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Original Article

Health Policy in Asia and the Pacific: Navigating Local Needs and Global Challenges

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Abstract

Asia and the Pacific is undergoing a remarkable economic transformation, which is occurring at an exceptional pace. There is clear evidence of an equally rapid epidemiological transition in the region. This article sets out the policy challenges of building healthy societies in the context of rapid economic change. The region's location at the crossroads of contemporary globalisation, resulting in intensified population mobility, large-scale trade and investment, and pressures to take collective action on shared problems, adds to the complexity of this task. The article argues that health is integral to building stable and sustainable societies, and that there are opportunities to develop more holistic approaches that bring together hitherto separate policy spheres.

Key words: health policy, globalisation, epidemiological transition, global governance, health care reform

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1. Introduction

Asia and the Pacific is undergoing a remarkable economic transformation, with many countries in the region experiencing rapid growth, rising living standards and closer integration with the world economy. The region now has four of the world's 12 largest economies—Japan, China, India and South Korea—and the annual growth in gross domestic product (GDP) for emerging Asian economies has been around 5 per cent since 2008, relatively unaffected by the global financial crisis (Hale & Kennedy 2012). Moreover, this transition, from developing to developed region, is taking place at an exceptional pace. The Industrial Revolution in Europe and the United States, from the 1760s, extended over a century. In Asia and the Pacific, the lives of 60 per cent of the world's population (4.2 billion people) are being transformed in mere decades.

This rapid change, however, has also posed public policy challenges, including the need to protect and promote population health amid transition. It was a consequence of the upheavals of the Industrial Revolution that the modern era of public health emerged during the nineteenth century, prompted by stark inequalities in living conditions, education and employment opportunities, which led to shifting patterns of health and disease. From John Snow's historic removal of the pump handle on Broad Street in Victorian London, to control a raging cholera epidemic, to the

establishment of national health systems across Europe after the Second World War, the pursuit of wealth and health became closely intertwined. Today, governments across Asia and the Pacific face similar challenges. Economic development remains a high priority in a region home to the majority of the global poor where 1.63 billon people live below the US$2 per day poverty line (Asian Development Bank 2011). At the same time, there is recognition that the pursuit of wealth must be balanced by due attention to building healthy societies.

The aim of this article is to stimulate submissions to this new interdisciplinary journal that advance research, knowledge translation and policy innovation on the challenges facing health policy in a rapidly transitioning region. The article begins by setting out the changing health needs of the region. Rising health care costs, as a result of population growth, demographic shifts and technological developments, for instance, are creating new fiscal pressures. Changing lifestyles, labour patterns and dietary practices are resulting in complex epidemiological shifts in patterns of health and disease across different population groups. Given a diversity of health needs across the Asia and the Pacific region, how should countries adapt their health policies accordingly? Furthermore, in an era of globalisation, where many health determinants, risks and outcomes cannot be geographically confined, health policies have local, regional and even global implications. This article reviews the challenge of balancing domestic needs and global change, a challenge especially acute in the Asia and the Pacific region. How should health policy in the region adapt to the porousness of national borders, and to the intensification of crossborder and transborder flows?

Given the above, the article then discusses the need for building effective health governance in the region. Historically, public policy has comprised distinct realms, with economic policy cast as a generator of monetary benefits (production), and social and environmental policies as largely costs (consumption). As a result, the latter can often be seen as competing with economic goals, such as employment generation, resource extraction, foreign investment and trade liberalisation. Since the late 1990s, however, there have been efforts to promote the closer integration of economic and health policy, as highlighted by the World Health Organization (WHO)'s Commission on Macroeconomics and Health led by Jeffrey Sachs (WHO 2001). The report and follow-up have helped stimulate increased investment in health development assistance, as well as global health cooperation. As the Asia and the Pacific region seeks to address changing health needs, what forms of institution building are required to underpin such efforts? How can more integrated policies be adopted and implemented to enable countries, at different stages of development, to build healthy societies? The article concludes by calling for submissions that advance health policy in the region in ways that address these key questions.

