Chapter 1. Governing complexity: The regional health architecture in Asia

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1.1   Introduction

In today's increasingly globalized world – characterized by the extensive movement of people, goods and services, capital and ideas across national borders (Kruk, 2012) – a wide range of transborder health threats, such as emerging and re-emerging infectious diseases, rising rates of noncommunicable diseases (NCDs) and spreading antimicrobial resistance (AMR), emphasize the need for collective action to promote and protect population health (Lee, Pang and Tan, 2013; WHO, 2002). New forms of collaboration are particularly important given that the social, economic, political and commercial determinants of health reside outside of the health sector. Within this transnational and cross-cutting arena, the efforts of governments or other relevant actors to steer collective action to address health and its determinants through whole-of-government and whole-of-society approaches constitute "governance for health" (Kickbusch and Gleicher, 2012). In this context, governance is diffused from a State-centred model to a collaborative one, and is influenced by a wide array of State and non-State actors, at times with competing interests and different approaches (Kickbusch and Gleicher, 2012). Spanning across multiple sectors, from governmental to private for-profit organizations, these actors may operate at the global, regional, national or subnational level (Szlezák et al., 2010).

Governance for health at the regional level has the potential to enhance coherence across national health policies, to shape and coordinate broad multicountry health initiatives, and to align domestic needs with global commitments (Kickbusch and Szabo, 2014; Riggirozzi and Yeates, 2015; Yeates and Riggirozzi, 2015). In this regard, effective governance can harmonize the agendas of various stakeholders and coordinate their actions. These actors can also participate in global governance for health by, for instance, contributing to agenda-setting and shaping global norms (Kickbusch and Szabo, 2014). The process of regionalizing health cooperation – which we define as the establishment of formal or informal arrangements for public health cooperation at the regional level (Liverani, Hanvoravongchai and Coker, 2012; Riggirozzi and Yeates, 2015) – was influenced by the World Health Organization (WHO), which has operated through a decentralized system of six regional offices since its establishment in 1948.

Being home to more than half of the world's population, Asia presents a breadth of economic, political, social, cultural and geographical diversity both across and within countries, associated with different health and development challenges (Lee, Pang and Tan, 2013). Nonetheless, important public health concerns are shared across Asian countries, particularly in subregional contexts (Lamy and Phua, 2012a & 2012b; Liverani, Hanvoravongchai and Coker, 2012 & 2013; Nodzenski et al., 2016; Pang, 2016; Thomas, 2006). For example, geographical areas in East and South-East Asia have been particularly vulnerable to transnational health threats, such as severe acute respiratory syndrome (SARS), dengue and highly pathogenic avian influenza H5N1. This shared vulnerability has encouraged the development of regional surveillance and response programmes (Liverani, Hanvoravongchai and Coker, 2012). Furthermore, regional programmes for political and economic cooperation have provided the institutional bases from which public health programmes can be developed and implemented (Liverani, Hanvoravongchai and Coker, 2012). Examples of such institutional venues include the Association of Southeast Asian Nations (ASEAN) and the South Asian Association for Regional Cooperation (SAARC).

This chapter gives an overview of these developments in regional governance for health in Asia, with specific examples and case studies from different contexts and health sectors. The chapter begins with a broad introduction to the regional health architecture – which we define as the group of actors with a primary intent to improve health by addressing common threats in the region, and the governance, financing and delivery arrangements in which these actors operate (Hoffman, Cole and Pearcey, 2015) – describing the key groups of actors and examples of existing frameworks for regional health cooperation. In the first part of the chapter, the case of ASEAN is discussed in-depth to illustrate institutional challenges to, and opportunities for, regional cooperation in Asia. The case of communicable disease governance in Asia is then presented to shed light on the wider governance dynamics in the region using infectious diseases as one of the policy tracers. Key achievements of, opportunities for and challenges to governance for health in Asia are discussed, following which we comment on the potential for the region to engage in and contribute more broadly to global governance for health.

