SUBMISSION TO THE AUSTRALIAN GOVERNMENT’S FOREIGN POLICY WHITE PAPER

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SUBMISSION TO FOREIGN POLICY WHITE PAPER
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Summary
Investing in global health is in Australia’s national interests

By substantially contributing to the economic growth and prosperity of our region
- Not only a human development and human rights concern, improvements in health contribute substantially to economic growth. Mortality reductions in low and middle income countries have been estimated to have contributed between 11% and 24% of their recent economic growth.

By promoting stability and human rights
- Where disease threatens to cross borders or internal regions, concerns on national and sub-national security and population health can destabilise governance.
- Cutting across SDG 10 and 3, growing inequities in health in many countries of our region is a risk to both stability and human rights.
- Supporting health as a human right - particularly for women, adolescents and children - also carries a high economic return of up to 75 times the amount invested.

By securing the health of our own population
- Key health threats lie in our region including multidrug-resistant tuberculosis (57% of cases occurring in the Asia Pacific region), artemisinin-resistant malaria and antimicrobial resistance.
- With regional economic development leading to a larger number of people migrating temporarily and permanently, support to countries’ prevention, early detection and containment systems is essential to protect regional health security.

By fostering innovation
- Australia has a strong reputation and track record in global health innovation with concentrations of expertise and partnership across research, private sector and international development.
- One recent example is the US $10 million investment by the Global Health Investment Fund in the Melbourne-based Medicines Development for Global Health for the registration and distribution of Moxidectin for Onchocerciasis, in collaboration with the Fred Hollows Foundation, a partnership facilitated through the Global Health Alliance, Melbourne.

By extending our expertise and diplomacy
- Australia has experience and expertise in key areas of health concern in neighbouring countries. Implementation of national health insurance, prevention and treatment of non-communicable disease and drug supply and cost control systems are just a few of these areas.
- Global health has and could continue to facilitate greater opportunity for exchange and collaboration across non-traditional as well as traditional partners.
Without attention and action, however, a confluence of trends could threaten regional health gains and our national interest

- Functioning primary health care systems are central to addressing growing health inequities, reducing the non-communicable disease burden and enhancing regional health security through improved prevention, detection and containment of disease.
- The returns on Australia’s investment in global health innovation and product development will be constrained by the ability of developing country’s health systems to distribute to, and ensure use by, the populations most at risk of diseases they target.
- The confluence of greater urbanisation, with expanding private sector involvement in health in areas of higher population markets and the associated risks of increased focus on tertiary and curative care (often associated with universal health coverage schemes) threatens the needed investment in primary health care.

Australia and particularly the Department of Foreign Affairs and Trade are to be congratulated on recent health investments

- In global health product development partnerships in Vaccines TB and Malaria (where estimates of economic returns to countries range from US$20-US$40 for every US dollar invested).
- In fostering regional Malaria leadership through Asia Pacific Leaders Malaria Alliance (APLMA) with the commitment to a malaria-free Asia Pacific by 2030.
- In sexual and reproductive health and the health of women, children and adolescents - one of the best investments that can be made (returning US$9-75 for every $1 invested).

Australia’s investment in this area, however, remains low and influence and impact in global health could be extended

- Recent reductions in Australia’s development assistance budget has disproportionately lowered investment in global health, sometimes more by coincidence than design.
- Greater investment should be made in collaborations that cut across traditional partner lines, addressing both health innovation AND the health system constraints to reaching the populations most in need.
- Australia can better harness opportunities for shared exchange and economic diplomacy on health issues of joint concern to Australia and our partner countries in the region. Examples include: access to health service markets in trade agreements; economic policy levers to address NCDs; and coupling health care cost control with effective coverage under expanding national health schemes and with aging populations.
Global health & Australia’s national interest

The Global Health Alliance Melbourne (GLHAM)
The Global Health Alliance Melbourne, established in 2016, brings together the city’s leading private, public, research and non-government global health and development organisations.

