International policy coordination and its impacts

The traditional dominance of Western nations in global governance is being increasingly counter-balanced by the rise of Asia, whose nations’ growing economic power and distinctive values, principles and strategies of international engagement may unsettle existing understandings of the processes, practices, and prospects for policy-making across borders. As Bice and Sullivan (2014) note, the ‘Asian Century’ is one amongst many manifestations of the globalisation phenomenon regularly identified. However, far from observing the erosion of national political borders and state capacity as proxies for globalisation, studies of international policy coordination in Asia have consistently observed a strong assertion and recognition of sovereignty at the nation state-level as a central and defining feature. In terms of international policy coordination, national sovereignty claims are expressed in norms of non-interference in internal affairs by global governance actors, a typical preference for international agreements that are non-binding and lack legal force as well as declarations that do not commit resources.

As a corollary, the general argument is advanced that such tightly held claims of nation state sovereignty in Asia limit international policy coordination. In dealing with the policy problems of growing economic interdependence and policy spillover effects across borders, assertions of nation state sovereignty is are argued, in many policy sectors, to cut into the options available for the effective implementation of international governing arrangements (for example, in health, see Stevenson and Cooper 2009, Fidler 2012). Ultimately, the arguments runs, successful international policy coordination relies on undermining national sovereignty and the development of strong, formal institutions at the international level are necessary.

In case study methods terms, Non-Communicable Diseases (NCD) policy is a typical case of international policy coordination in Asia; health is a policy sector where strong norms of national sovereignty tend to operate, and by hypothesis, these would be expected to act as a barrier to the development of effective governing arrangements for international policy coordination. Case allows us to explore the claim that national sovereignty limits the development of international governance for international policy coordination. It limits opportunities for innovation, proscribes certain options for coordination and precludes the establishment of hard, formal authority at the international level. The need for effective international policy coordination is manifest in the multiple disease patterns associated with globalization that cross-cross Asia, novel in the speed, intensity and directions of their pathways. Although the emergence of new infectious diseases in Asia are salient in global health agenda, the increasing burden of Non-Communicable Diseases (NCDs) in poor and middle income Asian countries is the dominant epidemiological transition driven by globalisation. This is both a health challenge and development problem in Asia; macroeconomic effects of chronic poor health and preventable early deaths are significant in Asia and at the level of the household, NCDs may act as a barrier to exit from poverty.
The central argument of the chapter is that there is greater capacity for international policy coordination in Asia in health than implied in the claim that national sovereignty obstruct effective international policy coordination to protect public health. The argument is developed first conceptually through an understanding of relationships between formal and informal institutions in the governance arrangements for international policy coordination in Asia. Next the argument is illustrated by the NCD case of international policy coordination in terms of the WHO Framework Convention on Tobacco Control and the ability of Thailand, India, Malaysia and Singapore to develop informally health related interpretations of formal institutions in intellectual property rights for medicines. The conclusion reflects on whether this is a health policy-only case or of more general relevance to thinking about international policy coordination in Asia.

International policy coordination: two ideal types

As a starting point for the analysis of governing arrangements for international policy coordination, Ginsberg (2010a; b) posits two ideal types: the first is some form of global constitutionalism, following the EU model of establishing supranational sovereignty, whilst the second is an emerging Eastphalia model constructed in terms of Westphalian sovereignty (see Krasner 2000 for discussion of mutual respect for the principle of non-interference in the affairs of another state and the formal equality of states). In an Eastphalia model, the commitment to state sovereignty is maintained alongside shallow and weakly institutionalised forms of mutual support and informal cooperation in international policy coordination that will be explored later in the chapter as the ‘ASEAN way’.

There is nothing distinctively Asian about the concept of Eastphalia. For example, one could plausibly read UK government preferences towards the EU over the last thirty years up to the Brexit vote of June 2016 as exemplary Eastphalian. However, as Ginsburg (2010a; b) employs the term, it does help to highlight a countertendency to claims of a global constitutionalism driving developments in global governance in which the EU model, at least in ideal form, is the pioneer of establishing formal legal architectures above and beyond states (for example, Slaughter 2006). In the EU, sovereignty is pooled so that formal legal integration has been able to underpin a regional governance arrangements in which the European Court of Justice sits above, and supervenes upon, the policy preferences and actions of the EU member states.