1.2 The need for collective action to manage transboundary health problems

Despite marked improvements in health indicators, many Asian countries face significant challenges, particularly in the context of rapid demographic and epidemiological transitions and the associated "double burden" of communicable diseases and NCDs, and an ageing population (Chongsuvivatwong et al., 2011; Narain and Bhatia, 2010; Nodzenski et al., 2016). Emerging and re-emerging infectious diseases are a key concern due to population movements, both intra- and cross-boundary, high-density urbanization and climate change, as are persisting inequalities in health outcomes (Chongsuvivatwong et al., 2011). Furthermore, the process of trade liberalization has seen the spread and growth of Asia's tobacco, alcohol and ultra-processed food manufacturers, associated with an increase in risks to health throughout the region (Baker, Kay and Walls, 2015). For example, China has witnessed a rapid increase in per capita alcohol consumption, from approximately 3 litres of pure alcohol in 2004 to just under 5 litres in 2009, alongside a steady rise in the production of alcoholic beverages (Tang et al., 2013). Asia is also vulnerable to natural and anthropogenic disasters, particularly in the South-East region, such as earthquakes, typhoons, floods, as well as other problems that affect health such as environmental pollution (Chongsuvivatwong et al., 2011). In recognition of the transnational nature of these threats, mechanisms to promote regional health cooperation and coordination have been established. While regional governance mechanisms already existed for other areas of public policy in Asia, health emerged as a new item on the agendas of national authorities and international organizations, particularly following the SARS and H5N1 outbreaks in 2003 and 2004, respectively, which demonstrated that health threats can have severe impacts on economic growth and stability (Nodzenski et al., 2016). For example, the World Bank estimates that the 2003 SARS outbreak cost the global economy US$ 54 billion (Jonas, 2013).

1.3 The regional health architecture

As discussed in the introduction, the regional health architecture consists of the actors who seek to address common health threats and their determinants in Asia, and the arrangements that shape their interactions

(Hoffman, Cole and Pearcey, 2015). In particular, central to the regional architecture are national governments (including ministries of health and other bodies such as ministries of finance), regional and non-regional donors, international organizations such as the WHO, civil society organizations (CSOs), private foundations, global health partnerships and for-profit private sector actors. There is, however, a lack of consensus among stakeholders as to how collective action to address transnational health problems should be supported and steered; indeed, regional health cooperation has been relatively limited in Asia as compared to, for example, the Americas with the Pan American Health Organization (PAHO) or Europe with the European Commission (Lee, 2013). In the following sections, we provide an overview of these different actors and their roles in regional governance for health.

1.3.1 WHO regional offices

WHO is central to the health architecture in Asia and its efforts are spearheaded by the Regional Office for South-East Asia, the Regional Office for the Western Pacific and the Regional Office for the Eastern Mediterranean. The regional offices are broadly composed of WHO Member States representing one geographical or cultural area; however, the particular composition of each region has changed over time as a result of historical political divisions between Member States (Fee, Cueto and Brown, 2016). For example, due to the enduring conflict between Pakistan and India, Pakistan joined the Regional Office for the Eastern Mediterranean despite its geographical proximity to the Regional Office for South-East Asia (Fee, Cueto and Brown, 2016). While carrying out much of WHO's programmatic work and ensuring coordination and coherence with the Organization's global policy objectives, the regional offices also maintain a certain autonomy, working according to their own health agendas through the resolutions and decisions of their respective regional committees (Youde, 2012). Although improved recently, cooperation between WHO regional offices had been a challenge in Asia due to the historical split of regional clusters into separate WHO regional offices soon after the Second World War. The division of offices and bureaucratic rigidity hindered regional collaboration and have contributed in part to fragmentation across health programmes (Chongsuvivatwong et al., 2011; Liverani,

Hanvoravongchai and Coker, 2012). Despite these challenges, the WHO regional offices play an important role in providing normative guidance and technical support to Member countries, as well as facilitating the formulation of policy and regulatory mechanisms in the region.

WHO also established the Asia Pacific Observatory on Health Systems and Policies (the APO) in 2011, a multisector partnership that is active in the region in terms of country-level policy development, health systems research and evidence generation, as well as strengthening of health systems capacity (APO, 2018). There are signs of growing regional cooperation around particular disease threats, such as pandemic influenza, focused on surveillance, monitoring and reporting (Lee, 2013). Indeed, the effective implementation of WHO's International Health Regulations (IHR) (2005), which require governments to build and strengthen their capacities to prevent, report and respond to public health risks of international concern, could also facilitate improved integration and coordination at the regional level in Asia (WHO, 2005).

