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GLOBAL HEALTH GOVERNANCE AND THE RISE OF ASIA

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Abstract

A rising Asia brings to the global arena a new set of increasingly influential players with their own values, histories and strategic considerations. It remains to be seen if these shifts will lead to a clash or convergence in the management of global issues. The critical issues include Asian actors' treatment of sovereignty, their preferences on institutional design, and conceptions of their role in global governance. Global health is fraught with a whole range of collective action problems, which we are failing to address effectively with existing institutional arrangements. This is in part because these institutions are embedded in an anachronistic world order in which Asia is governed rather than governing. Bridging this disconnect will require multiple adjustments. Existing actors involved in setting global health rules will need to adjust to take into account opportunities, constraints and perspectives from the Asian region that may have thus far been neglected. At the same time, Asian state and non-state actors need to be engaged as co-shapers of the global order – not just in terms of material contributions to existing initiatives, but also in terms of leadership and ideas for reforming and strengthening current institutions.

GLOBAL HEALTH GOVERNANCE AND THE RISE OF ASIA

Introduction

This special section examines how the rise of Asia affects the challenge of governing health in a globalizing world. Asia has particular relevance as it is often depicted as the epicenter of many transnational health threats, e.g. Severe Acute Respiratory Syndrome (SARS) and avian influenza outbreaks. Amid globalization and an emerging geopolitical multi-polarity, however, the world cannot be readily divided between the sources of such problems and the providers of their required solutions, between rule setters and rule takers, and between the governors and governed. The three papers presented here investigate how selected Asian state and non-state actors are engaging with efforts to govern global health.

The evidence and arguments in this section draw from case studies carried out by the Global Health Study Group of the S.T. Lee Project on Global Governance, Lee Kuan Yew School of Public Policy, National University of Singapore.[1] This overview paper sets out the major themes of the project and findings arising from the case studies. The next paper by Lee et al on 'Asian Contributions to Three Instruments of Global Health Governance' presents detailed analysis of Asian engagement with three instruments of global health governance - the International Health Regulations (IHR), Pandemic Influenza Preparedness Framework (PIPF) and Framework Convention on Tobacco Control (FCTC). The final paper by Florini et al on 'Global Health Governance: Analyzing China, India and Japan as Global Health Aid Donors' goes in-depth into the health development assistance strategies of China, India and Japan against the backdrop of evolving discourses and practices in the global health governance arena. For the purposes of this special section, the term 'Asia' refers to those countries in South, Northeast and Southeast Asia. The project has focused, in particular, on China, India, Japan, South Korea, Thailand and Indonesia as the most rapidly emerging leaders in the region and globally. It is argued that the findings and recommendations on global health governance have relevance for understanding Asia's role in collective action on a range of other global issues, from energy and climate change, to the world economy and security, as well as to the study of global governance more broadly.

The Rise of Asia

Developing Asia's[2] share of global gross domestic product (GDP) has tripled over the past three decades, growing from 8% in 1980 to 24% in 2010. The share of the Group of Seven (G7) countries, in contrast, has fallen from 56% to 40% over the same period.[3] (IMF World Economic Outlook Database) The region has also made substantial progress in basic socio-economic indicators. For example, China's Human Development Index (HDI) score rose from 0.43 to 0.72, while Indonesia's score rose from 0.47 to 0.69 between 1980 and 2010. (United Nations Development Program). As Asia achieves greater prosperity, and becomes more integrated with the world economy in the process, there are growing expectations for the region to make a fuller contribution to governing transnational problems such as economic crises, disease pandemics, climate change and transnational crime. However, there has been limited investigation to date of Asia's role in global governance and, in particular, how the region has participated to date in decision-making processes to achieve collective action at the global level. This includes its role in global health policy where Asian countries have been primarily cast as the source of threats (e.g. SARS, antimicrobial resistance, pandemic influenza, counterfeit medicines, climate change) or as protecting narrow national interests (e.g. Indonesia's refusal to share influenza virus samples), rather than as an active contributor to collective action.

A fuller understanding of the role of Asia is needed to address important gaps in how we understand global governance in an increasingly multi-polar world. Importantly, while the global governance literature has closely examined the normative and institutional plurality that currently exists,[4] there has been limited investigation of the extent to which governance efforts and discourses have been unrepresentative and thus unevenly accepted across the world. Analyses of global governance to date have focused on multilateral initiatives, largely led by North America and Europe, impacting on the developing world.[5] However, such approaches fail to take into account the dynamic nature of emerging institutional arrangements and, in particular, ongoing political, intellectual and normative shifts in the global (dis)order. How a rising Asia, with its values, histories, worldviews and strategic considerations, will shape the future of global governance thus deserves far greater scholarly attention. To what extent will there be increased conflict or consensus, or even the emergence of new paradigms, in the governance of global issues?

The Challenge of Global Health Governance

Among the major governance challenges the world faces, in an era of rapid and extensive globalization, are transnational threats to human health, including emerging and re-emerging infections, rising rates of chronic diseases, inadequate access to affordable and safe medicines, anti-microbial resistance and the health effects of climate change. Effective collective action to address such threats, known as global health governance, is made more difficult by rising multi-polarity and enduring contestation over the meaning of sovereignty, and appropriate roles for state and non-state actors. At the same time, the rise of health on the global agenda has brought immense institutional innovation. Since the mid 1990s, widespread recognition of the need for effective collective action on global health has led to many new initiatives and arrangements, supported by the mobilization of unprecedented resources. For the most part, however, these institutional structures have evolved in an ad hoc, rather than systematic, manner and have been defined as much by political agendas as by global health needs. Most significantly, this institutional landscape has been characterized by diverse state and non-state actors, fragmented and often poorly coordinated activities, varied and sometimes competing normative frameworks and, above all, a lack of recognized overall authority to allocate responsibilities and resources. The end result is a lack of strategic coherence and major governance gaps in global health. In recent years, emerging regions such as Asia have begun to add their voices to the creation of global health governance arrangements.