2. Changing Health Needs in the Asia and the Pacific Region

Over the past four decades, the rapid pace of economic change in Asia and the Pacific has been directly reflected in patterns of health and disease in the region. Given limitations in the availability of standardised and longitudinal data, including variation in the geographical definition of 'Asia and the Pacific', assessing health trends in detail by specific population groups over time remains an analytical challenge. Nevertheless, there is clear evidence of an equally rapid 'epidemiological transition' in the region, posing major challenges for health policy in terms of responding to changing health needs.

Akin to overall economic trends in the region, basic health indicators show marked improvements as a whole, spurred by rising wealth, higher living standards and better education across the region. Life expectancy at birth in 22 Asian countries (excluding the Organisation for Economic Co-operation and Development (OECD) members Australia, Japan, New Zealand and South Korea) was 72.2 years in 2010, an increase of more than 15 years from 1970. This compares favourably

with a 10-year increase among the 34 advanced economies of OECD countries to 80 years in 2010. Similarly, infant mortality rates were halved in the region between 1980 and 2010, declining to 26 deaths per 1,000 live births. This rate still remained six times the OECD rate of five deaths per 1,000 live births. The under-5 mortality rate (U5MRs), another important health indicator, as well as the development and well-being of a population, showed a sharp decline from around 100 deaths per 1,000 live births in 1980, to 32 deaths in 2010. Finally, maternal health has also improved significantly, with the maternal mortality ratio reduced by more than half the 1990 levels (OECD/WHO 2012, pp. 12–18).

While the region has achieved remarkable strides in basic health indicators, these headline trends obscure considerable variation across populations in terms of progress. A significant regional divide persists in life expectancy at birth, ranging from more than 80 years in high income countries, such as Japan, Singapore and Australia, to less than 65 years in Papua New Guinea (PNG), Cambodia, Myanmar and India. Interestingly, Vietnam and Japan have higher, and Brunei and Malaysia have lower life expectancies, than would be predicted by their GDP per capita alone. This suggests the need to better understand what other factors, in addition to wealth, contribute to longevity. A similar pattern of inequality can be found for infant and U5MRs. Geographically, infant mortality is lower in East Asian countries, and higher in South and Southeast Asia. Singapore, Japan, South Korea and Australia had rates lower than five deaths per 1,000 live births in 2010, whereas rates in Pakistan, Myanmar, India, PNG, Cambodia, Laos and Nepal had rates greater than 40. Inequalities also exist within countries, with the richest population quintile gaining access to key health interventions quicker than the poorest quintile. The difference in the U5MRs between the poor and rich is significant. For example, in India, children in the poorest 20 per cent of the population are three times more likely to die before their fifth birthday than those in the richest 20 per cent. In recent decades, the WHO (2008a) reports that no country for which trend data are available has managed to reduce inequalities while reducing child mortality. Overall, only four out of 43 economies in the region had reduced their U5MRs or child mortality rates to one third of 1990 values by 2010, and 28 economies are not expected to meet the Millennium Development Goal target by 2015.

Another important measure of the region's health is changing causes of death and disability, and their broad determinants, with variations illustrating the links between economic and epidemiological transition. The average mortality rate from all causes in 20 Asian countries in 2010 was 90.2 per 1,000 population, around twice the rate of OECD member states (OECD/WHO 2012, p. 18). For high income countries (e.g. Singapore, Hong Kong, Korea), the epidemiological transition is in full swing, and we see a clear shift from communicable to non-communicable diseases (Khoo & Morris 2012). In low and middle income countries, a 'double burden' is being faced of both communicable to non-communicable diseases (e.g. India, China). The Asia Pacific Cohort Studies Collaboration (2007) collected nationally representative data for 14 out of 40 countries (89 per cent of the region's population) and confirmed that excess weight, once predominantly considered a western disorder, is now a significant problem in many low and middle income countries in the region. There remains much debate about the factors contributing to upward trends in overweight and obesity in the Asia-Pacific region. Economic development, typified by greater consumption of dietary fat and animal products, and more sedentary lifestyles, has been cited as contributing to the increasing prevalence of obesity.