GLHAM’s goal is to provide a platform for innovation and collaboration, to enhance health, development and social equity.

The goals of the Alliance are to:

- increase the effectiveness, visibility and impact of the global health sector in Melbourne by mobilising and bringing together organisations across the academic, public and private sectors;
- cultivate innovative partnerships amongst traditional and unexpected organisations and people to expand the sector, leading to greater impact; and
- to strengthen the capability of the sector through collaborative projects and initiatives.

Founding organisations include the Nossal Institute, University of Melbourne, the Fred Hollows Foundation, Monash University, Burnett Institute, Bio Melbourne Network, Medicines Development for Global Health, Australian Red Cross, Global Ideas Forum and Save the Children. Support has also been provided by the Victorian Department of Health and Human Services and the City of Melbourne.

The Alliance has already facilitated innovative collaboration in important areas of global health such as the mental health of women and girls, and extending the application of Moxidectin to treat neglected tropical diseases. These successes place the Alliance in a particularly important position to contribute to directions in foreign policy that can extend Australia’s interests and impact in global health and sustainable development more broadly.

Australian national interest in global health
Investing in health initiatives in our region is strongly in Australia’s national interest: promoting prosperity, regional stability and security, fostering innovation from which Australia can benefit economically and intellectually, extending our influence, expertise and commercial interests.

Over recent years Australia has contributed substantially to global and regional health - promoting and facilitating the establishment of the Asia Pacific Leaders Malaria Alliance, funding product development partnerships in key infectious disease areas through the Global Fund, TB Alliance, FIND, GAVI, Medicines for Malaria Venture and continuing leadership in the area of sexual and reproductive health support including, importantly, in areas of crisis.
Successes in global health are visible...

Successes and health gains are highly visible and easily communicated. Reductions in children dying before their fifth birthday over the past 25 years demonstrates that it IS possible to make a difference. In 2015, children under five died at less than half the rate of 1990 (43:1000 live births versus 91:1000) and the speed of decline more than doubled during the Millennium Development Goal (MDG) period (2000-2015), versus the decade earlier (1990-2000) (UN IGME 2015). This decline has saved an estimated 48 million children since the year 2000, and it demonstrates that further increases in vaccine coverage could prevent the deaths of up to 3 million children under five years old each year (WHO, 2016a).

![Figure 1: Trends in under five mortality by key comparative region](Data taken from UN-IGME 2015 Levels and Trends in Child Mortality Report. Unicef. New York September 2015)

...and returns are high

Recent declines in all-age mortality have been estimated to have contributed between 11% and 24% of economic growth in low to middle income countries (Jamison et al 2013):

- each US dollar invested in packages of women, children, and adolescent health initiatives can return over US$6 – US$40, and even higher for some interventions (Sheehan & Stenberg 2012; Stenberg et al 2013; Every Woman Every Child, 2015);
- US$1 invested in tuberculosis can return benefits worth US$2 to over US$120 (Laxminarayan et al, 2009; Goodchild et al 2011; Vassall, 2014);
- in malaria between US$6 – US$40 (Shretta et al, 2016); and

The Global Health 2035 report suggested that overall, each US$1 invested in infectious, reproductive and maternal/child health, in low and lower middle income countries, could return between US$9 to US$20 and could enable those countries to reach performance levels similar to better performing middle-income countries (Jamison et al, 2013).

Yet Australia’s development assistance in global health has declined

Australia’s health-related development assistance has declined by over 25% in recent years. With a number of bilateral health initiatives ending in the period of aid budget cuts and concurrently not being renewed, some of this reduction may have been by coincidence rather than design.
Greater DFAT investment in global health could better promote economic growth, stability and health security in our region and extend Australia’s capabilities and influence. Benefits across these areas will be maximised with enhanced coordination between global and bilateral initiatives and across economic diplomacy, trade and development assistance.