Without doubting the analytical value of imposing a dichotomy between global constitutionalism and Eastphalia for a macroscale consideration of new world orders, for the practical concerns of public policy and international policy coordination these two ideal types already coexist in practice: policy-making across borders in Asia is typically some mix of formal institutions of supranational authority and formal institutions of nation state sovereignty. This chapter explores how the effects of this mix of formal institutions on international policy coordination is mediated by a set of informal institutions. This chapter looks, empirically in terms of NCD policy, at the combination of these two types of formal institutions with coexisting informal institutions and what these may imply for international policy coordination in Asia.

Although elusive and difficult to reign in analytically, the notion of an ‘ASEAN style’ of international policy coordination is a useful starting point for describing the hybrid of formal and informal institutions that govern international policy coordination in Asia. At a minimum, Fidler (2012) argues it is a preference for non-interference in internal affairs by global
governance actors, for weak formal institutions and non-binding coordination solutions. It is a helpful term here by serving as a convenient label to contrast two policy coordination styles: an ASEAN way as opposed to a more formalised global governance system, characterised by trends such as increasing the legalisation of international trade and investment flows (Goldstein and Steinberg 2008). As Fidler (2012), building on Somers Heidhues (2000), argues: the ASEAN way is characterised by consensus building rather than discord; pragmatism rather than higher order principles; and gradualism rather that abrupt change. For our purposes in this chapter, it also includes the preference for elite level policy negotiations conducted through informal networks rather than formal and strongly institutionalised regional organizations.

Once informality is recognised as a central feature in international policy coordination in Asia intertwined with the two types of formal institutions, we can state the core contribution of the chapter: investigating empirically the relationship between informal and formal institutions for international policy coordination in Asia. For example, although the ASEAN Free Trade Agreement (FTA) is weakly institutionalised, lacking an effective dispute resolution mechanism, ASEAN countries also participate regularly in the formal institutions of the WTO dispute settlement process. The ASEAN Regional Forum has developed as the main security structure for the region but as Ginsburg (2010a, p.865) argues, it is “…hardly institutionalized in the sense of its institutional structure having any independent effect on outcomes”. Rather, it is very much a Westphalian conception of discussions and relational, informal policy coordination. Yet ASEAN countries are also members of formal institutions within the UN system (Friedrichs 2012).

This chapter uses the case of NCD policy to explore the different institutional factors that may shape, constrain and enable the strategies of Asian countries in international policy coordination. Four pivotal relationships between formal and informal institutions are identified to help characterise distinctively Asian features of international policy coordination. The chapter will discuss the role of Asian nations in international coordination of NCD prevention policy. This can be divided a priori into two sub-cases: (a) tobacco. The development the Framework Convention on Tobacco Control (FCTC) has been frequently observed as a case of ‘binding’ international policy coordination; (b) other commodities. The regulation of the consumption of other commodities which are NCD risk factors, in particular alcohol and ultra-processed food, have conventionally been contrasted as a case of strong national sovereignty claims and relatively ineffective international policy coordination. These are employed in the chapter as illustrative cases of the different ways in which Asian nations might exert their leadership and influence across formal and informal institutions of international policy coordination in the coming decades.

Informal and formal institutions: relationships and interactions in international policy coordination in Asia

The key concept that this chapter seeks to reconsider and recast in terms of policy coordination in Asia is informality in institutional design and practice. The case studies in international health policy reveal different informal institutions, and their relationship to different formal institutions, as key aspects of governing international policy across Asia. Informality in international governance in Asia is most regularly asserted as a set of distinctly Asian norms and values – including mutual respect for state sovereignty - but for the purposes this chapter we can interpret the five principles of peaceful coexistence set out by Fidler (2013) as informal
institutions that operate in different ways alongside formal institutions in regional collaboration and international engagement.

Neo-institutional theory stresses the importance of examining institutions, organisations and the actors within them and the ways these interact to shape policy and its practice. In public policy terms, formal institutions refer to official rule-setting and legal obligations with coercive mechanisms acting as the key driving force for action. They count as formal in terms of being: codified, official, purposefully designed and third party enforced. From this perspective, behaviour is constrained and regulated formally: organisations act in a certain way because they have to and not necessarily because they want to. Informal institutions describe values and norms that not only define goals or objectives but also designate ways to pursue them. We can call these informal on the grounds they are unofficial, uncodified, self-regulated and often emerge rather than being designed. Like formal institutions, they can impose constraints but also, at the same time, empower and enable social action.