In a further set of lower income countries, communicable diseases continue to exact a heavy toll (Bandara 2005). In 2009, the highest prevalence of HIV among 15- to 49-year-olds was in PNG (0.9 per cent), and in Southeast Asian countries: Thailand (1.3 per cent), Myanmar (0.6 per cent), Cambodia (0.5 per cent) and Malaysia (0.5 per cent). Access to antiretroviral drugs for the population with advanced HIV infection is highest at over 50 per cent in Brunei, Laos, PNG and Thailand.

Table 1 Importance of 10 Causes of Death in Asia and the Pacific (1990–2010)

	A	B	C	D	E	F	G	H	I	J
High income Asia Pacific	2	5	1	4	3	9	7	6	8	10
Australasia	1	14	3	2	5	18	28	25	4	6
East Asia	2	9	1	5	8	14	6	22	13	4
Southeast Asia	4	3	1	15	20	11	18	33	31	5
Oceania	5	1	8	45	22	12	21	31	50	19

Key: A—ischaemic heart disease; B—lower respiratory infections; C—cerebrovascular disease; D—trachea, bronchus and lung cancers; E—self-harm; F—cirrhosis of the liver; G—liver cancer; H—stomach cancer; I—colon and rectum cancer; J—road injury.

Source: Compiled from Lozano *et al*. (2012), figure 9.

The incidence and prevalence rates of tuberculosis and the death rates associated with it declined in most of the region's economies. However, in the Marshall Islands and some Central and West Asian economies, the incidence of tuberculosis is higher in 2010 than in 1990. Although the incidence of malaria remains high in many of the region's economies that have data available, the death rates associated with malaria in 2008 were generally low, at less than 7 per 100,000 population, except in Myanmar and the Pacific. The Global Burden of Disease Study (1990–2010) confirms the links between economic and epidemiological trends in countries defined as high income Asia Pacific, East Asia, Australasia, Southeast Asia and Oceania (Table 1).

One disease risk that populations across the region, and indeed globally, may be at shared vulnerability are zoonoses (diseases transmitted from animals to humans). There is evidence suggesting that risks from emerging and re-emerging diseases have increased as a result of intensified population mobility, population density, environmental degradation, socioeconomic inequalities and changing lifestyles. For example, closer human habitation near domesticated and wild animal populations has resulted in increased risks from zoonoses (Bhatia & Narain 2010). Around 60 per cent of human pathogens are zoonotic, with more than 800 pathogens identified to date as causing zoonoses. More than 30 new pathogens have been identified in the past three decades, including severe acute respiratory syndrome (SARS) and Nipah virus, 75 per cent of which are zoonotic. Other zoonoses are emerging, that is, increased in incidence in the recent past or likely to do so. Potentially pandemic influenza viruses, notably H5N1 of avian origin, pose a serious risk to human health worldwide. The Asia-Pacific region is especially vulnerable to zoonoses because of the diversification of farming systems (intensified farming and animal husbandry methods); extensive antimicrobial use and resultant resistance; rapid urbanisation and industrialisation; changing food habits and lifestyles; deforestation; increased population mobility; increased trade, including illicit trade of wildlife; and environmental degradation, including animal habitats. The coming together of these factors, it is believed, is causing the region to be the epicentre of emerging and re-emerging zoonoses. As Bhatia and Narain (2010) write, 'Asia is now widely believed to be the epicentre of some of the most important infectious diseases that are of stupendous global public health importance'. Two of three influenza pandemics that occurred during the twentieth century originated in Asia. SARS, Nipah virus and H5N1 all originated in Asia.