1.3.2   ASEAN as an example of a regional health forum

Beyond national governments and WHO and its regional offices, the health architecture in Asia has seen a proliferation of actors from the health sector and beyond. In particular, health cooperation has featured on the agendas of several regional organizations in Asia, albeit to varying extents, including, for instance, the Asian Development Bank (ADB), the Asia Pacific Economic Cooperation (APEC) forum, SAARC, the Shanghai Cooperation Organization and ASEAN (Caballero-Anthony and Amul, 2014).

In South-East Asia, for example, ASEAN has emerged as a key institutional actor in the regional health architecture, with particular influence in convening national governments for negotiation and consensus-building for health (Nodzenski et al., 2016). Established in 1967 as a coalition of five countries in South-East Asia – Indonesia, Malaysia, Philippines, Singapore and Thailand – ASEAN aims to promote regional peace and stability, as well as political, economic and social cooperation among its members (ASEAN, n.d.-a). Since its establishment, the organization has progressively grown to include ten countries from South-East Asia, and has engaged deeply with neighbouring countries such as China, Japan and

the Republic of Korea in what is known as the ASEAN Plus Three process. While health was not a priority of ASEAN in the early history of this organization, after the SARS outbreak in 2003, public health has featured more prominently on ASEAN's agenda (Liverani, Hanvoravongchai and Coker, 2013). The 2007 ASEAN Charter was particularly influential in generating political momentum for public health as it established the Socio-Cultural Community (ASCC) pillar, which supports ASEAN's health-related programming (Nodzenski et al., 2016). However,regional health cooperation has largely focused on infectious diseases, whereas NCDs and health systems strengthening, for instance, have historically received less attention and fewer resources (Caballero-Anthony and Amul, 2014; Lamy and Phua, 2012).

Despite much promise for improved regional governance for health, previous ASEAN frameworks for health cooperation, such as the Strategic Framework on Health and Development (2010–2015), saw very few programmes being implemented on the ground (Lamy and Phua, 2012). Low-level institutionalization and a lack of funding (often with reliance on donor funding) and technical expertise are key barriers to effective collaboration across member states (Nodzenski et al., 2016). Indeed, without the necessary funding, other priority areas in the region, such as minimizing political conflict and maintaining regional stability (Lee, Pang and Tan, 2013), have tended to be prioritized (Liverani, Hanvoravongchai and Coker, 2012). Structural factors such as political diversity, economic inequalities and differences in operational capacity between ASEAN member countries are also barriers to effective health cooperation (Nodzenski et al., 2016). Finally, the principle of non-interference applied by the "Political and Security pillar", which is based on the primacy of State sovereignty, informs negotiations between member countries, recognition of which has led to the concept of the "ASEAN way", which involves a slow and complex decision-making process that operates by consensus (Liverani, Hanvoravongchai and Coker, 2013). Although these norms and practices can work to build trust among its members, when coupled with a lack of political integration and insufficient funding, they are thought to challenge cooperation and the design of regional health governance frameworks (Nodzenski et al., 2016).

Despite these challenges, ASEAN's re-organized Post-2015 Health Development Agenda – which was led by Thailand through a two-year negotiation aimed at improving performance of health collaboration and linking with global commitments to the 2030 Agenda for Sustainable Development – places ASEAN in a good position to take on a greater health leadership role in the region and globally. The new agenda also seeks to position its member countries in the broader global health space and to strengthen collaboration with non-regional countries and development partners (ASEAN, 2016). Moving away from a fragmented approach of more than 100 programmes and projects, the new regional health agenda is organized into four health clusters that provide strategic leadership to develop, implement, monitor and evaluate regional programmes with the aim of improved performance and effectiveness within their thematic focus areas: promoting healthy lifestyles, responding to all hazards and emerging threats, strengthening health systems and access to care, and ensuring food safety (ASEAN, 2016). Each regional project is coordinated by a lead country and co-led by another country with technical input solicited from other regional and global actors (ASEAN, n.d.-b). While non-legally binding, this new integrated governance framework may help improve health coordination and performance across member states horizontally by outlining joint health priorities and providing strategic leadership (ASEAN, n.d.-b). Progress is regularly reported to senior officials during the biannual meeting of Health Ministers. Of particular importance is the organization's recognition that health should be incorporated into all policies (ASEAN, 2016), which could encourage more policy coherence within the Socio-Cultural pillar as well as the other two pillars of the ASEAN community (Political-Security and Economic), and across initiatives in the region. At the same time, the new agenda may strengthen ASEAN's position as an intermediary between global normative frameworks such as the Sustainable Development Goals (SDGs) and national policy-making and implementation.