This paper draws together three key analytical themes undertaken within this study of Asia's role in governing global health - Asian perspectives on sovereignty, Asian preferences on institutional design, and conceptions of Asia's role in global governance. These themes were developed through a series of workshops and smaller discussions convened under the S.T. Lee Project, focused on identifying the key gaps in existing knowledge. The findings on each of these themes, arising from the case studies of the project, are summarized in the following sections.

Sovereignty and Global Health in Asia

On sovereignty, we are interested in examining how well traditional sovereignty functions as a principle for managing global issues amidst growing requirements for trans-boundary collective action. By taking a closer look at how Asian countries approach and use the sovereignty principle in managing different global health issues, we attempt to understand when, why, and how sovereignty is used as a governing principle. The case studies reveal several ways in which the sovereignty principle relaxes, clashes, converges and even evolves with governance objectives in global health. While there is evidence that national interests are sometimes pursued on the basis of sovereignty, and at the expense of global health outcomes, there are other instances where sovereignty concerns have been downplayed in favor of other goals. Asian states have also challenged global rules and regimes that have undermined health outcomes by contravening existing norms and pushing for greater national policy space. In other cases, sovereignty turns out to be a principle-of-last-resort in ordering relations in an ethnically and historically fractious region where trust remains thin. The multi-faceted ways in which sovereignty and globalization interact calls for a systematic examination of why tensions arise, and for constructing policy responses that are similarly wide-ranging.

Loosening and downplaying of sovereignty

Several case studies show Asian states adopting positions that downplay the importance of sovereignty as an issue in global health, both at the individual state level and at the level of international negotiations. As Florini et al discuss in detail in their accompanying paper, Asian countries such as China and India have willingly engaged with a range of global health institutions when they have been recipients of foreign aid. These global health players and initiatives range from foreign private entities such as the Bill and Melinda Gates Foundation (BMGF) to public-private partnerships like the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM). However, these positive engagements are often embedded within a broader strategic context. In his study on the interaction between the BRIC[6] countries and the international health community on dealing with HIV/AIDS, Gomez (2009) describes a twin dynamic of ‘receptivity’ and ‘resistance’ taking place. States such as India and China are

more receptive to the international health community when cooperation offers advantages of program expansion and reputation enhancement, or when there has been a history of collaboration. They have also resisted global health initiatives when there have been clashes with domestic policies, normative structures or pharmaceutical capacity. What these dual practices amount to is a growing strategic approach by these emerging nations. Gomez describes this as a demonstration by these countries that they are capable of dealing with their health issues – and as such a stronger exertion of their sovereignty. That said, the definition of sovereignty being asserted here is arguably one that is more flexible (both 'receptive' and 'resistant' depending on circumstances), and which implicitly accepts the legitimacy of engaging with non-state actors and non-traditional initiatives in the global health community.

In global rule-making efforts such as the International Health Regulations (IHR) revision process, various Asian participants raised objections during negotiations on the basis of sovereignty concerns. However, these concerns did not impede the successful revision of the IHR (details in Lee et al). The 2005 IHR represent a significant revision of outdated rules surrounding the governance of international disease threats. The new regulations expands the scope of diseases covered, strengthens the way in which information on disease events is used and shared, clarifies the responsibilities of states in their surveillance and response to potential health threats, and gives added authority to the WHO. The WHO can seek verification from state parties on disease events, and state parties are obliged to respond to the requests. Finally, the WHO is also able to share information from non-governmental sources with both state parties and inter-governmental organizations (Fidler and Gostin, 2006). During negotiations, the Chinese government objected to the IHR text on grounds of sovereignty in two areas – first in disease surveillance, reporting and investigation mechanisms, and second in the status and representation of Taiwan. Lee et al detail the process of the IHR negotiations and the IHR was successfully revised despite these concerns, providing some evidence of the 'loosening' or re-configuration of the sovereignty principle vis-a-vis the need to formulate new rules for governing global health.

The FCTC negotiations to come up with global rules for tobacco control provide hints of how Asian countries can and have actively shaped new understandings of how to balance sovereignty and global health needs. Of course, the positions of Asian participants were highly diverse. The Japan tobacco industry, for example, argued for national governments to retain control over what forms of regulation was best suited to their respective countries but

Japan ultimately ratified the FCTC. In contrast, Thailand and India played leading roles in negotiating a framework for tobacco control that moved state parties away from interests defined by territorial boundaries and towards transnational notions of public health protection (see details in Lee et al). The FCTC therefore represents an interesting case of some Asian states not just acceding to, but actively shaping, new rules of global governance that reflect a more flexible understanding of sovereignty.

Sovereignty as a tool to advance national interests

For the issue areas analysed for this project, there appears to be a preference in Asia for promoting state-centric forms of cooperation. The clearest evidence for this comes from the behaviour of countries such as Japan, China and India as *donors* in development assistance for health (DAH). Foreign aid is an area where the state has a high degree of discretion in setting the rules of engagement. As Florini et al (this issue) elaborate, Japan, China and India have all adopted DAH policy rhetoric that reflect a sensitivity towards respecting the sovereignty of recipient nations. Moreover, the three countries' management of DAH are all strongly driven by their respective foreign affairs ministries. These agencies in turn are likely to formulate policies to advance sovereign, rather than global health, interests. The institutions and mechanisms that the three countries have chosen to channel their development assistance further underscore preferences for state-centric modes of cooperation that further national objectives. What these objectives are, however, vary according to domestic context.