Regional and global trends in health
Some global and regional trends should be considered in relation to effective Australian investment in health globally, and more specifically in our region.

From double to triple burdens on health systems
Pressures of growing non communicable disease and gaining populations
Globally, there has been a large shift over the past decade in the burden of disease from communicable infectious disease and maternal and child health concerns to non-communicable diseases (NCDs) (GBD 2015 Collaborators 2016a & 2016b). This shift is even more prominent in our region (Figure 2).

Figure 2: Global and regional shift in disease burden toward NCDs
(Data taken from Global Burden of Disease, 2015. Regional data extracted using GBD Results Tool1).

The aging population demographic in many Asian countries is contributing to the rising NCD burden and will continue to place pressure on health systems and health care costs, as in Australia. The emphasis needed on primary and preventative health services that better and more efficiently address non-communicable diseases is threatened by frequent over-allocation of resources to hospital care, particularly as national health schemes are implemented.

Dealing with NCDs – Australian leadership in eye health
Australia has a record of success in partnering with countries in our region to address some of the non-communicable disease burden.

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1 Result tool accessed at http://ghdx.healthdata.org/gbd-results-tool
For example, Australia has been a leader in the Indo-Pacific region in dealing with avoidable blindness, and globally with strong NGOs in this space including The Fred Hollows Foundation, BHVI, and the Vision 2020 Consortium, supported by the Australian Aid program.

Since the launch of the Australian Government’s Avoidable Blindness Initiative in the Indo-Pacific region, blindness prevalence has reduced by 38.5% and 43% in Southeast Asia.

There remain 32.4 million people who are blind around the world and 4 out of 5 of them experience avoidable or treatable blindness. Continued prevention of avoidable vision impairment will be achieved only if effective, efficient, comprehensive eye health services are integrated into well-managed, well-monitored national health systems. The Australian Government and Australian NGOs are perfectly positioned and capable of achieving this goal.

Eye health and vision care programs are cost effective and work to remove a known constraint on economic growth and to eliminate a driver of poverty. Eye health and vision care programs target the poorest and most marginalised and work to empower women and girls to increase economic, social and lifestyle opportunities. The economic benefits of addressing blindness and vision impairment in the developing world significantly outweigh the costs. The PwC report, The Price of Sight, estimates a return of $4 for every $1 invested. The benefits for Australia’s reputation in the region and role in building people-to-people linkages cannot be underestimated.

Remaining gaps in infectious disease, growing drug resistance and reproductive and child health

At the same time as health systems cope with growing NCDs and aging populations, key infectious disease and maternal and child health challenges remain. Whilst HIV-related deaths have declined globally, the East Asia, South East Asia and Oceania region was one of the few regions in which a slight increase between 2005 and 2015 has been seen (GBD 2015a).

Globally, TB treatment averted 49 million deaths between 2000 and 2015, however two countries in the Asia Pacific - India and Indonesia - substantially contributed to the 4.3 million gap between estimated cases and those notified and hence having access to treatment (WHO, 2016b). Six of the fourteen countries of multiple high TB burden – TB, MDR TB and HIV/TB coinfection - are in the Asia Pacific Region: India, China, Indonesia, Myanmar, Thailand and PNG (WHO, 2015a). 57% of Multidrug Resistant TB (MDR-TB) cases occur in the Asia-Pacific, with only one in five completing treatment (WHO 2016b, Trauer & Chang, 2016).