1.3.3 International partners

In addition to State cooperation in regional organizations such as ASEAN and the core roles of national governments and WHO throughout Asia, bilateral donors from outside of the region, such as the United States of

America (USA), Australia and the European Union (EU), have also engaged in regional cooperation. Multilateral institutions are another group of key players in the regional health architecture, such as the ADB, the Islamic Development Bank, the World Bank and the World Trade Organization (WTO). For example, the ADB has outlined health infrastructure, health governance and financing as key priority areas in their Operation Plan for Health 2015–2020, which they will support by investing in information and communications technology (ICT) and public–private partnerships (ADB, 2015).

Despite the participation of Asian stakeholders in some of these global institutions such as the WTO, researchers have argued that the region has not yet achieved the impact that it could (Fidler, 2010; Gostin, 2013; Yeling, Lee and Pang, 2012). For instance, Gostin (2013) argues that Asia could be "a global leader in fighting unfair trade rules that disadvantage the region and other resource-poor regions of the world", while Asian institutions could capitalize on political and economic power in the region to promote more equitable international trade policy and arrangements, including South–South partnerships. For example, many Asian countries have pharmaceutical manufacturing capacity – such as China, India, Indonesia, Japan, Pakistan and Thailand – which uniquely positions the region (outside of Europe and the USA) in negotiations surrounding issues of access to medicines and intellectual property rights (Gostin, 2013; Moon and Szlezák, 2013; Smith, Correa and Oh 2009). Indeed, India has emerged as a world leader in this regard as a low-priced supplier of generic medicines. The value of pharmaceutical exports from India was US$ 17.27 billion in 2017–2018 and it is the largest supplier of generic medicines globally, contributing up to 20–22% of global export volume (IBEF, 2018). In particular, India manufactures generic antiretroviral medicines, which facilitated the rapid scale up of treatment for human immunodeficiency virus (HIV) in low-resource settings, particularly in Africa (Waning, Diedrichsen and Moon, 2010). Given their leadership around intellectual property rights and access to essential medicines, coupled with their strategic position as a BRICS (Brazil, Russia, India, China and South Africa) country, India is well placed to assume a broader leadership role for South–South health collaborations that facilitate access to medicines and medical products.

A number of foundations and global health initiatives, such as the Bill and Melinda Gates Foundation and the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund), have also played important roles in financing health programmes and, in some instances, health cooperation in the region. For example, for the period 2017–2020, the Global Fund allocated over US$ 2 billion to countries in Asia, in partnership with the ADB, to support the financing, design and implementation of HIV, malaria and TB programmes, as well as health systems strengthening activities, mostly through intercountry cross-border programmes and collaboration (The Global Fund, 2017a). In addition, Bloomberg Philanthropies has been active in the area of tobacco control in Asian low- and middle-income countries (LMICs) (Mackay, Ritthiphakdee and Reddy, 2013), particularly through the Bloomberg Initiative to Reduce Tobacco Use Grants Program (Tobacco Control Grants, n.d.). However, while international funding for health and social development has been important in Asia, within ASEAN, most member states currently rely on domestic funding to support such programmes, with few exceptions, including Cambodia and Lao People's Democratic Republic. Furthermore, all middle-income countries within ASEAN have transitioned or are in the transitioning process from funding support of the Global Fund and Gavi, the Vaccine Alliance.