New institutionalism allows that formal and informal institutions may be misaligned in certain contexts, which not only produces confusion and conflict, but may also provide conditions that are highly likely to give rise to institutional change. In their summary of new institutionalism, Lowdnes and Roberts (2013) observe a dialectic relationship between the formal and informal aspects of institutions and place analytical importance on agency in the shaping, bending and challenging of institutional practices. An emphasis on the interactions and influences of different institutional norms, culture and actors within a broader context helps gain traction on the balance of informal and formal institutions in international policy coordination.

A starting proposition for the study of international policy coordination is that political-administrative jurisdictions tend to have fixed territorial limits/borders; and these are fixed even as the territorial scale of economic activity has changed both globally but also variety in some cases, at regional and urban and local scales. These changing economic geographies change carry attendant policy problems at those scales which are mismatched with the scales of political-administrative jurisdictions and national sovereignty as the basis of international policy coordination.

Recent research has begun to uncover the role of informal governance in international policy-making for such problems (e.g. Stone 2013, Kleine 2014). A precise definition of informal governance in terms of transboundary policy issues remains elusive, however at a minimum we can say it refers to the unwritten rules, strong norms and/or shared expectations within the international system that may modify, complement or substitute for formal institutions such as treaty provisions (Stone 2013). So defined, informalism is everywhere: both within formal international organizations (IOs), as well as operating separately as informal institutions, and in a broad array of international policy networks constituted by state and non-state actors.

Importantly, whilst Stone (2013) argues that the informal may well complement or substitute for the formal, there remains an important possibility that has been neglected by current scholarship: a much more tense and problematic relationship where the formal can upset and even destroy informal institutions with severe and adverse consequences. For example, knowledge-based critiques of formal institutions argue that knowledge is necessarily fragmented and dispersed (and in large part tacit) which means that any attempt at ‘command and control’ or central planning is likely to be inimical to the informal because the ‘all knowing’ policy-maker and institutional designer is impossible. Conversely, and again ignored in the international governance literature, the work of Stinchcombe (2001) develops an argument in
favour of formalism: when a formal institution is designed to correct and update itself over time in response to feedback, it can be successful in adapting and learning formally about processes which are in essence informal.

This chapter argues that it is in the different interactions between formal and informal interactions that we may explore the claim that national sovereignty undercuts effective international policy coordination. As noted, most institutionalist work in international policy tends to see the formal and informal as substitutable and existing in a coordinate relationship; for example, Stone (2013) describes the growing informality of international governance where non-state actors perform important functions in advocating for, implementing provisions within and reinforcing the legitimacy of formal treaty arrangements. In other literatures, the informal develops in the shadow of the formal, and a symbiotic relationship develops to ensure efficacy and stability of the formal.

Background to case of international NCD prevention policy coordination in Asia

An important feature of Asia’s rise in economic power has been trade liberalization, the systematic reduction in barriers to cross-border trade and investment. It has facilitated the development of the region’s advanced cross-border production networks that underlie its status as a ‘global industrial dynamo’ (Asian Development Bank 2011). In recent decades, and especially since the Asian financial crisis, trade liberalization has accelerated in both pace and scope through unilateral structural adjustment, accession to the multilateral (i.e. World Trade Organization) system, and more recently through the proliferation of a ‘noodle bowl’ of preferential trade agreements (PTAs) at the bilateral and regional levels.

Amongst its many social and economic consequences, trade liberalization has been identified with some large-scale negative effects on the health of Asian populations by facilitating the spread and growth of the region’s tobacco, alcohol and ultra-processed\(^2\) food industries. Consumption of these commodities is rapidly increasing in the region, especially within the industrializing middle-income countries (Baker, Kay et al. 2014). Thus, by way of the commodities they produce, advertise and distribute, these industries have been identified as a key driver of the region’s rising burden of non-communicable diseases (NCDs), predominantly cardiovascular disease (CVD), cancer, diabetes and chronic respiratory diseases. NCDs are the leading causes of death and disability in Asia, accounting for 17 million or 65% of regional deaths in 2008 (Dans, Ng et al. 2011, Baker, Kay et al. 2014). Alongside still prevalent rates of infectious diseases, NCDs are generating considerable harms for Asian societies through costs to health systems, workforce productivity losses, and implications for poverty (Baker, Kay et al. 2014).