The Asia-Pacific is second only to Africa in malaria burden with around 16 million cases in 2015 (85% of cases outside Africa) and 28,000 deaths (WHO2016c). Whilst SEARO and WPRO regions experienced the greatest declines in malaria mortality rates between 2010 and 2015 - 58% and 46% respectively (WHO 2016c) - a review of past malaria control has shown how easily resurgence can occur if there is a decline in leadership and resources (Cohen et al 2012). Artemisinin resistance is spreading and has now been detected in five countries in the Greater Mekong subregion, prompting a reinvigorated focus on elimination in these high-risk sub regions (WHO 2015b). Reaching underserved and at-risk populations, including migrants, is central to malaria elimination efforts in the Asia Pacific (APLMA 2015). Countries in both WPRO and SEARO regions exhibit large gaps between malaria detection and the receipt of appropriate tests and treatment, largely driven by high rates of case management from private providers who are less likely to adhere to appropriate national protocols (WHO 2016c).
Better integration of private providers in national malaria control efforts - including detection, diagnosis, treatment and reporting - requires strong leadership in ways that APLMA is well placed to support².

Integration of private providers should also be central to efforts to fight antimicrobial resistance (AMR) more broadly. By 2050, if left unchecked, drug-resistant infections may kill up to 10 million people a year and cost the worldwide economy $100 trillion³. Global concern resulted in the UN General Assembly declaration in September 2016 on combatting antimicrobial resistance, and in larger investments being made by the US and UK governments. The Asia Pacific region is known to be a melting pot of antimicrobial resistance, with self-medication from private pharmacies and over and inappropriate prescribing known to be poorer in the growing number of private health providers than in an already challenged public system (Widayati et al 2011; Nguyen et al 2011; Kotwani et al 2012).

Despite the improvements in child mortality described above, progress was not sufficient to reach the 2015 MDG target of two thirds reduction, therefore 16,000 children under five years of age still die every day. Nearly half of these deaths are due to infectious disease and the remaining deaths are in newborns under 28 days, where mortality rates have not declined as rapidly as in other under-five cohorts. Many of these deaths can be prevented by known cost effective approaches, but reaching underserved populations remains a challenge for many health systems. Around 60% of the estimated 19.4 million infants who are still not reached with routine immunisations live in ten countries, including Indonesia and the Philippines (WHO, 2016a). Though the Hib vaccine has reached 64% coverage globally, coverage is only 25% in the Western Pacific and 56% in the South East Asia region. Global initiatives such as GAVI have called for proposals for approaches to further uptake and scale⁴ but Australia is also well placed to support work to understand and address coverage constraints through bilateral health partnerships.

Cervical cancer is the second biggest killer of women worldwide with over half a million new cases estimated to occur in 2015, likely to cause around 270,000 deaths per year. 85% of cervical cancer deaths are estimated to occur in developing countries and incidence rates in females of low and middle income nations are around 20-40:100 000 versus 9:100 000 in high income countries (GBD 2015b). Pacific Island nations carry a disproportionate burden of cervical cancer with incidence rates averaging at 43 per 100,000 women (but with large variation between countries). 70% of cervical cancers can be prevented by human papilloma virus (HPV) vaccines⁵ (WHO 2016d). Developed after Australian research, these are now available in over 120 countries with over 200 million doses provided to date. Global actors including GAVI and UNICEF are extending access in low and middle income countries, negotiating a record low price of $4.50 per dose and hoping to reach over 30 million girls across 40 countries by 2020 (GAVI 2012).

² Private health care provider integration in national systems for malaria elimination, however, did not appear substantially in APLMA’s malaria elimination roadmap (APLMA 2015).
⁴ See http://www.gavi.org/infuse/
⁵ The vaccine also works to protect against other HPV related cancers.
Greater economic growth… and inequity within countries

Many countries in our region have shifted from low to middle income status. This has been coupled with greater domestic financing for health in Asia Pacific countries and lower proportionate contributions from health development assistance. This has rightly shifted the focus to other forms of cooperation in health, and a re-think about how limited Australian development assistance can be best used to influence the larger pool of domestic resources, to achieve better outcomes.