That said, the environment for emerging donors is highly dynamic, and the DAH strategies of the three countries are evolving – though in different directions. Florini et al (this issue) describe how Japan has revised its foreign aid principles, which are today framed under the concept of Human Security – defined less by territorial boundaries and more by universal human needs. Japan has also played a leading role in promoting health in different high-level multilateral fora such as the G-8. Increasing scrutiny over China's international behavior, and growing expectations for China to be a responsible stakeholder, have also pushed China to clarify its role in managing global issues. In contrast to Japan, China's *White Paper on Foreign Aid,* issued in April 2011, staunchly upholds the principles of non-interference and equality.[7] These various developments underline the non-linear and complex ways in which

major and emerging Asian powers will challenge, influence and be shaped by current development discourses.

Sovereignty as a tool to challenge global rules

The sovereignty principle was also found to be employed, in some cases, to challenge global rules perceived to be unfair and detrimental to public health outcomes. In relation to intellectual property (IP) rights, for example, the TRIPS regime severely constrained the national policy space for access to medicines for developing countries in the 1990s. Moon and Szlezak (2012, Forthcoming) point out that while the formal TRIPS regime allowed governments flexibilities such as compulsory licensing, in practice the political space for exercising such options was restricted by external pressure and trade interests. They further detail how the actions of governments and civil society in Malaysia, Thailand and India championed new rules that challenged TRIPS and re-asserted health-centered interests. However, the authors carefully note that it was not simply governments fighting to reestablish national policy space. Instead, efforts were made in collaboration with civil society, transnational coalitions, international organizations and the scientific community to reassert the right of WTO member states to use flexibilities on the grounds of protecting national public health interests: 'Thus, in a globalizing system, the reassertion of sovereignty was made possible by taking a more permeable approach to the very concept of sovereignty.'

In another example, Indonesia announced in 2007 that it would withhold H5N1 influenza virus samples from the WHO on the grounds of inequities in rules surrounding access to anti-viral drugs and vaccines (Jakarta Post, 2007). The government framed its protest around the notion of 'viral sovereignty'. Indonesia's assertion sparked global controversy, and was criticized for being based on outdated notions of sovereignty that dangerously undermined collective global health security (Holbrooke and Garrett, 2008). However, the country's protest nonetheless highlighted fundamental inequities in the system of vaccine production and access, that some low and middle-income countries identified with. . The challenge of existing virus-sharing norms led to the creation of new rules under the Pandemic Influenza Preparedness Framework (PIPF) regarding virus sharing, intellectual property, and revised responsibilities for drug manufacturers (see Lee et al (this issue), and Fidler and Gostin, 2011).

Sovereignty as the lowest common denominator

Finally, one reason for the strong reliance on state-centric modes of cooperation in Asia appears to be the presence of historically deep political, ethnic, religious and economic divisions within the region that continue today to hinder collective action. The absence of trust or agreed norms of cross-border cooperation has hindered modes of collaboration that might bring in more diverse actors working in trans-border partnerships or networks. Sovereignty has instead ordered relations between a set of politically, ethnically and geographically diverse grouping of nations. Lee et al (this issue) examines the governance gaps that has resulted from this state of affairs. For example, pandemic governance has focused on at the border controls, rather than on a systemic strengthening that transverses state territories. In addition, the region's deep adherence to the norm of non-interference has created a policy environment where transnational issues of mutual concern are not discussed, for fear of infringing upon the domestic affairs of other states. We elaborate on this issue in the section below on institutional diversity.

Understanding sovereignty through multiple lenses

The multiplying transnational governance challenges wrought by globalization bring new tensions to the relevance and application of the sovereignty principle in global affairs. Indeed, there are plenty of examples of rising Asian countries using sovereignty as a tool to advance their individual national interest – often to the detriment of global governance needs. However, the evidence summarized here also suggests that a focus only on this clash may yield limited insights into how global governance can be strengthened. Indeed, the sovereignty principle can be equally used to either advance individual national interest at the expense of global public needs, or in order to address inequities in the global system of rules and norms, or simply to maintain peace and stability in the absence of deeper institutional arrangements. These difficult tensions point to the need to analyze sovereignty and globalization through multiple perspectives, and to distinguish between different sources of tension.

In cases where global rules and standards are driven by one dominant set of interests, or without participation from critical stakeholders, governance mechanisms can be perceived as illegitimate, inequitable and ill-fitted for the world's diversity of socio-economic settings. In

such situations, sovereignty remains a useful tool that states can wield to push for a revision of the rules. Even in such cases, as the experience of Thailand, India and Malaysia in influencing new norms for IP and access to medicines demonstrate, assertions of sovereignty under conditions of globalization are more effective when undertaken with the participation of transnational networks and non-state actors. In other cases, where a lack of trust undermines global governance, the problem lies with an absence of alternative mechanisms that can create new incentives for collective action.

As such, recommendations for improving global health governance should derive from the motivating factors behind various uses of the sovereignty principle. Rather than acting at odds to each other, sovereignty and globalization could instead be understood as being 'mutually embedded' (Väyrynen, 2001). A more flexible and multi-dimensional approach to devising policy responses could be considered. If sovereignty is being used as a tool for advancing individual national interest, an examination of the political economy behind national interest formation could open up avenues to push for a more health-centric and transnational construction of foreign policy goals. If sovereignty is being used as a tool to challenge existing global rules, an assessment of the *process* by which these rules are made, and adjustments to include neglected voices and concerns, might be in order. If sovereignty is being used as a last-resort principle to order relations in the absence of trust, then confidence building at the regional level, or a focus on informal institutions and networks, might offer progress in improving health outcomes.

Diversity and Preferences in Institutional Design

The preceding discussion on sovereignty underscores the challenge of designing institutions to effectively take into account the myriad factors and alignment of interests involved in governing global health. On the one hand, allowing space for innovation in governance structures allows for experimentation in collective action to manage transnational problems. On the other hand, the anarchic policy environment with its multiplicity of interests, norms and actors can lead to incoherence and fragmentation. In this section, we examine how Asian actors are engaging with institutional pluralism from two angles: the composition of state and non-state actors across the governance of various health issues, and connections between global, regional and local institutions. The underlying question is whether health outcomes

are enriched or weakened by the institutional diversity in the global health governance landscape, and the roles played by Asian actors – whether they are acting as governors influencing the shape of various institutions, or being governed across different health issues.