Trade liberalization allows transnational risk commodity corporations (TRCCs) to move investments, technologies, production capacity, raw materials and final products more easily across borders and thereby drive risk commodity consumption transnationally (Baker, Kay et al. 2014). Attracted by their young and growing populations, burgeoning middle-class consumer base, and rapid economic growth rates TRCCs have increasingly targeted developing Asian markets. Although trade remains important, market penetration is primarily achieved through foreign direct investment (FDI) whereby TRCCs establish new affiliates or acquire complete or partial ownership of existing firms. Subsequently, FDI inflows are correlated with higher rates of risk commodity consumption and NCDs globally (Stuckler 2008). Among developing countries East Asia was the recipient of more net FDI inflows than any other region since 1990, equating to 64.5% of the world’s total in 2013 (World Bank 2014). Many countries
are also home to large state-owned risk commodity enterprises that compete with TRCCs, particularly in the tobacco sectors of China, Thailand and Vietnam (Barraclough and Morrow 2010).

A menu of policy instruments are available to regulate these industries and attenuate risk commodity consumption including raising product prices through taxation, marketing, promotion, and sponsorship restrictions, and product labelling controls (Magnusson and Patterson 2014). However, because trade agreements contain formal institutional rules about how markets are regulated they may constrict ‘domestic regulatory space’ or the ‘freedom, scope, and mechanisms available to governments to adopt, design and implement such regulations in the public health interest’ (Baker, Kay et al. 2014). The evolving global and regional trade regimes are likely, therefore, to influence risk commodity consumption and associated health risks in Asia.

In order to apprehend more fully different dimensions of the relationship between formal and informal institutions and their consequences for international policy coordination, the next section sets out four distinctive patterns: informal institutions support formal institutions; informal institutions complement formal institutions; informal institutions undermine formal institutions; informal institutions coordinate formal institutions. These are neither a comprehensive set of relationships nor mutually exclusive sets, but instead offered as a means to explore the salient patterns of intersection and interaction between formal and informal institutions operating in international policy coordination. In doing so, we unpack some of the hidden drivers in the chapter’s initial argument that national sovereignty claims in Asia tend to undermine international policy coordination such as the existence of negative or positive feedbacks from the informal to the informal; and the relevant consistency issues between formal and institutions and the possibility is that informal institutions may operate at variance with formal institutional arrangements with the potential to undermine them or expand the scope of policy coordination beyond them.

Informal institutions supporting formal institutions: prospects for NCD policy coordination in Asia

At the multilateral, global governance level Asian nations are members of the two principal institutions governing health and trade respectively – the World Health Organization (WHO) and the World Trade Organization (WTO). Regulations developed by these institutions are likely to be critical to future capacities to address trade in risk commodities and health in Asia. But the participation of Asian countries in other institutions whose functions spillover into health, including the UN General Assembly (UNGASS), Food and Agricultural Organization (FAO), Codex Alimentarius (Codex), World Bank, World Intellectual Property Organization (WIPO), and United Nations Conference on Trade and Development (UNCTAD) is also highly relevant (Smith, Lee et al. 2009). The capacity of this system to address trade in risk commodities in Asia is limited for several reasons.

The first is the limited capacity of these institutions to develop, independently and in unison, effective regulations addressing trade in risk commodities. This stems at least partially from the divergent roles and powers of WHO and WTO. Although it has enabling constitutional powers to make legally-binding rules that could in principle regulate risk commodity trade, in practice WHO is a largely technical and normative agency that shapes national health policy through its power to convene national health ministries and to develop technical standards and
guidelines. The WTO in contrast institutionalises a set of binding trade rules (i.e. General Agreements on Tariffs and Trade (GATT) and subsequent WTO agreements) supported by enforcement panels, and engages more powerful ministries of finance and trade (Lee, Sridhar et al. 2009, Magnusson 2010). Provisions in GATT/WTO agreements designed to protect health (so-called ‘flexibilities’) have been interpreted very narrowly to date. Health is therefore subject to trade rules much more so than trade rules are subject to health regulations.

There is, however, potential for Asian states to use informal institutions to strengthen policy capacity within the formal institutions of trade governance. Most Asian countries, as former members of the GATT, became members of the WTO upon its establishment in 1995. Others, concerned with the protection of domestic industries from foreign competition, proceeded with a more cautious approach to determining the depth and timing of trade liberalization, acceding to the WTO considerably later: China in 2001, Cambodia in 2004, Vietnam in 2007 and Laos in 2013 (Baker, Kay et al. 2014). Although the GATT/WTO agreements prohibit governments from adopting measures (policies and other regulations) that discriminate between foreign and domestic goods and investments, and between the goods and investments of different countries, trade restrictive measures are permitted if they are non-discriminatory, not used as disguised barriers to trade, and when the content of those measures is consistent with international standards including those developed by the WHO.