Key challenges have also emerged in the context of international partners' support for health and development programmes. Ensuring accountability and effective coordination of donors and donor-sponsored programmes has been a long-standing issue in Asia, as well as in other LMIC settings, at times leading to inefficient duplication of health programmes and gaps in the delivery of essential services. In Cambodia, for instance, fragmentation of donor-sponsored health programmes has been a challenge for many years, although new mechanisms have been developed recently to promote local ownership and to improve coordination between the government and international development partners (Box 1.1). The Philippines has faced similar challenges in coordinating various actors and programmes, and also offers important lessons in terms of establishing institutional arrangements, such as the Sector Development Approach for Health (SDAH) (World Bank, 2011), to ensure alignment of priorities and to harmonize activities to enhance donor and lender accountability (Box 1.2).

Box 1.1 International organizations and health sector governance in Cambodia

Following decades of turmoil and conflicts, from the early 1990s, Cambodia has engaged in a process of democratic transition and institutional reforms, which opened the country to the involvement of the full spectrum of international development actors, including regional donors such as the Japan International Cooperation Agency (JICA) and the Korea International Cooperation Agency (KOICA) and non-regional donors such as the United States Agency for International Development (USAID), Department of Foreign Affairs and Trade (DFAT) Australia, Department for International Development (DfID) in the United Kingdom (UK), and the Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ). In the health sector, sustained efforts have been made to improve service delivery and address health challenges and inequities, with substantive financial and technical support from international partners; it was estimated that the official development assistance (ODA) for health to Cambodia increased by 628% in the period 2000–2010 (WHO, 2010). These efforts, combined with domestic economic growth, have contributed to a general improvement in population health, especially in the areas of infectious diseases, child and maternal health. However, coordination of international donors, and between different donor-sponsored initiatives, has been a major challenge in Cambodia, at times resulting in the duplication of programmes and a lack of synergies. In addition, international organizations have tended to focus on vertical programmes in keeping with the global health agenda, but other important public health priorities in the country (such as the increasing burden from NCDs) have been neglected (Liverani, Chheng and Parkhurst, 2018).

In the past decade, however, new policy mechanisms have been developed to support more efficient policy dialogue and coordination between domestic and international stakeholders. In particular, established in 2004, the Technical Working Group for Health (TWG-H) is a participatory forum for health policy-making to improve aid effectiveness, harmonization and alignment with development partners (Liverani, Chheng and Parkhurst, 2018). Second, the strengthening of institutional structures in the Ministry of Health (MoH) and economic growth have increased local capacities for decision-making and programme implementation. In 2007, for example, the Cambodian government introduced a Midwifery Incentive Scheme, which aimed to reduce maternal mortality rates by paying midwives US$ 15 or US$ 10 per live birth

at public health centres and government hospitals, respectively. This scheme, which is entirely implemented and financed by the national government, illustrates a shift to local leadership in policy formulation and management. The Cambodian government has also taken greater financial responsibility for health policies that were originally introduced and supported only by international actors – such as the "health equity funds", a financing mechanism to improve access to health services for the poor – another indicator of change, which may improve sustainability of interventions and local ownership (Khan et al., 2018).

Box 1.2   Health cooperation in the Philippines

Over the past two decades, Development Assistance for Health (DAH) in the Philippines has played a supportive role during the implementation period of the Millennium Development Goals (MDGs) and the revitalization of universal health coverage (UHC) under the Aquino administration. As an LMIC in South-East Asia, Philippines has been a recipient of external funding that supported ongoing domestic health reforms and investments. Major bilateral partners include the USA, Japan and Spain, with whom the Philippines has deep historical ties; newer partners include Germany and Republic of Korea. Multilateral donors and lenders include the ADB (with its headquarters in Manila), the EU, the Global Fund, the World Bank, WHO and other UN agencies.

The Philippine National Health Accounts reveal that while health spending from external sources increased from Philippine pesos (PhP) 7.681 billion (US$ 144 million) in 2009 to PhP 13.976 billion (US$ 261 million) in 2016, their share of the total budget remained at slightly more than 2% over the ten-year period (National Statistical Coordinating Board, 2013; PSA, n.d.). The Department of Health (DoH) also estimated that DAH for the period 2014–2019 amounts to PhP 22.8 billion (US$ 426 million), the majority of which is in the form of grants. DAH-supported projects and programmes include technical assistance to improve the delivery of health services in maternal and child health, malaria, tuberculosis (TB) and HIV (DoH, 2014).