Zoonoses illustrate the dual challenge of development and underdevelopment amid globalisation in the Asia-Pacific region. Poverty, accompanied by poor housing, close and continuous coexistence of human and animal populations, and weak public health infrastructure, has increased the vulnerability in the Asia Pacific to the emergence and spread of zoonotic infections. These risks pose local, regional and global threats to human health. As Bhatia and Narain (2010, p. 388) write, there is a clear need for 'a multisectoral and multidisciplinary approach to prevent and control zoonotic diseases'. Moreover, zoonoses pose a

serious economic risk to the region, in the form of direct impacts to the animal husbandry sector, and more widely to businesses hurt by decreases in trade, tourism and other travel to the region.

Overall, there is a wide diversity of health needs across Asia and the Pacific, as countries find themselves at different stages of the interrelated processes of industrialisation, urbanisation and globalisation. This has produced different patterns of health and disease, between countries and among populations within countries, with varying trajectories and levels of resources to address them. The 'double burden' faced by the region's poor, with populations suffering rapidly rising rates of non-communicable diseases at the same time as communicable diseases rates remain persistent, poses particular pressures (Lozano et al. 2012). How will countries adapt their health policies to tackle this shifting burden of disease? How does health policy need to link with economic policies shaping the broader context of these epidemiological trends?

3. Health Policy in a Globalising Region: Balancing Domestic Needs and Global Change

Health care systems worldwide routinely face the difficult task of reconciling unlimited demands with limited resources. Phua and Chew (2002, p. 11) define health care transition as 'the process of organised collective action to promote health and prevent disease in response to changing demographic, epidemiological, and socioeconomic conditions'. The search for effective ways to deliver appropriate health care services, and sustainable financing mechanisms to pay for them, has prompted a wide variety of health care reforms in recent decades (Twaddle 1996; Mushlin & Ghomrawi 2010). This task is rendered even more complex in the early twenty-first century by the impacts of factors and processes that lay beyond the capacity of national governments to address independently. Health policy, in this context, faces new challenges. An intensification of population movements, trade of goods and services, capital and labour flows, technological change, and environmental degradation, for example, are contributing to crossborder, and even transboundary (deterritorialised), flows of health determinants and outcomes (Lee et al. 2011).

In Asia and the Pacific, these challenges are particularly acute given the region's location at the crossroads of contemporary globalisation. At the national level, the diversity of countries, their historical trajectories, demographic composition and corresponding health needs of their populations are inevitably reflected in the development of different health care systems (Chongsuvivatwong et al. 2011). Collectively, however, there are also shared challenges. Ageing populations, an expanding middle class and technological advances will require adaptation of health care services, while needing to control already rising costs. The region's health care market was worth US$370 billion in 2012 and is expected to reach US$752 billion by 2018, growing more than twice the growth rate globally. Furthermore, health disparities and inequities abound across the region, and any changes to health care financing and service provision will impact affordability and access. The region already has the world's highest levels of dependence on out-of-pocket expenditure to finance health services. For high income countries experiencing economic growth, governments have the opportunity to redress this balance with prepayment and risk-pooling (e.g. tax-based financing, compulsory social insurance), both of which improve access to health services. For emerging economies, the transition from aid recipients also offers opportunities to shift, from the fragmentation often caused by the presence of multiple providers and donors, to a more comprehensive and unified system of health financing. For low income countries, resource constraints remain the key challenge, which may be overcome by the reallocation of donor support to populations in greatest need, and the strengthening of regional approaches. For all of these reasons, there is now substantial interest in strengthening health care reform across Asia and the Pacific (Ensor 1999; Ho & Gostin 2009). Grappling with the health needs of domestic populations will be essential, but

this will not be possible without clear attention to transboundary factors shaping this rapidly globalising region.

3.1 Population Mobility and Health Policy

As well as being the most populous region in the world, with over 4.2 billion people in 2010 (UN 2011), Asia and the Pacific has seen intensified population mobility within the region, and between the region and the rest of the world. The number of people on the move, frequency of travel and the geographical distances crossed are all greater than ever before (Hugo 2005). Major (somewhat overlapping) trends in population mobility, associated with the region's economic transition, include the following:

Large-Scale Urbanisation
In 2010, 43 per cent of the Asia and the Pacific population lived in urban areas, the second lowest urban proportion of a region in the world. Since 1990, however, the urban proportion has risen by 29 per cent, more than any other region. Twelve of the world's 23 megacities (cities with at least 10 million people) are found in Asia, with Asia predicted to have 21 megacities by 2025.