In this regard, the 2003 Framework Convention on Tobacco Control (FCTC) (adopted under Article 19 of the WHO constitution) is a legally binding treaty that can be used to uphold domestic tobacco legislation in trade disputes. This was exemplified recently in arguments used by Australia to defend its plain packaging legislation in response to WTO dispute arbitration and in a dispute bought by the tobacco company Philip Morris under the Hong Kong-Australia FTA (Commonwealth Government of Australia 2011). In this way, formal institutions can provide a legal mandate for Asian countries to protect domestic regulatory space to address risk commodities in trade disputes. However, developing informal institutions alongside the formal to help provide WHO with financial and political support to develop stronger multilateral risk commodity standards is a key potential opportunity for addressing risk commodities in the region.

For ultra-processed foods and alcohol, however, standards comprise non-binding recommendations (adopted under Article 23), especially the 2004 Global Strategy on Diet, Physical Activity and Health, and 2010 Global Strategy to Reduce the Harmful Use of Alcohol respectively. The former states that no provisions in the recommendations should be construed as justification for trade restrictive measures, while the latter recognizes the important role of trade as a determinant of alcohol consumption. The feasibility of and approaches for strengthening international standards to address ultra-processed foods and alcohol have been explored elsewhere, and may include the development of more selective mechanisms targeting particular products (e.g. soft drinks) or services (e.g. advertising) as well as standards set by other international organizations including Codex Alimentarius on food labelling, health claims and food composition (Magnusson 2007, Barraclough 2009).

The second challenge concerns the power of Asian nations to influence the development of international standards. Some, such as Thailand and India played important supportive roles in the development of the FCTC. Their role in strengthening future risk commodity standards is, however, uncertain but likely to be constrained by several factors. Evidence suggests that Asian governments have engaged in global health negotiations in a largely state-centric and individualistic manner rather than through regional configurations (Lee, Pang et al. 2013). This reflects the commitment to state sovereignty discussed earlier and related lack of sense of
interdependence due to the diverse political and economic positions of the countries that may seek to act collectively in this regard. At present Asian governments also make relatively small contributions to the financing of multilateral organizations governing health and trade, likely to weaken their capacity to influence the respective agendas. A much improved understanding of the potential for Asian nations is needed in this regard, especially given that their increasing economic and political power is likely to lead to greater influence in global health and trade governance more generally (Lee, Kamradt-Scott et al. 2012, Lee, Pang et al. 2013).

Many Asian nations are also at a disadvantage in using WTO rules due to existing asymmetries in bargaining power and the resources available to nations to make or defend disputes. Of the 26 WTO trade disputes made against Asian nations pertaining to agriculture, alcohol, tobacco and pharmaceuticals between 1996 and 2013, 21 were made by the United States (US) and European Community (EC) alone and of these 9 were against developing countries. Disputes pertaining to alcohol were most common. To the contrary only 5 claims were made by developing Asian countries against the US and EC (Baker, Kay et al. 2014). These difficulties are accentuated when the delegations of the US and EU countries are backed by deep-pocketed TRCC lobbyists and extensive legal teams (Shaffer 2003).

Related to sovereignty and lack of sense of shared interests is that relative lack of programmatic capacity within the multilateral system in Asia. In 2006 the World Health Assembly adopted a resolution on trade and health, calling for engagement with trade policy-makers to ‘take advantage of the potential opportunities, and address the potential challenges that trade and trade agreements may have for health’. The WHO Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013–2020 (GAPNCD) further recognizes the role of WHO in offering technical assistance to developing country governments to mitigate the impact of trade agreements on health. The GAPNCD also calls on the FAO to ‘Support ministries of agriculture in aligning agricultural, trade and health policies’ and on the WTO to ‘...support ministries of trade in coordination with other competent government departments (especially those concerned with public health), to address the interface between trade policies and...noncommunicable diseases’ (World Health Organization 2013, p74). Such assistance may be critical to addressing the proliferation of risk commodity industries in Asia, especially in developing countries with limited institutional capacity.