Horizontal diversity across issues

The degree of institutional diversity and effectiveness in global governance varies according to the subject of regulation and alignment of interests. This project found varying forms of state engagement in Asia across a range of different institutional designs, from DAH to international arrangements such as the PIPF, IHR and FCTC.

In DAH, Florini et al (this issue) find a disconnect between the role of Asian actors as recipients versus donors of aid that mirrors their, at times, variable positions on sovereignty. As aid recipients, India and China accept and engage with a diversity of institutions and actors, and have provided fairly open operating space to these actors (e.g. the Global Fund, and the Ford, Clinton and Gates Foundations). As donors, however, India and China prefer to engage bilaterally rather than multilaterally. They tend to be focused on state-to-state partnerships, with contributions tending to be largely material rather than ideational. This balance of priorities begs the question of what other health problems are being neglected, and what opportunities are lost in terms of tapping into the capacity of non-state actors to play governance functions that governments, acting alone and within territorial jurisdictions, cannot address.

In governing pandemic influenza with the aforementioned PIPF, and governing disease outbreaks with the 2005 revised IHR, there appears to be a disconnect in Asia countries between a recognition of the potentially transboundary nature of infectious disease outbreaks, and the institutional *responses* that remain based on state-centric mechanisms. The SARS outbreak alerted the world to the need to strengthen global governance around pandemic influenza, giving state agencies a much-needed prompt to revitalize efforts to update the IHR. The surveillance aspect of the IHR has arguably been enhanced through the provision allowing the use of non-state sources of information. However, as Lee et al (this issue) describe, Asian countries did not play an active role in the revision process, and participation was highly state-centric. Similarly with pandemic preparedness, efforts in Asia have revolved

around governments and to a lesser extent international or regional inter-governmental organizations.

In other, less traditional institutional arenas that actively engage non-state actors in new forms of decision-making, it is difficult to characterize a common approach by Asian states. One example is tobacco control. The FCTC process represented an innovative approach to drafting global rules, at least on health, by incorporating participation by a range of stakeholders (e.g. the public health community, industry, farmers) in a public hearing and allowing participation by NGOs with official relations with the WHO as observers and providers of unofficial briefings during negotiations. While Japan and China played the role of spoilers during the negotiations, the enhanced role given to NGOs was central to raising attention and scrutiny over the pro-tobacco stance of the Japanese and Chinese governments, and eventually in pressuring the two countries to adjust their positions somewhat. The governments of India and Thailand, moreover, played leading roles in the successful negotiation of the Framework, with Thailand pushing strongly for the participation of NGOs (details in Lee et al, this issue and Lee and Kao, 2012, Forthcoming).

Domestic foundations to global institutions

Our findings suggest that the degree and nature of Asia's role in influencing global health institutions depend very much on domestic decision-making structures, as demonstrated through the leadership roles played by India and Thailand in shaping the FCTC. As Lee et al (this issue) point out, the open participation and engagement of civil society in India and Thailand's domestic health policy process was directly related to these countries' support at the global level for the FCTC to include substantive voice and responsibilities for NGOs. Regarding access to medicines, India and Thailand again were leaders in developing national intellectual property institutions that advanced public health interests. Moon and Szlezak (2012, Forthcoming) attribute India and Thailand's challenging of existing IP rules to the close networks between their civil societies and governments to the global access to medicines movement, as well as the political space afforded to civil society to influence IP policies through both the legal and administrative systems. China's IP institutions, in contrast, have not taken public health concerns into account. The authors argue that China's domestic and external policy environment has much to do with this difference – the heightened trade pressure on China to toughen its IP standards, the narrower space for civil

society to operate in China, and the thinner ties between domestic NGOs and global public health networks.

In DAH, the domestic health needs and institutional environments in Japan, India and China similarly shape these countries' approach in addressing public health needs at regional and global levels. Florini et al (this issue) elaborate how the bureaucratic fragmentation of agencies dealing with overseas assistance in China and India has created DAH policies that do not amount to any focused or coherent approach on health. Japan, in contrast, has a more structured inter-agency process and one implementing agency (the Japan International Cooperation Agency). While Japan frequently engages the participation of non-state actors in the formation of state DAH policies, China and India have not allowed non-state actors to play much of a role. The lack of participation by non-state actors – particularly civil society – is mirrored by the state-centric nature of resulting policies. The result is that China and India's domestic DAH policy communities are disconnected from broader discourses on global health governance.

Regional institutions

Our research has found that the political diversity in Asia, and lack of consensus about what role the region should play in managing trans-national health problems, and thus which institutions work best, has hindered the building of regional institutions. Asian countries (except for China) were largely disengaged from the IHR negotiations, and regional institutions played no role either in the preparatory stages or actual intergovernmental discussions. As Lee et al (this issue) describe, 'Asian governments approached the IHR in an individualistic and state-centric manner, declining to form regional alliances.' While ASEAN and APEC were active in organizing cooperative efforts and discussions on pandemic preparedness, they were also heavily criticized for being inefficient and ineffective. Historical mistrust, socio-economic and political diversity within the region were cited as standing in the way of cross-border collaboration. In terms of material contributions to global health, Florini et al (this issue) note that the amount of funding that the Asian Development Bank (ADB) channels to health projects has been minimal (1% in FY 2009). As the number of issues requiring collective action multiplies, the weaknesses of Asia's regional institutions are coming under increasing critique.[8] It is precisely because trust appeared so thin in Asia,

and countries are at such varied stages of economic development, that the core function of these intergovernmental institutions is seen as minimizing conflict and maintaining stability, rather than fulfilling broader regional governance needs. This is the corollary to the region's attachment to sovereignty as an organizing principle to preserve peace.