Labour Migration
More than three million workers in the region leave home to work in another country, joining some 25 million who are already abroad. Most remain within the region, representing a wide spectrum of skills and occupations. The estimated stock of Asian migrant workers abroad was 41.4 million in 2008 (UNDP 2010). Many countries in the region (e.g. Singapore) also depend on foreign labour forces to offset population ageing, secure new expertise and talent, promote entrepreneurship, and develop markets abroad.

International Migrants
During the 1970s and 1980s, outward migration from Asia for permanent or semi-permanent settlement grew dramatically, with the main destinations being North America, Australia and the oil economies of the Middle East. Since the 1990s, migration within Asia has grown, particularly from low income countries with labour surpluses, to fast-growing newly industrialising countries. While many countries now experience substantial emigration and immigration, it is possible to differentiate between mainly destination countries (Brunei, Hong Kong, Japan, Singapore, South Korea, Taiwan), countries with both significant immigration and emigration (Malaysia and Thailand), and mainly source countries (Burma, Cambodia, China, Indonesia, Laos, Philippines and Vietnam) (Castles & Miller 2009). The estimated number of individuals from the region emigrating to a country outside their birth was 31.5 million in 2010 (International Migration Organisation 2011).

International Tourism
Tourism is experiencing significant growth in the region, which accounted for 22 per cent (910 million) of the world's inbound arrivals in 2010. Outbound departures grew by 5.5 per cent per annum between 2005 and 2009 (UN 2011). Tourism has become an important engine of development for some economies, especially in the Pacific (e.g. Palau, the Cook Islands, the Maldives, Vanuatu and Samoa).

International Students
There were 2.7 million students studying abroad in 2011 worldwide, with the OECD predicting growth to eight million by 2020. Around 42 per cent of international students come from Asia, with a strong presence of students from China, Korea and Japan continuing. However, Singapore, Malaysia and China/Hong Kong are becoming 'education hubs', seeking to attract millions of students to the region in the coming decades (Kell & Vogle 2012).

International Retirement Migration
A growing number of individuals from outside and within the region, who are seeking an affordable place to retire and/or purchase an additional home, are migrating abroad. By the middle of this century, Asia's elderly population is projected to reach 922.7 million,

representing 17.5 per cent of the population, an increase from 4.1 per cent in 1950 (Asian Development Bank 2009). International retirement migration is predicted to be a significant migration trend for the region in the coming decades, accompanied by the migration of caregivers and service providers for the elderly (Jones 2008).

Irregular Migration

Data on 'undocumented' migrants, those travelling without official permission, are limited and likely to underestimate true numbers. This category includes overstaying foreign visitors and workers, and trafficked and smuggled persons. Asia and the Pacific has especially high levels of undocumented migration, numbering in the millions, believed to exceed official migrants, due to strict migration laws in the region especially against unskilled labour (Hugo 2005).

The intensification of population mobility in the region raises a range of health policy challenges. Much analysis to date has focused on migration as a 'vector of disease' (e.g. HIV/AIDS and migrant workers) or as a 'cash cow' to fuel a booming, largely private, health care industry (e.g. medical tourism). While these policy issues are valid, there is an urgent need to address more fully the complexity of contemporary migration patterns in Asia and the Pacific, and the health issues arising from them. There is a persistent public perception, for example, that migrants are disease carriers or pose a disproportionate burden on the health care systems of host countries. Evidence shows that migrants are, in fact, generally younger and healthier than host populations, underutilise health care services in their destination countries, and in the case of migrant health care workers contribute positively to local health needs (Calderone et al. 2012). Similarly, the migration of health care workers, and increasingly patients, requires a regional policy framework. The concerns about 'brain drain' are legitimate for some countries, but other countries, such as the Philippines, engage in the strategic export of health workers as a source of employment and remittances. Medical tourism (worth US$100 billion worldwide) is a major growth market in Asia and the Pacific, driven by both supply and demand, but there is a need to develop regulatory measures to ensure mutual benefits for host and migrant populations, as well as clinical appropriateness and quality of care (Tungsuwan 2013).