Some WHO programmes have been established to this end. A programme on globalisation, trade and health was initiated in 2000, ‘to strengthen knowledge, develop analytical methods, and produce training materials for supporting member states in addressing trade and health issues’. This led to some collaboration with WTO staff, including the production of a joint report on trade and health, although further commitments and activities have been vague (Lee, Sridhar et al. 2009). More recently this programme was merged into the WHO programme on global health diplomacy, which has produced a number of publications and offers executive training including on trade and health. Health diplomacy is likely to be a key force in achieving health and trade policy coherence for attenuating risk commodities, as it already has for access to medicines under the WTO’s TRIPs agreement (Aginam 2010). This includes building leadership capacity within the health community, and skills for advocating public health principles and methods in trade policy-making and implementation (Lee, Sridhar et al. 2009, Magnusson and Patterson 2014). WHO has, in the past, provided critical assistance to Asian governments during risk commodity trade disputes. For example Thailand successfully defended a 1990 GATT dispute, bought by the US Trade Representative on Thailand’s tobacco import restrictions, partly due to scientific evidence provided by WHO officials (Drope and Lencucha 2014).
The future of such programmes is uncertain, however. Political pressures from powerful donor countries, particularly from the US and EU countries which are home to some of the largest TRCCs (Lee, Sridhar et al. 2009), alongside increasing industry engagement (tobacco excepted), has led to reluctance from within WHO to tackle issues likely to cause confrontations with powerful industries (Lee, Sridhar et al. 2009, Magnusson and Patterson 2011). WHO is also challenged by significant structural changes in global health governance (GHG) more broadly that weakens its capacity to govern responses to risk commodities. This includes the proliferation of new state and non-state actors in GHG, so-called ‘third-way norms’ and an expanded role for economic actors through public-private partnerships, philanthrocapitalism, and the financing / disciplinary power of international financial organizations. At present many of these actors, particularly the most powerful, give little priority to financing or supporting the prevention or control of NCDs (Sridhar and Batniji 2008). More broadly, these contemporary changes in GHG significantly constrain the capacity of WHO and its regional offices in Asia (SEARO and WPRO), to enhance responses to risk commodities at the health-trade nexus.

Informal institutions complementing formal institutions: trade rules and NCD prevention policy

Notwithstanding the US withdrawal from the Trans-Pacific Partnership (TPP), the proliferation of bilateral and regional preferential trade agreements (PTAs) in Asia, alongside various investment provisions and treaties, is the salient feature international economic policy coordination (United Nations Conference on Trade and Development 2012). Trade negotiations within the multilateral system have stalled since the failed Doha Development Round in the mid-2000s and PTAs have provided an alternative institutional mechanism for high-income countries to achieve accelerated trade liberalization. Initial agreements may also trigger a domino effect as other countries initiate further PTAs to retain trade competitiveness (World Trade Organization 2011).

Countries involved in PTA negotiations must comply with relevant WTO rules governing such agreements. This includes an ‘enabling clause’, permitting developing countries to protect certain sectors from liberalization and foreign competition. However, compared with the formal institutions of the international trading system, increasing regionalism creates significant challenges for regulating in the interests of public health. First, such PTAs are becoming increasingly ‘deep’ with commitments and concessions that go beyond those required by the WTO system (WTO-plus), but also those outside of it (WTO-X) (Friel, Gleeson et al. 2013, Baker, Kay et al. 2014). These are not so much concerned with facilitating trade but with removing ‘behind-the-border’ regulations that represent threats to global intra- and inter-firm supply chains. Four types of WTO-X provisions are most significant in recent PTAs: competition policy, intellectual property rights, investment liberalization and the movement of capital. These are the same issues ruled off the agenda by developing countries during the multilateral Doha Development Round, but are now common in PTAs led by developed countries, including the Trans Pacific Partnership currently under negotiation and involving a number of Asian countries (Friel, Gleeson et al. 2013).

Further, while the multilateral system does provide aforementioned flexibilities on public health grounds these can be excluded from or highly restricted within PTAs. In the WTO system trade disputes are also made by one government against another, whereas the investor-state dispute settlement (ISDS) provisions in many PTAs enable corporate investors to enact
proceedings directly against governments to recuperate losses resulting from the adoption of
domestic regulations (including health regulations). Finally, PTA negotiations are usually
‘closed door’, therefore lacking the greater transparency of multilateral negotiations and the
checks-and-balances that come from closer scrutiny by civil society (Friel, Gleeson et al. 2013,
Baker, Kay et al. 2014). These observations underpin the importance of Asian governments
acting unilaterally and collectively to build informal institutions to protect regulatory space in
such agreements.

