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DRAFT CHAPTER

Bice, S. and H. Sullivan (eds)
Public Policy in the 'Asian Century': Concepts, Cases and Futures

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

150 institutions that operate in different ways alongside formal institutions in regional collaboration
151 and international engagement.
152
153 Neo-institutional theory stresses the importance of examining institutions, organisations and
154 the actors within them and the ways these interact to shape policy and its practice. In public
155 policy terms, formal institutions refer to official rule-setting and legal obligations with coercive
156 mechanisms acting as the key driving force for action. They count as *formal* in terms of being:
157 codified, official, purposefully designed and third party enforced. From this perspective,
158 behaviour is constrained and regulated formally: organisations act in a certain way because
159 they have to and not necessarily because they want to. Informal institutions describe values and
160 norms that not only define goals or objectives but also designate ways to pursue them. We can
161 call these *informal* on the grounds they are unofficial, uncodified, self-regulated and often
162 emerge rather than being designed. Like formal institutions, they can impose constraints but
163 also, at the same time, empower and enable social action.
164
165 New institutionalism allows that formal and informal institutions may be misaligned in certain
166 contexts, which not only produces confusion and conflict, but may also provide conditions that
167 are highly likely to give rise to institutional change. In their summary of new institutionalism,
168 Lowdnes and Roberts (2013) observe a dialectic relationship between the formal and informal
169 aspects of institutions and place analytical importance on agency in the shaping, bending and
170 challenging of institutional practices. An emphasis on the interactions and influences of
171 different institutional norms, culture and actors within a broader context helps gain traction on
172 the balance of informal and formal institutions in international policy coordination.
173
174 A starting proposition for the study of international policy coordination is that political-
175 administrative jurisdictions tend to have fixed territorial limits/borders; and these are fixed
176 even as the territorial scale of economic activity has changed both globally but also variety in
177 some cases, at regional and urban and local scales. These changing economic geographies
178 change carry attendant policy problems at those scales which are mismatched with the scales
179 of political-administrative jurisdictions and national sovereignty as the basis of international
180 policy cooridnation.
181
182 Recent research has begun to uncover the role of informal governance in international policy-
183 making for such problems (e.g. Stone 2013, Kleine 2014). A precise definition of informal
184 governance in terms of transboundary policy issues remains elusive, however at a minimum
185 we can say it refers to the unwritten rules, strong norms and/or shared expectations within the
186 international system that may modify, complement or substitute for formal institutions such as
187 treaty provisions (Stone 2013). So defined, informalism is everywhere: both within formal
188 international organizations (IOs), as well as operating separately as informal institutions, and
189 in a broad array of international policy networks constituted by state and non-state actors.
190
191 Importantly, whilst Stone (2013) argues that the informal may well complement or substitute
192 for the formal, there remains an important possibility that has been neglected by current
193 scholarship: a much more tense and problematic relationship where the formal can upset and
194 even destroy informal institutions with severe and adverse consequences. For example,
195 knowledge-based critiques of formal institutions argue that knowledge is necessarily
196 fragmented and dispersed (and in large part tacit) which means that any attempt at 'command
197 and control' or central planning is likely to be inimical to the informal because the 'all knowing'
198 policy-maker and institutional designer is impossible. Conversely, and again ignored in the
199 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

246 are also home to large state-owned risk commodity enterprises that compete with TRCCs,
247 particularly in the tobacco sectors of China, Thailand and Vietnam (Barraclough and Morrow
248 2010).

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

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

272

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

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

285 The first is the limited capacity of these institutions to develop, independently and in unison,
286 effective regulations addressing trade in risk commodities. This stems at least partially from
287 the divergent roles and powers of WHO and WTO. Although it has enabling constitutional
288 powers to make legally-binding rules that could in principle regulate risk commodity trade, in
289 practice WHO is a largely technical and normative agency that shapes national health policy
290 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

338 interdependence due to the diverse political and economic positions of the countries that may
339 seek to act collectively in this regard. At present Asian governments also make relatively small
340 contributions to the financing of multilateral organizations governing health and trade, likely
341 to weaken their capacity to influence the respective agendas. A much improved understanding
342 of the potential for Asian nations is needed in this regard, especially given that their increasing
343 economic and political power is likely to lead to greater influence in global health and trade
344 governance more generally (Lee, Kamradt-Scott et al. 2012, Lee, Pang et al. 2013).