In accordance with the 2005 Paris Declaration on Aid Effectiveness, the DoH adopted the SDAH in 2007 (World Bank, 2011) – a variation of the sector-wide

approach (SWAp) implemented in several countries to ensure alignment of priorities, harmonize activities and processes, and enhance donor and lender accountability. SDAH ensures that development assistance is aligned with the national health strategy, effectively coordinated to reduce duplication and fragmentation, and projects are sustained and institutionalized in appropriate agencies. Through its Bureau of International Health Cooperation, the DoH coordinates with bilateral and multilateral partners, oversees the implementation of DAH-supported projects, and convenes coordination mechanisms with partner agencies such as the annual Joint Appraisal and Planning Initiative (JAPI) meetings where government and development partners jointly review and report on progress towards the implementation of UHC.

Apart from the health-related MDGs and implementation of UHC, another area of international health cooperation and development assistance unique to the Philippines is emergency preparedness and humanitarian response. Due to the Philippines' high vulnerability to natural disasters such as typhoons, storm surges, earthquakes and volcanic eruptions, external partners have supported the efforts of the DoH in building capacity for disaster preparedness and providing essential health services in the immediate recovery and long-term rehabilitation phase. During times of calamity, the cluster approach adopted widely in the humanitarian response community is activated across all sectors. With support from the WHO country office, the DoH activates the health cluster, which convenes organizations involved in the systemwide response, including bilateral and multilateral agencies, and nongovernmental organizations (NGOs). For example, when the Philippines was hit in 2013 by Typhoon Haiyan, the strongest typhoon to ever hit land in history, the country received substantial humanitarian aid to fund immediate recovery and long-term rehabilitation. The Financial Tracking Service of the UN Office for the Coordination of Humanitarian Affairs (UN OCHA) recorded that in 2014, US$ 54.1 million went to health, US$ 14.5 million to nutrition, and US$ 61.5 million to water, sanitation and hygiene (WASH), covering 68.1%, 96.4% and 76.0% of the projected need for each sector, respectively (UN OCHA, n.d.).

The Philippines has also been leading internationally in trade in health services. In response to a rising demand from high-income countries (HICs), health workers, particularly nurses, have become one of the Philippines' most valuable exports. The emigration of health professionals has been facilitated by a regulated system supported by a substantial number of nursing and caregiver schools, recruitment agencies linked to overseas employers, and the use of bilateral labour agreements with destination countries that ensure the

protection of migrant workers (Institute of Health Policy and Development Studies, 2005). Meanwhile, the Philippines has also become a world leader in business process outsourcing, providing cheap labour for clients in HICs to deliver a wide range of remote services, including medical transcription services. In 2005, the size of the Philippine medical transcription business was estimated at US$ 150 million, although it only accounted for 1.7% of the industry globally (Ramo, 2005). Finally, in recent years, the Philippines has also pursued initiatives to promote its growing medical tourism industry. However, as the country continues to grapple with health care problems domestically, it is struggling to compete with neighbouring countries with more mature medical tourism industries, such as Malaysia, Singapore, and Thailand (Pocock and Phua, 2011).

Currently, the Philippines is also engaging in bilateral and multilateral partnerships to strengthen its national health system. For instance, the country has been an active participant of the Joint Learning Network on Universal Health Coverage (JLN), which seeks to co-develop "global knowledge products" that help implement complex health systems reforms to progress towards UHC (JLN, n.d.). Furthermore, the DoH is closely working with the Ministry of Public Health of Thailand on building capacity for health policy and systems research. Thai experts have trained Filipino practitioners on topics such as health technology assessment, while Philippine DoH staff have been seconded to Thailand's International Health Policy Program (IHPP) and Health Intervention and Technology Assessment Program (HITAP) to gain experience in health policy research.

Finally, in addition to being a recipient of DAH, humanitarian aid and technical expertise, Philippines has become an emerging partner, leader and contributor in regional health cooperation within ASEAN. Over the past two decades, Philippines has collaborated with fellow ASEAN countries on joint initiatives to tackle diverse regional health issues such as pandemic preparedness, disaster management and NCDs. The Philippines has strongly advocated for crafting mutual recognition arrangements (MRAs) to facilitate international mobility of doctors, nurses and dentists as part of ASEAN regional economic integration, which started in 2015 (Invest in ASEAN, n.d.). In 2017, the Philippines served as the chair of ASEAN and led the 50th anniversary celebrations. The Philippines spearheaded the drafting of three health-focused, high-level declarations signed by the heads of State on ending malnutrition, enhancing disaster management and addressing AMR (ASEAN, 2017).