Zimmerman et al. (2011) offer a policy framework that accounts for a fuller range of health issues arising from migration in the twenty-first century. With an estimated 214 million people on the move internationally, and approximately three quarters of a billion people migrating within their own countries, the framework considers the full experience of each migrant (pre-departure, journey, arrival and return), as well as health issues arising for host and home communities. In this way, migration and health are seen as a collective action problem, challenging countries to approach the issue as a shared one that offers both costs and benefits. Calderone et al. (2012) draws similar attention to the need to 'move the policy discourse on migration health' in the Asian region in five ways: conduct a review of labour, migration and health policies at the national level; designate migration health focal points to coordinate policy and program responses; pursue bilateral and regional dialogue and cooperation, including agreements and information-sharing mechanisms; standardisation of data; and incorporation of migrants' views into policy formulation and program implementation. Importantly, addressing migration and health policy, strictly as an 'at the border' immigration issue, is largely obsolete in a hyper-globalised region. If population mobility is recognised as a core and desirable feature of the region's transformation, then health policy must become more closely aligned with economic, labour, education and transport policies.

3.2 Trade and Investment for Health in Asia and the Pacific

Trade has played a central role in the economic transformation of the region, and indeed the world economy, in recent decades. Asia and the Pacific accounted for 34 per cent of the

total world exports of merchandise goods in 2011, compared with 25 per cent in 2001. As measured by the ratio of merchandise exports to GDP, the regional dependence on trade increased from 11 per cent in 1990 to 31 per cent in 2011. Imports increased from 25.1 per cent in 2002 to 34.7 per cent in 2011. In contrast, the shares of Europe and North America in world merchandise exports for the period 2002–2011 dropped from 43.6 per cent to 36.1 per cent and 14.6 per cent to 10.6 per cent, while the share of imports declined from 41.1 per cent to 36.1 per cent and 21.2 per cent to 14.9 per cent, respectively. Intraregional trade is also high, with more than half of exports in 2011 going to economies within the region. Foreign direct investment (FDI) increased from US$351 billion in 2009 to US$431 billion in 2010. In 2010, the major sources of FDI outflow in the region were China, Japan, the Russian Federation and Hong Kong, China. Collectively, in 2010, they provided almost one fifth of the world total FDI outflow. All of these indicators have been negatively affected by the global financial crisis since 2008, but the region is predicted to recover relatively strongly (UN 2012). This frenetic activity has been spurred by the proliferation of trade agreements in the region, with prospects for further liberalisation under the proposed Trans Pacific Partnership between the United States and 10 Asian and Latin American countries (Dent 2006).

Within this dynamic trade and investment environment, to date health policy has been given insufficient consideration. The negative effects of major disease outbreaks, such as SARS and pandemic influenza, on the region's economy have attracted considerable concern within the business community (Brahmbhatt & Dutta 2008). There has been less of a perception of shared interests, however, in addressing the links between trade and the alarming rise in non-communicable diseases (NCDs). Trade and tobacco control policies, for example, have had a checkered history, beginning with the forced opening of Asian markets to transnational tobacco companies (TTCs) by the US Trade Representative from the 1980s (Mackenzie & Collin 2012). The targeting of the region by TTCs ever since has been well documented, setting the region up for an escalation in death and disease from tobacco-related diseases in the coming decades (Knight & Chapman 2004). The Western Pacific region now accounts for 48 per cent of world cigarette consumption (WHO).