Informal institutions undermining formal institutions: the challenge of policy coherence in
NCD prevention

Growing economic integration in Asia brings the need for regional-level trade and health policy
coherence. Yet in Asia, relative to the process of European integration, there has been an
evolution of a hybrid mixture of formal and informal institutional arrangements that govern
health and trade relations, reflecting the region’s economic, social and political diversity. In
economic terms, for example, there is a 55-fold difference in Gross National Income (GNI) per
capita (Atlas method) between Japan and Cambodia (World Bank 2014). Politically the region
accommodates Marxist-Leninist Communism in Laos and Vietnam, unitary authoritarian
parliamentary systems in Singapore and Indonesia, and the world’s largest parliamentary
democracy in India. Unlike in the EU and North America, regional economic hegemony is also
contested. This is evident in the two competing opportunities towards further regional
economic integration, the first led by China, the Regional Comprehensive Economic
Partnership (RCEP) involving the ASEAN+6 countries, the second involving the United States,
the Free Trade Agreement of the Asia Pacific (FTAAP) to which the TPP is a pre-cursor (Lewis
2013).

This institutional diversity in Asia creates particular challenges for collective action to address
trade in risk commodities. Regional institutions governing trade include the Asia Pacific
Economic Cooperation forum (APEC), the East Asia Summit (EAS), and the Association of
South East Asian Nations (ASEAN). Regional institutions governing health include ASEAN,
and the offices of the World Health Organization (SEARO and WPRO) as well as bilateral
agreements for health (Lee, Kamradt-Scott et al. 2012, Fidler 2013). The effectiveness of these
institutional arrangements in global and regional health governance has been variable. During
negotiations of the FCTC for example, ASEAN and WHO regional offices served as important
platforms for consolidating a regional position. These same organizations however, have been
particularly ineffective at generating regional consensus in other areas including negotiations
of the International Health Regulations and pandemic influenza response (Lee, Kamradt-Scott
et al. 2012).

For historical reasons, WHO has divided East Asia into two regions, a significant challenge for
building cohesion and co-ordination (Lamy and Phua 2012). Although WPRO is developing
an evidence base to inform regional trade and health policies in the Pacific, neither SEARO
nor WPRO appear to have engaged with the same topics in regards to Asia. Although ASEAN
has played, at times, an important role in facilitating regional cooperation for health its role
been relatively minor, and ASEAN health ASEAN Post-2015 Health Development Agenda
exhibits the characteristics described by Fidler (2013): the predominance of national
sovereignty over collective action, a culture of consensus-building rather than open conflict,
and highly politicized decision-making processes. For example, it remains problematic in the ASEAN Health cooperation that is that one of it key constituent members, Indonesia, is yet to ratify the FCTC.

Despite the primacy they give to trade liberalization, ASEAN and APEC have recently demonstrated increased commitment to addressing regional health issues, in particular infectious disease threats (Lamy and Phua 2012). The ASEAN Health Ministers Meeting is held biennially, yet it has confined its work largely to infectious disease control and disaster preparedness, with agreements to date focused largely on sanitary and phyto-sanitary measures. However, in a joint statement in 2012, ASEAN+3 Health Ministers recognized the region’s growing NCD burden and affirmed their commitment to implementing the UN General Assembly’s *Political Declaration on the Prevention and Control of Non-communicable Diseases* (Association of Southeast Asian Nations 2012). Actions to address NCDs have fallen under the ASEAN Strategic Framework on Health Development (2010-2015) with working groups established for regional tobacco control, but not ultra-processed foods or alcohol (Association of Southeast Asian Nations 2012).

The literature has yet to apprehend fully the potential for ASEAN and other regional bodies to constitute an effective platform for generating regional positions or informal institutions to address trade and risk commodities. Lamy and Phua (2012) have argued that increased cooperation on social issues through ASEAN, including health, is likely to strengthen its ‘soft power’ as a regional and global actor. However, weak financial commitments and human resource capacities may limit an ASEAN-led response. Such capacity could be buttressed by expanded technical collaboration between WHO and ASEAN, by achieving greater financial and technical commitments from China, Korea and Japan through the ASEAN+3 framework, and through stronger engagement with regional non-government organizations and epistemic communities working to address risk commodities (Lamy and Phua 2012).

**Coordinating formal and informal institutions: tobacco control as an exception**

In assessing the capacity of norms as informal institutions to contribute to health and trade policy coherence in Asia there are several relevant considerations. Health actors often view trade as a threat to population health, taking a ‘harm-minimisation’ approach, with little consideration for trade objectives. Trade actors, conversely, tend to view health as a barrier to trade with the objectives of reducing barriers to cross-border commercial flows and economic growth (Smith, Lee et al. 2009). Trade and health debates usually pivot, therefore, around norms of ‘anti-trade’ and ‘open-trade’. For example, between an international tobacco control norm on the one hand and open tobacco trade on the other (Drope and Lencucha 2014).