1.3.4 Regional leadership: DAH, technical expertise and influencing global norms

In addition to traditional donors, the involvement of several countries within Asia, such as China, Japan, India and the Republic of Korea, has been an important aspect of regional cooperation for health, particularly in the context of decreasing assistance from Western donors as countries transition from low- to middle-income status (The Asia Foundation, 2014). Japan (Box 1.3) has long been a major donor in Asia, although other countries are now providing increasing support to health programmes in the region, including LMICs such as Thailand through its International Cooperation Agency (TICA). Indeed, China has transitioned from being the world's largest recipient of aid to a net provider of foreign assistance by 2011, and, while hotly contested, its "New Silk Road" or the so-called "Belt and Road Initiative" has promised to transform the landscape of DAH (Gostin, 2018). Moreover, the Government of Indonesia has recently announced that it will be establishing a single agency for its international aid programmes called Indonesian Aid with an initial budget of US$ 74 million (Sheany, 2018). Development banks in Asia, namely the ADB and the New Development Bank (NDB), are becoming increasingly influential in the regional health architecture, particularly in funding health programming and generating coherence across health policy and other areas of public policy and their lending priorities. Much of the health programming in the region is also dependent on contributions from innovative global health initiatives, such as the Global Health Innovative Technology (GHIT) Fund and the Public Health Foundation of India (PHFI).

In addition to financial contributions, some Asian countries are also emerging as regional leaders through the provision of technical assistance, such as Thailand (Wenham, 2018), and the facilitation of regional health policy discussions, as demonstrated by the case of Philippines (Panel 2). More South–South collaboration around trade and health is important in Asia, given the context of a rising burden of NCDs that are driven in part by policy incoherence between trade policies and public health (Baker, Kay and Walls, 2015). For example, while most ASEAN member countries have embraced the WHO Framework Convention on Tobacco Control (FCTC) (except Indonesia) and have actively implemented some form of tobacco control policy, many States also invest in or promote the tobacco industry

where tobacco manufacturing is a State enterprise in some countries, often justifying such behaviour on the grounds of poverty alleviation and economic growth (Chongsuvivatwong et al., 2011).

Asian states are improving regional governance for health by both implementing and shaping regional and global health agendas and norms. For instance, many Asian states have been signatories to global health frameworks, including, for instance, the IHR (2005) and the FCTC. Implementation of tobacco control measures with the FCTC, however, has been mixed. For example, exposure to second-hand smoke is a common problem across Asia; in Pakistan, for instance, more than 80% of people are exposed to second-hand smoke in restaurants (Drope et al., 2018). Other countries such as Indonesia have yet to sign the FCTC despite 76.2% of men in the country smoking daily (The Tobacco Atlas, n.d.). By contrast, some countries are leading by example in implementing global commitments; Singapore has been one of the top performers in progressing towards the health-related SDGs, ranking in the highest quintile of countries across the globe (Lim et al., 2016).

In addition to implementing global health norms at the national level, Asian States are also increasingly shaping these norms and frameworks. During the FCTC negotiations, for example, the governments of India and Thailand strongly advocated for the participation of CSOs, which proved to be critical to the success of implementing the FCTC (Lee, Pang and Tan, 2013). ASEAN and the WHO Regional Office for South-East Asia also played important roles in the FCTC process by balancing various tobacco-related interests and generating consensus among discordant States at the regional level before engaging in global negotiations at the Conference of Parties (Lee, Pang and Tan, 2013). In terms of UHC, Japan (Box 1.3) and Thailand (Box 1.4) have been influential in advocating for national prioritization of UHC in the region and at the United Nations General Assembly (UNGA).

At the same time, however, it has been argued that Asian countries have largely been "rule takers" instead of "rule makers" in terms of global health frameworks and norms, largely due to their limited capacity to engage in global health negotiations in a proactive way and to enduring tensions between notions of sovereignty and collective action (Yeling, Lee and Pang, 2012).

