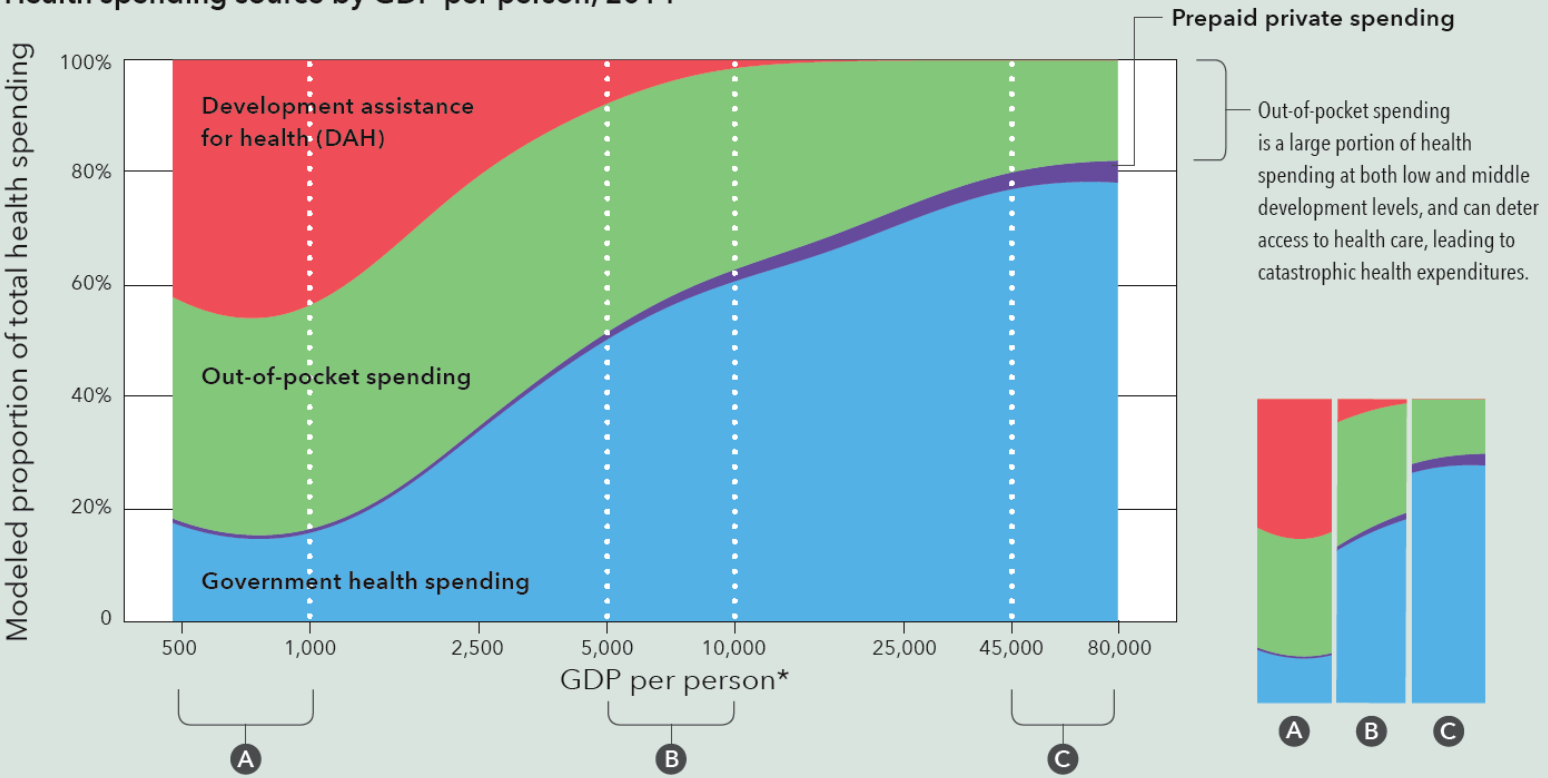
catastrophic spending on health services by the poor[4]. It should be noted that all of the countries listed in Table 1 below (except Fiji) have a GNI/GDP of less than US$5,000.

[4] Institute for Health Metrics and Evaluation (IHME). *Financing Global Health 2016: Development Assistance, Public and Private Health Spending for the Pursuit of Universal Health Coverage*. Seattle, WA: IHME, 2017. http://bit.ly/fgh2016

Trends in spending

- Health spending tends to increase exponentially with economic development.
- While these trends are observed on average, across all countries, country-specific health financing varies dramatically.

Health spending source by GDP per person, 2014



Out-of-pocket spending is a large portion of health spending at both low and middle development levels, and can deter access to health care, leading to catastrophic health expenditures.

At low levels of economic development, countries tend to rely on DAH and out-of-pocket financing for health, but DAH drops off quickly as countries develop.

As countries develop, they replace DAH with domestic spending, but when governments lack the capacity to increase health spending, much is left to be financed out-of-pocket.