However, the case studies also reveal some areas where the actual functions of managing trans-border issues are being built within the region, and where historical differences can be overcome. Evidence suggests that in some issue areas, elite-level policy negotiations through informal networks play a stronger role in governance than formal regional organizations. In pandemic preparedness, for example, Kamradt-Scott et al (2012, Forthcoming) observe that for the IHR, '(m)any of the new links are based on informal networks between public health and scientific colleagues who share information on a regular basis via email, telephone, or the Internet. Many of these professional networks have not been documented, and have emerged distinct from more formalized intergovernmental processes.' In addition, the FCTC experience demonstrates the potential of regional institutions to play a part in negotiating the heterogeneous preferences within Asia. Lee et al (this issue) detail the role that WHO's Southeast Asia Regional Office (SEARO) and ASEAN both played in balancing the wide-ranging tobacco interests in the region, and in building regional consensus prior to discussions at the global level.[9] This case study suggests that the enduring hostilities that divide Asian countries might be overcome to address specific issue-areas, in the presence of strong leadership and where domestic constituencies are included in policy processes.

Vertical Connections – from local to global

It has been frequently observed that the institutional environment in global health is currently marked by fragmentation[10]. Mechanisms are heterogeneous across different issues and operate in silos. Policies and actors are disconnected vertically between local, regional and global levels. The result is an institutional landscape lacking in coherence to address globalizing health problems. Be it in DAH, in pandemic preparedness or revising the IHR, Asian actors have by and large also preferred to act individually rather than collectively. Exceptions to the rule exist, of course, as the papers in this special section point out. Nonetheless, the tendency is for global health issues to be shaped by independently driven and state-centric approaches. One longer term implication, therefore, is that the emerging

multi-polarity in global affairs to likely to lead to a further fragmentation of global health institutions.

These disconnects apply not just to the formulation of rules for global health, but also with implementation. In pandemic preparedness, the IHR and tobacco control, implementation is left to the national level without strong enforcement by global institutions. This point is particularly relevant for Asia because, while some countries in the region are rapidly modernizing and becoming more economically powerful, their social and institutional development has lagged behind. The result is greater globalization of health issues, but without requisite institutional capacity to respond to multiplying health needs.

In sum, Asia's engagement with and promotion of different institutional designs vary horizontally across issue areas and vertically through global, regional and local levels. As health aid recipients, Asian states have shown a willingness to engage with a whole range of state and non-state actors, and transnational public-private partnerships such as GFATM. As health aid donors, however, states such as India and China have chosen to focus on state-centric relationships and projects. On the whole, there appears to be a regional preference for using state-centric mechanisms to manage health problems, although as discusses earlier, the make-up of local political structures matter as well. Those countries, whose domestic processes included participation from non-state actors correspondingly either promoted or were open to institutional designs that afforded greater diversity of partners at the supra-national level. The role of regional organizations such as ASEAN or WHO regional offices appears to be highly varying. ASEAN was found to be highly ineffective in managing issues such as pandemic influenza governance and played no role in fostering discussions in the run-up to IHR negotiations. In the FCTC, however, regional-level discussions were critical in resolving differences and consolidating positions in the WHO negotiations. The precise factors driving this variance are a topic deserving further research.

Conceptions and Contributions from Asia

We now turn to the third analytical theme on conceptions from Asia on global governance and Asia's role in managing global health problems. Normatively, there has been an explosion in the ideas, principles and ethics that shape efforts to govern global health. Each competing viewpoint is promoted by a different combination of interests and actors, with the

result that none of the various conceptualizations of global health is universally accepted (Lee 2009, Dodgson and Lee 2004). Existing literature on global health governance extensively maps out the development of these various normative approaches and discourses in global health.[11] The range of conceptions includes, among others: (a) market-based approaches of production and delivery of health goods; (b) universalist approaches grounded in the right to health, equity, social transformations and community empowerment; (c) global security implications of poor health policies; and (d) scientific approaches to health promotion focused on specific diseases and targeted medical interventions (for a detailed discussion see Lee 2009). The literature has paid less attention to the degree to which these various conceptions are accepted or rejected across different geographic regions. As the world continues to grow more interdependent, it will become increasingly important to understand how state and non-state players from China, Japan, Thailand, Indonesia, India, and so on, conceive health problems domestically and globally, and correspondingly, how these conceptions shape their contributions to global health governance.

Building an inclusive understanding of global health governance

Rather than a common 'Asian' conception of global health governance, the case studies reveal incoherence and a tendency for health to be framed and managed piecemeal. The region's immense political diversity further impedes the formation of common approaches to dealing with global health issues. The case studies presented in this special section have, with exceptions, shown a state-centric, and fairly passive approach to managing global health in Asia. Florini et al (this issue) underscore that China and India's contributions to global health remain material rather than ideational, but also note that both countries are becoming more active donors. The passive disengagement of Asian participants in the IHR negotiations show that actors in the region remain content with letting others shape the rules in some global health issues. Nor has our research found that regional institutions are playing a strong role in bridging the normative and conceptual divides at the global and local levels. In intellectual property and access to medicines, for example, Moon and Szlezak (2012, Forthcoming) point out that the positions of various Asian states are driven, not by any shared conception of IP or cultural or historical basis, but rather by their individual level of economic growth and degree of political space offered for civil society participation.