345 Many Asian nations are also at a disadvantage in using WTO rules due to existing asymmetries
346 in bargaining power and the resources available to nations to make or defend disputes. Of the
347 26 WTO trade disputes made against Asian nations pertaining to agriculture, alcohol, tobacco
348 and pharmaceuticals between 1996 and 2013, 21 were made by the United States (US) and
349 European Community (EC) alone and of these 9 were against developing countries. Disputes
350 pertaining to alcohol were most common. To the contrary only 5 claims were made by
351 developing Asian countries against the US and EC (Baker, Kay et al. 2014). These difficulties
352 are accentuated when the delegations of the US and EU countries are backed by deep-pocketed
353 TRCC lobbyists and extensive legal teams (Shaffer 2003).

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

368 Some WHO programmes have been established to this end. A programme on globalisation,
369 trade and health was initiated in 2000, ‘to strengthen knowledge, develop analytical methods,
370 and produce training materials for supporting member states in addressing trade and health
371 issues’. This led to some collaboration with WTO staff, including the production of a joint
372 report on trade and health, although further commitments and activities have been vague (Lee,
373 Sridhar et al. 2009). More recently this programme was merged into the WHO programme on
374 global health diplomacy, which has produced a number of publications and offers executive
375 training including on trade and health. Health diplomacy is likely to be a key force in achieving
376 health and trade policy coherence for attenuating risk commodities, as it already has for access
377 to medicines under the WTO’s TRIPs agreement (Aginam 2010). This includes building
378 leadership capacity within the health community, and skills for advocating public health
379 principles and methods in trade policy-making and implementation (Lee, Sridhar et al. 2009,
380 Magnusson and Patterson 2014). WHO has, in the past, provided critical assistance to Asian
381 governments during risk commodity trade disputes. For example Thailand successfully
382 defended a 1990 GATT dispute, bought by the US Trade Representative on Thailand’s tobacco
383 import restrictions, partly due to scientific evidence provided by WHO officials (Drope and
384 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 charactersitics described by Fidler (2013): the predominance of national sovereignty over collective action, a culture of consensus-building rather than open conflict,

476 and highly politicized decision-making processes. For example,m it remains problematic in the
477 ASEAN Health cooperation that is that one of it key constituent members, Indonesia, is yet to
478 ratify the FCTC.

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

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

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502

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

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

512 Asian nations have differed considerably in how they have balanced the above norms as they
513 relate to addressing risk commodities. For example, during the FCTC negotiations, Japan and
514 China took steps to weaken the binding nature of adopted measures, making assertions of
515 'protecting sovereignty'. In contrast Thailand and India demonstrated considerable leadership
516 in building regional consensus towards a strong tobacco control treaty, alongside their adoption
517 of 'enabling' legislation at the national level. Thai delegates explicitly emphasised the need to
518 achieve a strong treaty with provisions that take priority over trade rules (Lee, Kamradt-Scott
519 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.

For example, increasing participation in international trade agreements requires countries to strengthen their domestic policy capacity; to evaluate the costs and benefits of entering into trade agreements; to ensure compliance with their international obligations when they do; and to ensure adequate protections for domestic regulatory space (Walls, Smith et al. , Baker, Kay et al. 2014). This is a significant challenge especially for poorer countries that may struggle to develop the required scientific and legal expertise, as well as formal institutional capacity. However, networks of informal institutions operation across Asia, such as technical support and mutual capacity-building, are important in supporting the functioning of formal 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.

564 In public health policy terms, Asia is also home to exemplary countries that have sought to
565 advance public health through staunch assertions of national sovereignty through unilateral,
566 and uncoordinated, regulation their domestic markets. Thailand, for example, has one of the
567 most comprehensive tobacco control regimes globally (Chantornvong and McCargo 2001). It
568 has implemented a hypothecated 2% tax on alcohol and tobacco to fund its Thai Health
569 Promotion Foundation (Casswell and Thamarangsi 2009). The re-regulation of risk commodity
570 markets policy option is a key consideration for governments that have already liberalized the
571 relevant sectors; this requires the development of informal institutions around formal
572 institutions of trade agreements. For example, Thailand is a world leader in establishing novel
573 informal institutional designs for public health with trade agreements. Its Trade in Health and
574 Social Services committee, for example, brings together officials from ministries of industry,
575 public health, food and agriculture, as well as various professional groups to investigate how
576 trade agreements effect health, to advocate for the inclusion of health in trade negotiations, and
577 to coordinate action between concerned agencies (Smith, Lee et al. 2009).

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

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