The health consequences of other products, notably food and drink, are less well understood, in part because of a lack of regional data on the burden of NCDs; causal factors for this burden; methods of prevention, patient treatment and care; and knowledge about policy implementation (Ebrahim et al. 2013). Yet it is known that rocketing rates of NCDs have coincided with globalisation. For example, Pacific Island countries have among the world's highest rates of obesity (75 per cent) and diabetes (47 per cent). This phenomenon has been attributed, in large part, to a shift from traditional diets to reliance on highly processed foods of poor nutritional value, many of which are imported (Parry 2010). Lack of regulation, consumer information and education facilitate this trend.

Trade and investment in health-related goods and services is another area of policy concern. A more prosperous Asia and the Pacific represents lucrative opportunities for market growth for pharmaceutical and biotechnology companies, health insurers, medical equipment manufacturers, and e-health providers. In the pharmaceutical industry, these trends are especially notable. Four of the largest global pharmaceutical companies—Pfizer, Novartis, Sanofi and GlaxoSmithKline—already earn a third of their revenues outside of their traditional markets. Domestic pharmaceutical companies in Asia are consolidating and expanding outside their home bases, competing with 'Big Pharma' for the region's markets. For example, by 2016, China is expected to leapfrog Japan to become the world's second largest pharmaceuticals market, with sales of around US$160 billion, while Indonesia will become the sixth largest (Jones Lang LaSalle 2011).

The impact of trade liberalisation on access to medicines has been a subject of concern to non-governmental organisations (NGOs), such

as Oxfam, since the 1990s. With the continued lull in multilateral trade negotiations, under the World Trade Organization, NGOs argue that the new forms of intellectual property rights affecting essential medicines, beyond measures under the Agreement on Trade-Related Aspects of Intellectual Property, are being adopted under bilateral and regional trade negotiations (Oxfam International/Health Action International 2009). This, in turn, is believed to harm access to medicines by the poor.

The realm of trade and health, in short, is a direct meeting place for economic and health policy. To date, the former has taken precedent over the latter as governments have prioritised integration with the world economy. The hitherto focus on behavioural change appears to be somewhat misplaced without appropriate attention to the structural factors. As Gill (2006, p. 9) writes, 'numerous and diverse factors, including environmental and social factors, influence behaviours that in turn can lead to excessive weight gain'. Rapid economic transition, in particular, appears to represent 'the most likely cause for the increase in population weight in Asia'.

The public health community has been a virtual non-participant in trade negotiations, with efforts to assert the importance of health policy constrained by a lack of transparency, resources, technical expertise and regulatory frameworks. The challenge for the region in the coming decades, in the face of an alarming human toll from NCDs, is how the region's growth can take a healthier trajectory. Improved data and analyses are needed to inform the best use of regulatory measures, such as labelling, taxation and social marketing. For example, a report by the Asian Development Bank (2012) found that increasing tobacco pricing through taxation by 50 per cent in the five highest burden Asian countries would reduce users by almost 70 million and tobacco-related deaths by almost 30 million. Higher taxes would also generate tax revenue average of 0.30 per cent of GDP (US$24 billion per year), enough to cover the direct medical costs of treating tobacco-related illnesses.

4. Building Effective Health Governance in Asia and the Pacific

Asia and the Pacific has been largely depicted as a major source of global health 'threats', in the form of disease outbreaks or tainted products, such as illicit drugs, counterfeit cigarettes or medicines. More recently, the region has been understood in relation to the concept of 'vulnerability' defined by Woodward et al. (1998) as sensitivity to displacement (resistance) and adaptation (or resilience). The two are closely linked. Like the upheavals of the Industrial Revolution, the large-scale changes created by contemporary globalisation have made some human populations vulnerable to broad determinants of ill health. The resultant human health risks, in turn, risk becoming deterritorialised by globalisation.