Asian nations have differed considerably in how they have balanced the above norms as they relate to addressing risk commodities. For example, during the FCTC negotiations, Japan and China took steps to weaken the binding nature of adopted measures, making assertions of ‘protecting sovereignty’. In contrast Thailand and India demonstrated considerable leadership in building regional consensus towards a strong tobacco control treaty, alongside their adoption of ‘enabling’ legislation at the national level. Thai delegates explicitly emphasised the need to achieve a strong treaty with provisions that take priority over trade rules (Lee, Kamradt-Scott et al. 2012).
These observations tend to suggest that norm divergences serve to misalign informal institutions and thereby threaten the potential to undermine any collective action to coordinate policy on risk commodity control by Asian nations. Conversely, state sovereignty has also been invoked in the public health interest: by India, Malaysia and Thailand to challenge intellectual property rules governing access to essential medicines, and by Indonesia to challenge perceived inequities in rules governing access to vaccines (Lee, Kamradt-Scott et al. 2012, Kamradt-Scott, Lee et al. 2013). Although these are different issues strong assertions of sovereignty may have, therefore, potential utility when it comes to protecting domestic policy space for risk commodity control. Overcoming anti-trade vs. open-trade debates is also another path forward. Such debates often ignore the potential for trade agreements to promote health. The liberalization of the tobacco sector, for example, could potentially result in the dismantling of powerful state-owned enterprises SOEs thereby removing the conflict of interest arising from the state as both producer and regulator (although admittedly to be replaced by TRCCs) (McGrady 2011).

The future: Emerging Asian varieties of international policy coordination

The chapter has explored the argument that assertions of national sovereignty and the primacy of formal national level political institutions in policy-making tends generally to undermine international policy coordination in Asia. The NCD prevention policy case presents some suggestions that there is greater international policy coordination capacity in Asia than this argument implies. In addition to challenging the scholarly utility of an ideal type dichotomy in international policy coordination of the EU and Eastphalian models in which the latter is seen as an immature and weaker version of the former, this case study casts light on the importance of informal institutions and their intersection and articulation with formal institutions in international policy coordination. This latter insight is developed conceptually in the chapter through sketching some possible simple relationships between formal and informal institutions.

Options identified by the WHO for attenuating risk commodity consumption include raising product prices through taxation, restrictions on product marketing, promotion, and sponsorship, and product labelling controls (Magnusson and Patterson 2014). This necessitates informal institutions to establish collaboration between health and trade policy-makers to protect policy space in future trade agreements (Thow and McGrady 2014). By reducing tariff revenues and imposing significant costs associated with compliance and negotiation, trade agreements may also reduce the resources available to governments used to fund policies and programmes to address risk commodities. Consumption taxes are a key strategy for off-setting such losses, and can therefore be adopted for both revenue-raising as well as public health reasons.
In public health policy terms, Asia is also home to exemplary countries that have sought to advance public health through staunch assertions of national sovereignty through unilateral, and uncoordinated, regulation their domestic markets. Thailand, for example, has one of the most comprehensive tobacco control regimes globally (Chantornvong and McCargo 2001). It has implemented a hypothecated 2% tax on alcohol and tobacco to fund its Thai Health Promotion Foundation (Casswell and Thamarangsi 2009). The re-regulation of risk commodity markets policy option is a key consideration for governments that have already liberalized the relevant sectors; this requires the development of informal institutions around formal institutions of trade agreements. For example, Thailand is a world leader in establishing novel informal institutional designs for public health with trade agreements. Its Trade in Health and Social Services committee, for example, brings together officials from ministries of industry, public health, food and agriculture, as well as various professional groups to investigate how trade agreements affect health, to advocate for the inclusion of health in trade negotiations, and to coordinate action between concerned agencies (Smith, Lee et al. 2009).

Although the health sector was selected for investigation as a typical case of international policy coordination challenges, it is moot whether the details of the NCD prevention policy explored here is generalizable directly to other policy sectors. However, it is hoped that the sketch of basic and potential intersections and articulations between formal and informal will help public policy scholars begin to apprehend the variegated patterns, processes and practices of international policy coordination in Asia across different sectors.

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