Figure 3a – Equity gap in under 5 mortality – rural urban by selected Asian country
(Analysis based on DHS data accessed through the Global Health Observatory, Health Equity Monitor, WHO)

The majority of the world’s poor also now live in middle income countries. Stability is put at risk by wide, and in some cases, growing inequities in economic development and health between subgroups within countries. Reaching underserved populations with benefits from health investments is crucial for more equal growth, stability and health security, but remains a challenge for health systems in the Asia Pacific region. Noticeably, Figure 3b shows that although child mortality has declined significantly in many Asian countries, reductions have been far less within the poorest 20% of their populations.

Figure 3b – Equity gap – under 5 mortality by socioeconomic status (quintile)
Urbanisation
High rates of urbanisation, particularly in the Asia Pacific, exacerbate these inequities, with rural poor populations often the most excluded from the health benefits that return to the rest of the population. 45% of the Asia Pacific population reside in urban areas and urban population is expected to grow another 60% from 2.1 to 3.4 million people by 2050 (ADB 2016).

Urbanisation poses both health threats and opportunities. Infectious disease can spread more rapidly in urban environments, there is less space and opportunity for incidental exercise, and higher pollution and crowding can pose additional risks for non-communicable disease, injury and mental health. This has led recently to a greater focus on safe and healthy city development by entities including the UN. Private sector health providers are more likely to place themselves in urban areas of higher population markets, and this can exacerbate rural-urban and socioeconomic inequities. Australia, facing similar health system challenges, can be a useful partner to our Asian neighbours in confronting these issues.

Greater population mobility
Greater economic development and cooperation in our region has been accompanied by increasing levels of temporary and permanent migration. In 2015/16 Australia reached its highest level of migration, nearing the planned 190,000 intake, with India and China being the most frequent country of origin (Department of Immigration and Border Protection, 2016). Pacific seasonal worker numbers also grew by 50% in 2015/16 to 4700 (Howes & Sherrell, 2016). Such movement is beneficial to migrants, their families and regional economies, as well as to Australia, and hence should not be threatened by reactions to potential or actual disease risks. Bilateral and regional partnerships and investment in disease prevention, detection and treatment is key to ensuring such risks are mitigated. However reaching migrants - as an important but often underserved population - requires new types of regional cooperation in cross border systems development, program planning and monitoring.

New global health innovation partnerships and financing mechanisms
Global health provides great opportunity for innovation and partnership across public, private and research sectors. Over recent years there has been significant growth in the number of global initiatives to promote the development of diagnostics, treatments and other supporting technologies to address chronic and emerging global health challenges. Various global and regional facilities provide: incentives for development not otherwise in the market; facilitation of registration processes and; a platform for collaboration across partners who might not otherwise work together.

FIND, the Foundation for Innovative New Diagnostics, has delivered more than one new test a year to support the detection of TB, malaria and other diseases. The TB Alliance supports development of lower cost and burden treatments for tuberculosis, to improve access and treatment completion rates. GAVI is successfully increasing financial access to, and roll-out of, a range of vaccines in low and lower middle income countries and has disbursed over US$70 million in the South East Asia region in 2015.

New financing arrangements are helping to ensure these developments are available to the countries who need them most.
Recent innovative financing mechanisms such as the Priority Review Voucher Scheme of the US Food and Drug Administration⁶ appear to be providing useful incentives for global health research and development in the United States and, to a lesser extent, beyond (Berman & Radhakrishna 2017). Social impact investment has grown dramatically and the demand for investments that can provide both a social and financial return to investors is currently said to outweigh supply. Many of these investments require some risk sharing, such as upfront financing or loss guarantees, which are important entrées for public-private partnership in Australian development assistance.

The Global Health Investment Fund (GHIF), for example, is a $108 million social impact fund emphasising infectious disease and maternal and child health in low and middle income countries⁷. GHIF supports late-stage innovations and seeks opportunities that have a high probability of successful commercialisation within three years. The Fund employs a range of innovative financing arrangements with partners including equity, convertible debt and project financing. It was enabled by initial funding from the Gates Foundation who guarantee the first 20% of any losses if they occur.