This gap between the growing expectations for emerging Asia to play a larger role in global health governance, and the nature of engagement found in our research, suggests that a rising Asia is being governed by global rules set elsewhere, insofar as many remain recipients of aid and most have not played an active part in setting the rules surrounding many of the current initiatives. Moreover, existing global institutions remain largely perceived as entrenched within rules set by a small number of high-income countries, even as the issues requiring collective action challenge the scope and capacity of these institutions. The concept of 'global health governance' as it has been defined and debated in the literature and in global policy circles, does not appear to be a concept that is actively 'owned' and debated within Asia. The result is a disconnect between emerging conceptions of 'global health governance', as debated and promoted by scholarly and policy communities worldwide, and the engagement with global health policies within the Asian region. As such, there is a risk that as Asia continues to develop economically, health issues becomes subsumed and governed piecemeal under the other driving forces – such as in foreign policy or economic competition. These considerations point to a need for more coordinated efforts to manage the twin dynamics of globalization and the rise of Asia. A whole range of effort is needed, from trust and capacity building across borders, to pushing for greater political leadership, and generating a more inclusive dialogue on the meaning, challenges and responsibilities of global health governance.

Health as the Vanguard of Global Governance?

Analysis of Asia's rise in relation to the region's engagement with global health governance has implications beyond the field of health. There is relative consensus worldwide on the importance of strengthening collective action to address global health needs. This is reflected in the increased attention to global health in foreign policy. . As such, even those countries that take more traditional views on sovereignty and world order are more likely to take a positive stance towards cooperation with global civil society and other non-state actors on health. These factors combine to suggest that innovations in global health governance could be at the vanguard of developments in global governance more generally.

However, insofar as we can imagine a future where Asian countries are increasingly willing to challenge the status quo, it is not clear what new rules and norms will be put forth. Fidler (2012, Forthcoming) contends that Asian countries' commitment to the Five Principles of

Peaceful Co-Existence[12] will shape the nature of their engagement with global governance. Given that sovereignty and non-interference sits as a core tenet in the Five Principles, there could be a potential clash with existing discourses in global health governance that advocate more flexible interpretations of sovereignty and the role of non-state actors. Fidler (2012, Forthcoming) also cites Ginsburg's argument, that '[t]he greatest conceptual innovation of Asian states in international law in the past several decades has been a regressive one, namely the idea that 'Asian values' offered an alternative to liberal universalism'.

Evidence from this project provides support for both of these arguments. As an aid recipient, China has demonstrated its willingness to engage non-state actors and innovative global initiatives that do not adhere to classical interpretations of sovereignty. China's ratification of the FCTC, despite the political strength of its domestic tobacco industry, may also demonstrate China's desire to be seen as a responsible emerging power (Lee and Kao, 2012, Forthcoming). Asian countries are also becoming more active participants (though not leaders or rule-setters) in some innovative global health governance efforts, such as the GFATM and the GAVI Alliance (Fidler, 2012, Forthcoming).

There are growing examples of Asian countries taking leadership roles and asserting themselves to advance health-centric goals. For example, Japan has championed health issues at the 1994 Global Issues Initiative on Population and AIDS and the 2000 and 2008 G-8 meetings (Florini et al, this issue), while Thailand and India have effectively altered the status quo on the rules governing access to medicines (Moon and Szlezak, 2012, Forthcoming). India and Thailand's leadership in the FCTC process, in particular, demonstrates the potential for Asian countries to proactively shape new rules in global health governance (Lee and Kao, 2012, Forthcoming). It also shows that, in the presence of effective leadership supported by open and participatory domestic decision-making structures, regional solidarity can be built and historical mistrust overcome.

In the area of DAH, however, where states are able to proactively set the rules, the nature of their health assistance is very much entrenched within a worldview emphasizing classical notions of sovereignty, utilizing traditional tools and relying mainly on state-to-state cooperation (Florini et al, this section). Huang Yanzhong (2010) suggests that the disconnect, in the case of China, arises out of a fundamental difference in world view: 'Although China recognizes that solutions to global health problems necessitate neoliberal strategies of

cooperation over disease prevention and control, its actions on global health problems are still justified from the lens of classical realism that focuses on power, influence, and security.'

Asian efforts to strengthen pandemic preparedness further revealed a clear preference for state-based action to deal with what has been accepted as a trans-border issue**.** Institutional responses have lagged behind conceptual understandings of the transnational problem at hand. It is important, however, to reiterate that the roots of the region's commitment to state-based responses and to classical sovereignty are not solely about conceptual disconnects. The lack of trust, and historical and socio-economic diversity remains a fundamental barrier to collective action. The lack of institutional capacity to implement basic response and regulatory functions, further impedes more innovative trans-boundary solutions.

Health Cooperation versus Competition

Emerging multi-polarity will intensify normative debates in global governance. In areas where health objectives are poorly conceived and weakly governed, the potential for strategic competition to outweigh governance needs will heighten. For example, health development aid in China and India are largely shaped by ministries such as foreign affairs and commerce. Huang (2010) articulates the risks of this approach of health clearly:

> China's active engagement in global health is primarily driven by a foreign policy agenda that focuses on expanding international influence while improving international image. … The danger is that when health is placed in the realm of realpolitik, it runs the risk of being "dependent on the logic of such politics—which is not based on science and not subject to public deliberation and peer review, but on the Machiavellian instincts of those in power."

Therefore, as long as health is conceived in these countries as a foreign policy tool, it might increasingly be a source of competition, rather than collective action, across countries. The resulting governance gaps and policy distortions are plentiful. In terms of health aid, while there are severe capacity deficits in many health systems in Asia that hamper the implementation of the IHR or of efforts to strengthen pandemic preparedness, Asian donors are not channeling resources into this area.

Indeed, the sources of competition extend beyond aid. As Moon and Szlezak (2012, Forthcoming) point out, India and China's capacities in pharmaceutical R&D are expanding with the active investment from multinational companies, local firms, academic and government institutions. These countries would in time become net exporters of IP products. As such, the potential for the logic of economic competition to take priority over health needs will continue to expand. Insofar as there tend to be less clear state-corporate divisions in some parts of Asia (e.g. those societies that have developed through state corporatist or market authoritarian models), the economic rise of these countries bring interesting implications for how the rules surrounding global health IP issues will be influenced and re-shaped.