High-income countries tend to finance health care using government spending and prepaid private insurance schemes.

The following table shows the per capita GNI/GDP, population living below the poverty line, out-of-pocket health expenditure, and trends in Australian aid in selected South and Southeast Asian and Pacific countries.

Table 1: Per capita GNI/GDP, Percent population in poverty, and out-of-pocket expenditure (OOPE) on health, selected Indo-Pacific countries (2016). Sources: World Bank and Asian Development Bank.

	Per capita GNI/GDP (US$)	Population below poverty line (%)	Population below poverty line (Number)	OOPE (% of all health expenditure)	Change in Australian aid budget between FY 2017-18 and 18-19
Indonesia	3,570	11	28 million	47	-42.8 m (-12%)
Philippines	2,951	21.6	22.3 million	51	+2.2 m (+2%)
Bangladesh	1,359	12.9	21 million	63	-30.1 m (-33%)
Myanmar	1,275	26	13 million	82	-7.3 m (-9%)
Vietnam	2,185	7	6.5 million	37	+2 m (+2%)
Cambodia	1,270	14	2.2 million	63	-5.5m (-6%)
Papua New Guinea	4,190	40	3.2 million	16	+31.2 m (+6%)*
Solomon Islands	2,000	22.7	136,000	6	+50.1 m (+37%)*
Vanuatu	2,860	12.7%	34,000	10	-2 m (-3%)
Fiji	5,153	28%	250,000	21	-3.6 m (-6%)

* includes funding of the Undersea Telecommunications Cable Project

These data demonstrate that in a number of South and Southeast Asian countries where the overall Australian aid budget has significantly declined since 2014 and where health is not a major priority in aid investment plans, there are large numbers of people living in poverty and where out-of-pocket expenditure is a high proportion of total health expenditure. These people are at high risk of catastrophic health expenses that will drive them more deeply into poverty. It should be noted that out-of-pocket health expenditure is relatively low in PNG and small Pacific island states.

According to the World Health Organization (WHO), an estimated 80 million people living in Southeast Asia face catastrophic health expenses, and 50 million people are impoverished due to out-of-pocket payments for health services[5]. An example of extreme vulnerability comes from a 700 household survey of out-of-pocket and catastrophic health expenditure conducted in Magway Township, Myanmar, in 2012[6]. In total, 25.2% of households in urban areas and 22.7% in rural areas experienced catastrophic health expenditure during the previous year. In Indonesia, where government expenditure on health is 1.5% of GDP – one of the lowest in the world -- out-of-pocket health expenditure (% of total expenditure on health) was reported at 47% in 2014, according to the World Bank. At this level, annually at least 10% of the population will experience a catastrophic payment at the point of health service[7].

[5] WHO. Health financing strategy for the Asia Pacific region (2010–2015). 2009.
[6] Khaing et al. Health Care Expenditure of households in Magway, Myanmar. Nagoya J. Med. Sci. 2015. 77:203-212.
[7] World Bank, 2016. http://pubdocs.worldbank.org/en/841891492102642178/110298-HFSA-Indonesia-Published.pdf

Conclusions

1. The severe cuts in the Australian aid budget over the past five years and the freeze at $4 billion over forward estimates until FY 2010-21 have most likely resulted in Australia being regarded as an unreliable development partner, especially in Asia.
2. The curtailment of existing aid programs and the lack of flexibility to launch new initiatives have affected the Australian aid program's ability to foster confidence, stability, sustainability, innovation, capacity and to attain community-determined goals and best outcomes.
3. The decline in investment in health by the Australian aid program is a barrier to achieving one of the prominent pillars of the aid program strategy -- *Gender equality and empowering women and girls.* Despite rapid economic growth in many Asian countries, South Asia still accounts for one third of global maternal mortality. Maternal mortality rates remain unacceptably high in a number of other Indo-Pacific countries, such as Papua New Guinea and Timor-Leste.
4. No headline funding amount is listed in the 2018-19 aid budget for sexual and reproductive health despite the pledge by Australia at the 2012 family planning summit in London to spend $50 million annually by 2016. Meeting the need for family planning would reduce the number of maternal deaths globally by 29%[8]. It is also central to other development priorities including the empowerment of women and girls and poverty reduction.
5. While we welcome the increase in resources allocated to some Pacific island countries in the FY2018-19 budget, this should not be at the expense of Asian low-and-middle income countries where there are large numbers of people living in poverty.
6. In contrast to Pacific island countries, the poor in most Asian countries experience high levels of out-of-pocket expenses for health care. This puts them at high risk of catastrophic health expenditures that worsen their poverty. Therefore, we believe that reducing poverty, with a focus on equity, in countries in the Indo-Pacific region should be the over-arching mission of the Australian aid program. Addressing the financial burden of health care by the poor would help achieve this goal.
7. The 2018-19 aid budget papers make little reference to the SDGs. The SDGs are, in many respects, a blueprint for the next phase of human development and Australia is a signatory to the relevant United Nations General Assembly resolution. In our submission, we have focused on three of those SDGs – Goal 3: Good Health and Well-Being, Goal 4: Education, and Goal 10: Reduced Inequalities.
8. The success of the SDGs will depend a great deal on robust data, the embedding of research, and reliance on evidence in all decision-making. Innovation, the development and application of appropriate technology, and knowledge generation will be critical components of the approaches adopted to meet SDG targets. In a resource constrained international development world, making intervention choices based on robust evidence and effective tools will be crucial.
9. We have recommended an increase in Australian aid-funded health research in a number of previous submissions to Parliamentary inquiries[9] [10] [11]. In this submission, we emphasise the need for research on effective approaches to increasing health equity and strengthening community engagement.