Australia can and has benefited from these innovation partnerships through leverage of our financing and support to Australian global health innovation companies and researchers. Recently Medicines Development for Global Health (MDGH) - a Melbourne based global health not-for-profit-company - received $10 million from the GHIF to support the FDA registration process for Moxidectin to treat onchocerciasis (river blindness) after they licensed the data from WHO. If successful, MDGH will then be eligible for a US FDA priority review voucher.

Global health Innovation partnerships, however, go beyond drug and testing development, and include examples of health system innovation. One example is DFAT’s current partnership with Bloomberg on data for health which will strengthen health statistics and death reporting, crucial for better allocation of health system resources and to monitor progress toward the SDGs (Bloomberg & Bishop 2015).

The three pieces of the pathway from new health intervention to health improvement must work together - development, financial accessibility and the ability of a health system to deliver interventions effectively to those who need them. It is the third that is often the greatest constraint to health gains and regional health security. As Australia invests more in global health product development platforms and partnerships, an emphasis on health systems, particularly primary health care systems, needs to be protected through bilateral economic and development assistance partnerships.

**Australian response**

**Promoting human rights and prosperity**

Australia should enhance its narrative about the importance of global health investment, beyond human development, to the importance for economic growth and human rights.

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With mortality reductions estimated to relate to more than 10% of economic growth in low and middle income countries, health investment is central to the continuing prosperity of the Asia Pacific region, increasing opportunities for economic partnership, investment and trade for Australia. The right to health is universally accepted and clear in international law. With large disparities in health status and service access in Asia Pacific countries, investment in the health of poorer populations can be viewed as an important contribution to the rights of the most vulnerable in our region. Partnering with neighbouring countries to support access to affordable health care through universal health coverage is essential in bridging these gaps and also an area of significant Australian reputation and expertise.

Recognising the human rights dimensions of health in the White Paper, and recommending additional investment in this area, will assist Australia with its bid for a seat on the UN Human Rights Council.

A key role for investing in the health of women, adolescents and girls
The UN Human Rights Council has highlighted the importance of the health of women, children and adolescents, and has issued technical guidance for countries in applying human rights standards and principles in relevant programs. Investment in women’s, children’s and adolescents’ health has wide returns to both individual life extension, quality and economic contribution and the wellbeing of future generations through greater investment in education, nutrition and well-being via longer life expectancy of mothers and via having fewer children (Onarheim et al, 2016). Reductions in fertility and the saving of young lives changes the demographic make-up of a population, which can contribute a “demographic dividend” to economic growth (Ashraf et al 2013). Indonesia, for example, could reap an estimated dividend of 0.25 additional percentage points in per capita GDP growth.

Mitigating risk – regional stability and health security
Weak health systems, leading to delays in case detection and reporting, are known to have contributed to Ebola spread in Guinea, Sierra Leone and Liberia whereas in neighbouring countries with stronger health systems, the spread was more controlled (WHO, 2015c). The Asia Pacific region remains vulnerable to disease outbreaks exacerbated by weak health systems and communicable disease threats such as resistance treatments for TB and malaria. Global and regional spread of antimicrobial resistance (AMR) in pathogens is one of the largest threats to health security currently. With cross border implications through migration and trade (particularly in pharmaceuticals) this regional issue has been high on APEC’s agenda since 2010 (APEC Health Working Group 2014).

Perceived and actual risks of cross border disease spread could destabilise populations and bring greater resistance by Australians to the regional cooperation which is essential to Australian growth, prosperity and safety. Investments in regional health systems can be better ‘sold’ as an investment in Australia’s own health security. Investments in TB control in PNG for example have shown to potentially return over four times the benefit back to Australia (Nguyen et al, 2015).