Fidler (2012, Forthcoming) warns that not only would such competition deepen forces that are fragmenting global health governance initiatives, but that resulting policies will increasingly serve narrow state interests rather than the objective of advancing global health through collective action. In the absence of agreed objectives, rules and enforcement mechanisms, commercial or national strategic interests will continue to play a dominant role in driving the substance and direction of the vast array of health research activities. The risks of this situation are that the needs of disenfranchised populations are not met, and their voices not included in the decision-making process.

A Call for Constructive Dialogue

The fundamental question connecting the above discussions is whether emerging multi-polarity in global affairs will make it even harder to build a consensus around the objectives and rules of global health governance, with multiplying normative sources of conflict in the face of deepening interdependencies. Another question is whether these dynamics are taking place with an inclusive and representative debate on sovereignty and the norms by which global health ought to be governed.

It is not clear if the much-needed discussions on sovereignty and global health governance are taking place in policy and academic communities in Asia – domestically and regionally. It is even less clear as to whether conversations of this nature are taking place across East and West. Without an active debate, the danger is that health governance in Asia will continue to

rely heavily, by default, on state-based and state-led mechanisms, possibly leading to a weakening of efforts to strengthen global health governance. Another danger is that by refusing to engage on the wider debate on sovereignty, Asia will be left to accept the rules that get revised, and concerns and perspectives from the region will end up being neglected.

Conclusion

The search for effective global governance, to enable collective action on a broad range of transnational challenges, requires deeper understanding of the role of rising states, the increased importance of non-state actors, and a re-assessment of the relationship between sovereignty and globalization. Global health governance is an opportunity to make progress on this process because of the universal recognition of the core importance of health to human well-being.

However, this is not to say that global health governance is not highly political and fraught with contestation. As the case studies of this project demonstrate, international relations is riddled with a whole range of collective action problems which are failing to be addressed effectively by existing institutional arrangements. This is, in large part, because they are embedded in an anachronistic world order in which Asia, is being governed rather than participating in governing. Bridging this disconnect will require geopolitical, institutional and ideational adjustments. The setting of future global health rules will need to take into account opportunities, constraints and perspectives from emerging regions such as Asia that have thus far been relatively neglected. Such adjustments require a reconsideration, not just of decision-making processes, but also preferences for institutional forms and normative frameworks. At the same time, Asian state and non-state actors need to be engaged as co-shapers of the global order – not just in terms of contributing material resources and participation in existing initiatives, but also in terms of leadership and ideas for reforming and strengthening current institutions.

Policy Implications

- Sovereignty is asserted in a variety of ways across different global health issues, and policy responses should therefore be similarly diverse, tailored to the specific factors present in each context. .

- Governance structures at the global level are not only shaped by state actors, but can be shaped in part by bottom-up policy processes. This is a reflection of the degree to which domestic environments allow for non-state actor participation, as well as how these local actors are connected to transnational networks and discourses.

- The implementation of global rules remains dependent on local capacity and political will. As such, more donor attention (including Asian donors) could be called to the institutional weaknesses in the Asian region.

- While regional organizations remain focused on maintaining stability, the FCTC experience has shown that regional distrust can be overcome in the presence of leadership and with inclusive national-level policy processes. .

- Emerging multi-polarity threatens to deepen strategic competition between powerful and rising states, thereby further fragmenting efforts to govern global health Such competition could be mitigated by empowering a greater range of actors in Asia with interests in advancing health needs.

- Asian state and non-state actors have an opportunity to play a bigger role in reforming existing global health governance institutions. One way to facilitate this stronger governance role is to foster inclusive dialogue and constructive debate on the importance of global health governance in the region.

REFERENCES

Bennett, S., Pang, T., Chunharas, S. and Sakhunpanit, T. (2012). "Global Health Research Governance – An Asian perspective on the need for reform", in K. Lee, T. Pang and Y. Tan. (eds.) *Asia's Role in Governing Global Health.* Routledge (Forthcoming)

Dodgson, R. and Lee, K. (2004) "Global Health Governance: A Conceptual Review" (WHO).

Elliott, L. (2003) "ASEAN and environmental cooperation: norms, interests and identity", *The Pacific Review*, 16: 1, pp. 29 — 52

Fidler, D. and Gostin, L. (2006) "The New International Health Regulations: An Historic Development for International Law and Public Health." *The Journal of Law, Medicine & Ethics*. Volume 34, Issue 1, pp. 85–94, Spring.

Fidler, D. (2007) "Architecture amidst Anarchy: Global health's Quest for Governance," *Global Health Governance* 1, no. 1, January.

Fidler, D., (2012). "Asia and Global Health Governance: Power, Principles, and Practice." in *Asia's Role in Governing Global Health.* Routledge (Forthcoming)

Fidler, D., and Gostin, L. (2011) "The WHO Pandemic Influenza Preparedness Framework: A Milestone in Global Governance for Health." *JAMA*, July 13 —Vol 306, No. 2

Gomez, E. (2009) 'The Politics of Receptivity and Resistance: How Brazil, India, China, and Russia Strategically use the International health Community in Response to HIV/AIDS: A Theory.' *Global Health Governance: Volume III (1)*, pp. 1-29.