[8] Office of the UN Secretary-General's Special Envoy for Financing the Health MDGs. http://www.mdghealthenvoy.org/health-areas/maternal-health/.

[9] Burnet Submission (#10) to Inquiry into the United Nations Sustainable Development Goals, 2018. https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Foreign_Affairs_Defence_and_Trade/SDGs/Submissions

[10] Burnet Submission to the Australian Government's Foreign Policy White Paper, 2017. https://www.fpwhitepaper.gov.au/sites/g/files/net3551/f/submission/170228-381-burnet-institute.pdf

[11] Burnet Submission (#4) to Inquiry into Australia's aid and development program, 2014. https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Foreign_Affairs_Defence_and_Trade/Overseas_aid/Submissions

Burnet Institute
Medical Research. Practical Action.

Recommendations

1. The Australian Government should reinstate – and seek bipartisan support for – the goal of the Australian aid budget reaching 0.5% of GNI by a set date, at least before 2025. This will help restore Australia's reputation in the Indo-Pacific region as a reliable and predictable development partner.
2. The aid program should focus on reducing inequities in the Indo-Pacific region, including low income countries AND the poor in middle-income countries, such as Indonesia and Papua New Guinea.
3. The Australian Government should restore the proportion of the aid budget allocated to the education and health sectors to pre-2014/15 levels. At least 50% of the aid budget should be allocated to human development (including health, education, women's empowerment, social protection, and livelihoods).
4. Given that the aid budget for Pacific island countries has remained relatively stable, and actually increased in FY 2018-19, the goal of Australian health sector development assistance in these countries should be to strengthen the capacity of public health systems to deliver high quality services to the entire population.
5. In contrast to the Pacific, the poor in Asian countries, such as Myanmar, Indonesia, The Philippines, Bangladesh, and Cambodia, face high out-of-pocket health care costs and a high risk of catastrophic medical expenses. Therefore, to promote equity, the Australian aid program should consider restoring health sector support in these countries that is focused specifically on the poor and especially on reducing the risk of catastrophic health expenditure.
6. The Australian aid program should maintain a broad and flexible range of aid delivery modalities to achieve health equity both in the Indo-Pacific region and globally. These should include the following:
   - Bilateral programs and sector-wide approaches managed by contractors awarded through a competitive tender process;
   - Multilateral agencies, such as WHO, UNICEF, World Bank and Asian Development Bank;
   - Global health partnerships, such as Gavi, the Vaccine Alliance; the Global Fund to Fight AIDS, Tuberculosis and Malaria; and the Global Polio Eradication Initiative; and
   - Development NGOs, both national and international, which are often best-placed to access the poorest communities and to support innovation and investigation through operational research.
7. We encourage more of the 'catalytic' research supported by the Regional Health Security Initiative in the broader development assistance program. Research makes development more effective and efficient if done well and can leverage other research funds, such as the NHMRC, the Medical Research Future Fund, the Bill and Melinda Gates Foundation, and the Wellcome Trust, especially as a direct adjunct to development efforts through implementation and operational research.
8. In addition to the broader health and medical research recommended by the Burnet Institute in submissions to previous Parliamentary inquiries referenced earlier, we urge the Australian aid program to support operational research that assesses the effectiveness of strategies to reduce health inequities and to increase community engagement with the health system. Examples might include an assessment

of the impact of community-based health literacy[12]. Another example is an evaluation of the Community-Based Monitoring (CBM) model, which includes village health assemblies, village health cards, citizen charters at health facilities, and community involvement in district planning. CBM is currently being piloted in Bobonaro municipality of Timor-Leste by the DFAT-funded Partnership for Human Development[13].

9. Each annual aid budget should include a headline funding amount for sexual and reproductive health that will enable monitoring the $50 million per year pledged by Australia at the London family planning summit in 2012.

[12] Health literacy is the degree to which individuals and communities have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions. Source: https://health.gov/communication/literacy/quickguide/factsbasic.htm
[13] DFAT. Australia Timor-Leste Partnership for Human Development. Six monthly progress report. January–June 2017. Page 19. http://dfat.gov.au/about-us/publications/Pages/timor-leste-partnership-human-development-six-monthly-progress-report-jan-june-2017.aspx