The growing disparities in health status and access to services which characterise a number of Asian countries can strain stability between regions and populations within countries. The rapid expansion of universal health coverage schemes to provide greater financial access to services, is partly assisting to address inequities.

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8 Work undertaken by DFAT Indonesia program, 2014.
Australia has much to offer in health systems strengthening to support universal health coverage with world recognised best practice in our Medicare and Pharmaceutical and Medical Benefits Schemes.

**Seizing opportunity - Investing in our key assets and capabilities**

Australia has a track record in health research, innovation and the development of global reach such as in the development of vaccines against human papilloma virus (HPV) which is now available in over 120 countries. Figure 4 (below) illustrates the level of Australian involvement in malaria-related product development. We have a large health innovation industry, with medical technology firms alone employing over 20,000 individuals (Deloitte Access Economics, 2015) and a renowned medical research sector.

![Figure 4: Australian involvement in malaria R & D](image)

**Source:** Reddy D (2015) Malaria R&D in time of global partnerships. Presentation at Development Policy Centre Crawford School of Public Policy, Australia National University 29 June 2015. Medicines for Malaria Venture.

There are many opportunities for Australia to invest in these assets to capitalise on a growing global health innovation sector. The Australian government has recently established more translational research facilities such as the $500 million biomedical translation fund (BTF), promoting collaboration across traditional partner lines, including the public and private sectors. While these are primarily focussed on the health of Australians, they could be efficiently extended to global health. This would involve greater cooperation between Industry, Health, and the Foreign Affairs and Trade Departments and could produce greater benefit to Australia, through complementarity in addressing regional and Australian health concerns whilst seizing opportunities to access the growing number global health funds and markets.
Other possibilities include approaches similar to the US FDA Priority Review Voucher Scheme where expedited review for PBS/MBS listing of drugs/health technologies by the same company could provide commercial incentives for further growth in Australia’s global health innovation sector.

With partners cutting across research, private, and non-government development sectors The Global Health Alliance – Melbourne can provide a trusted source of advice and collaboration in this regard.

**In summary – what do we need to do differently and better?**

1. **Consider an increased focus on global health in new Australian health translational research and innovation facilities and funds, collaborating across Departments of Foreign Affairs and Trade, Health and Industry to better access increased global opportunities in health funding, innovation and trade markets.**

2. **Couple DFAT’s global drug and health technology development investment with regional and bilateral partnership on health systems strengthening, particularly for primary health care. This will best address multiple health concerns, will ensure health improving products reach those who need them, will address health inequities and will protect regional health security. High priority should be placed on the integration of private health providers in national and regional detection, treatment, monitoring and reporting systems. This will require high level leadership and new regional cooperation structures across public and private sectors.**

3. **Critically, build in the evaluation of the effectiveness of programs right at the beginning, as opposed to only evaluating the use of monies. Our health system support should include greater investment in applied research that tests and evaluates the best approaches to solve the blockages in health system and service delivery - finding out what works in what context. This will better influence and leverage the growing domestic resources for health being allocated in our region.**

4. **Better harness opportunities for shared exchange and economic diplomacy on health-related issues of concern to both Australia and our neighbouring partner countries. Examples include:**
   - Promoting the benefits of preferential access to health service markets through trade agreements, such as that which has occurred with China;
   - The growth in non-communicable disease and the effectiveness of potential taxation and trade policy levers to address them;
   - Coupling health care cost control with effective health coverage under national health schemes and, in the face of aging populations;
   - Greater emphasis on delivering health care to rural populations, and addressing health inequalities within countries;
   - Promoting health through urban development and city planning, given rapid urbanisation; and
   - Building on years of goodwill generated by Australian NGOs working in the region on projects funded with Australian aid.

5. **Greater coordination between bilateral, regional and global multilateral health support would ensure any changes in overall level of health funding are planned and to maximise returns on investments made.**

6. **Introduce a health-related pledge into the Australian bid for a seat on the Human Rights Council.**
REFERENCES