Huang, Y. (Winter 2010) "Pursuing Health as Foreign Policy: The Case of China." *Indiana Journal of Global Legal Studies.* Vol. 17 #1

Information Office of the State Council, The People's Republic of China (April 2011) "China's Foreign Aid." http://news.xinhuanet.com/english2010/china/2011-04/21/c_13839683.htm

International Monetary Fund World Economic Outlook Database
http://www.imf.org/external/pubs/ft/weo/2011/01/weodata/index.aspx

Kamradt-Scott, A., Lee, K. and Xu, J. (2012) "The International Health Regulations (2005): Asia's Contribution to a global health governance framework." in K. Lee, T. Pang and Y. Tan. (eds.) *Asia's Role in Governing Global Health.* Routledge (Forthcoming)

Lee, K. and Kao, W. (2012) "Case study of Asian contributions to the negotiation of the Framework Convention on Tobacco Control." in K. Lee, T. Pang and Y. Tan. (eds.) *Asia's Role in Governing Global Health.* Routledge (Forthcoming)

Lee, K. (2009) "Understandings of global health governance: The contested landscape," in Adrian Kay and Owain David Williams, eds., *The Crisis of Global Health Governance: Challenges, Institutions and Political Economy* (London: Palgrave Macmillan)

Leonard, M. (2008) *What Does China Think?* (London: Fourth Estate),

Ministry of Foreign Affairs, People's Republic of China. (2000) "China's Initiation of the Five Principles of Peaceful Co-existence."
http://www.fmprc.gov.cn/eng/ziliao/3602/3604/t18053.htm

Moon, S., & Szlezak, N. (2012) "Rule-makers, Rule-shapers, and Rule-takers: What role for Asia in the Global Governance of Intellectual Property Rules and Global Health?" in K. Lee, T. Pang and Y. Tan. (eds.) *Asia's Role in Governing Global Health.* Routledge (Forthcoming)

Ng, N and Ruger, J. (2011) "Global Health Governance at a Crossroads." *Global Health Governance*, Vol. 3, No. 2, pp. 1-37

Pilcavage, C. (2012) "Japan's ODA in the health sector and global health governance." in K. Lee, T. Pang and Y. Tan. (eds.) *Asia's Role in Governing Global Health.* Routledge (Forthcoming)

Sridhar, D. (2009) "Global Health: WHO can lead?" *Chatham House World Today*, vol. 65, no.2, February.

Holbrooke, R., and Garrett, L. (August 10, 2008) " 'Sovereignty' That Risks Global Health" *The Washington Post.* http://www.washingtonpost.com/wp-dyn/content/article/2008/08/08/AR2008080802919.html

The Jakarta Post (February 17, 2007). **"**RI 'will not share' flu samples." http://www.thejakartapost.com/news/2007/02/17/ri-039will-not-share039-flu-samples.html

Thomas, C and Weber, M. (2004). "The Politics of Global Health Governance: Whatever Happened to "Health for all by the Year 2000"?," *Global Governance* 10, no.2: 187-205

United Nations Development Program. Human Development Index. http://hdr.undp.org/en/data/trends/

Väyrynen, R. (2001) "Sovereignty, Globalization and Transnational Social Movements" *International Relations of the Asia-Pacific.* Vol 1. pp. 227-246.

Wang, Q., Liu, M., Liu, A., Wei, T. and Li, H. (2012) "Global Health Governance in China: The Case of China's Health Aid to Foreign Countries." in K. Lee, T. Pang and Y. Tan. (eds.) *Asia's Role in Governing Global Health.* Routledge (Forthcoming)

Walt, G., Spicer, N., and Buse, K. (2009) "Mapping the Global Health Architecture," in Buse, K., Hein, W., and Drager, N. eds., *Making Sense of Global Health Governance: A Policy Perspective* (New York: Palgrave Macmillan).

Walt, G., and Buse, K. (2006) "Global Cooperation in International Public Health," in Merson M, Black RE, Mills A. eds. *International Public Health, Diseases, Programs, Systems and Policies*, 2nd edition (New York: Jones and Barlett.)

[1] The case studies examined the role of Asian countries in the governance of the following health issues: Development assistance for health, the Framework Convention on Tobacco Control (FCTC), the 2005 revision of the International Health Regulations (IHR), pandemic influenza preparedness, global health research, and intellectual property. In addition, papers were commissioned on the interactions between global health and the rise of Asia, sovereignty and institutional innovations. These papers will be published in an edited volume (Routledge, forthcoming).

[2] Classified by the IMF to include: Islamic Republic of Afghanistan, Bangladesh, Bhutan, Brunei Darussalam, Cambodia, China, Fiji, India, Indonesia, Kiribati, Lao People's Democratic Republic, Malaysia, Maldives, Myanmar, Nepal, Pakistan, Papua New Guinea, Philippines, Samoa, Solomon Islands, Sri Lanka, Thailand, Timor-Leste, Tonga, Tuvalu, Vanuatu, Vietnam

[3] All figures in purchasing power parity terms.

[4] For example, see Fidler (2007), Dodgson and Lee (2004) and Lee (2009).

[5] For example, see Walt et al 2009, and Walt and Buse (2006)

[6] Brazil, Russia, India and China

[7] The White Paper describes one of the basic features of China's foreign aid policy as: 'Imposing no political conditions. China upholds the Five Principles of Peaceful Coexistence, respects recipient countries' right to independently select their own path and model of development, and believes that every country should explore a development path suitable to its actual conditions. China never uses foreign aid as a means to interfere in recipient countries' internal affairs or seek political privileges for itself.'

[8] In environmental governance, for example, Elliott (2003) criticizes the 'anti-institutionalism' displayed by ASEAN as becoming a growing obstacle to the cross-border cooperation needed to deal with environmental management.

[9] While SEARO played a technical role, ASEAN is more of a political platform. Discussions in these two institutions therefore played complementary roles in the FCTC negotiation process.

[10] See for example Fidler (2007); Lee (2009); Dodgson and Lee (2004); Ng and Ruger (2011) and Sridhar (2009).

[11] See for example Lee (2009); Thomas and Weber (2004); Fidler (2007); and Walt et al (2009).

[12] (1) Mutual respect for each other's territorial integrity and sovereignty; (2) mutual non-aggression; (3) non-interference in each other's internal affairs; (4) equality and mutual benefit; and (5) peaceful co-existence.