Casting the region as either 'villain' or 'victim', however, is unhelpful for encouraging regional institutions to take collective action to manage globalisation. Global governance is premised on the notion that, in a world in which social relationships are increasingly detached from physical geography—affecting our material existence, own identities and perceived interests, and our impacts on the social and natural worlds—institutions that serve our collective needs must also evolve as political entities. How can the human species evolve politically to meet these collective needs fairly and sustainably? Can the governing of societies' transition, from a world of 194 'pieces of land' each governed as self-interested sovereign states, to a deterritorialised world of global citizens enabled by institutions to tackle shared problems?

It is within this higher order question that the challenges facing health policy in Asia and the Pacific can be located. So far, the region has played a hesitant role in global health governance, in part, because of ambiguities towards existing institutions. The United Nations, along with initiatives such as the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria, is seen as historically dominated by the US and European countries. Major charitable foundations, led by the Gates Foundation, are western in origin. NGOs have a

varying presence across Asia, and in general limited role in health policy. Finally, the study of global health governance remains in its infancy within the region. In North America and Europe, global health now permeates academic research, medical education and training, policy initiatives, and funding bodies. There are signs of possible change. China, India and South Korea have joined Japan as donors of health development aid, albeit with a strong preference for bilateral rather than multilateral channels. Academic initiatives have begun to seed, including global health institutes in China, Taiwan, Japan and Singapore. The region is also the locale for policy innovation on NCDs as demonstrated by the leadership of Australia, Thailand and India. And Asia and the Pacific has ambitions to be a major producer of health-related goods and services in the coming decades, thus requiring deeper engagement with global health governance issues, such as intellectual property rights, regulation and approvals (Lee et al. 2012).

The lack of consensus about what role the region should play in managing transboundary health problems, and thus which institutions work best, continues to hinder the building of regional institutions. Regional cooperation is relatively limited compared, for example, with the Americas (led by the Pan American Health Organization) or Europe (with a growing role of the European Commission in regional public health issues). There are two WHO regional offices operating across Asia and the Pacific, raising concerns about coordination, alongside long-standing questions about the organisation's waning global authority (Lee 2008). There are signs of closer regional cooperation around specific disease threats (e.g. pandemic influenza), focused on surveillance, monitoring and reporting. Increased integration might also be achieved through compliance with agreements such as the International Health Regulations of 2005 (WHO 2008b), which requires governments to build capacity to report public health emergencies of international concern. Regional efforts to adopt the One Health approach to zoonoses, integrating the governance of human, animal and environmental health, offer further opportunities (Lee & Brumme 2012). The Asian Development Bank and ASEAN have limited, albeit growing, health interests and expertise. What institutional structures and processes are needed to facilitate health policy across such a diverse region? How can health policy be integrated more effectively with other policy realms? What might health policy look like at different levels of authority and function, and across them, to ensure the best outcome for meeting health needs in the region and beyond? What are the strengths and weaknesses of existing arrangements, and what is needed?

5. Conclusions

The aim of this article has been to stimulate submissions on health policy in Asia and the Pacific with particular recognition of (i) the health needs of a region in rapid transition, (ii) the specific challenges of globalisation, and (iii) the need to strengthen collective action within and across countries to protect and promote population health. There is little doubt that Asia and the Pacific is undergoing a historic transition, with countries in the region expected to overtake North America and Europe to become leading economies during the twenty-first century. How will the health of populations in the region fare in this process? What role should health policy play, not only in protecting and promoting health in the region, but as part of broader public policy debates about economic and social development.

In this sense, the establishment of a new regional public policy journal on public policy is an opportunity for new research on the impacts on human health resulting from rapid transition, knowledge translation for addressing those impacts, and policy innovation to bridge health policy and other policy realms. The latter might draw on a promising shift by a growing number of governments towards measuring and monitoring national well-being at the individual and population levels. The concept of well-being has been developed as a response to the limitations of economic indicators, such as GDP, as a

measure of a society's success and progress (UK Parliamentary Office of Science and Technology 2012). Definitions of well-being have varied, but the approach is stimulating new approaches to defining and measuring economic and social goals, and how to achieve them. The application of such an approach in the Asia and the Pacific region is both timely and urgent.

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