Box 1.3   Japan's global health leadership

Japan has long prioritized global health in its approach to international diplomacy. For instance, action on health issues has been central to Japan's agenda in all of the Group of Seven (G-7) Summits it has hosted (Sakamoto et al., 2018). At the Okinawa Summit in 2000, Japan's leadership on infectious diseases was critical to the establishment of the Global Fund, to which the country continues to provide funding support. In 2016 alone, Japan pledged US$ 800 million for 2017–2019 to the Global Fund's Fifth Replenishment, a 46% increase compared to its previous pledge, and the largest proportional increase among government donors (The Global Fund, 2017b).

Japan also hosted the G-8 Summit in Hokkaido in 2008 where it highlighted the importance of strong health systems. Importantly, Japan will host, for the first time, the G-20 Summit in Osaka in June 2019 where the country's health priorities and strategies will be presented. The Summit will be followed by a Health Ministers' Meeting in October 2019 in Okayama.

Japan's leadership was also critical to the inclusion of UHC in the SDGs (Abe, 2015), which Japan continued to promote throughout its G-7 presidency in 2016 (Sakamoto et al., 2018). Drawing on its great progress towards UHC since the early 1960s during a time of rapid economic development, Japan continues to provide assistance to LMICs to work towards achieving resilient and sustainable health systems and reducing inequalities (Shiozaki, 2016).

The country has also led the global community on innovation in global health through, for example, the GHIT Fund, an international public–private partnership that funds research to address the burden of priority infectious diseases and poverty in LMICs (GHIT Fund, n.d.). Japan was also the fifth-largest global health donor among members of the Organization for Economic Co-operation and Development (OECD) Development Assistance Committee (DAC) in 2016 (Donor Tracker, n.d.).

Recently, Japan has not only identified but also led and contributed to global health as a key tenant of their long-term health-care policy vision, "Japan's Vision: Health Care 2035", which will guide the country's health systems reforms over two decades (Miyata et al., 2015). Importantly, as the fastest ageing nation, addressing domestic health-care challenges associated with ageing societies will be critical for Japan and will also enable them to share lessons with other countries in the region regarding how health systems can be sustainable while ensuring equity (Shiozaki, 2016).

Box 1.4   Thailand as a role model for regional health cooperation

Thailand is another key global health leader, particularly given its domestic progress towards UHC at a relatively low cost (Reich et al., 2016). Given that the country's rapidly growing economy has attracted many migrants from neighbouring Asian countries, particularly from Cambodia and Myanmar, the country has also emerged as a leader in extending coverage to registered and non-registered migrants working in the formal sector (Suphanchaimat, Pudpong and Tangcharoensathien, 2017; Tangcharoensathien, Thwin and Patcharanarumol, 2017), although there have been challenges in extending coverage to those with a precarious immigration status (Guinto et al., 2015).

Thailand chaired the long negotiation for a WHO Global Code of Practice on the International Recruitment of Health Personnel, the second WHO voluntary Code at the 2010 World Health Assembly and has been playing an active role in health workforce policies (Taylor and Dhillon, 2011). As Chair of the Foreign Policy and Global Health Group (a group of seven countries convened through the Oslo Ministerial Declaration, comprising Brazil, Indonesia, France, Norway, Senegal, South Africa and Thailand), in 2017, Thailand had tabled two UNGA resolutions related to UHC; inter alia, one calls for a UN high-level meeting on UHC in 2019 and the other proclaims 12 December as International UHC Day (Oslo Ministerial Declaration, 2007). Thailand has also led by example when it comes to generating coherence across trade and health policies (Thaiprayoon and Smith, 2015), sharing its experiences of health systems development, and providing humanitarian and technical assistance to neighbouring countries in Asia, as well as outside of the region in Africa and the Pacific Islands (Ministry of Public Health, 2017).

As noted above, Thailand has played important roles in negotiating global frameworks such as the FCTC, as well as in challenging global intellectual property regulations to improve access to medicines (Moon and Szlezák, 2013). Global health cooperation will remain a top priority on the national agenda, as evidenced by the adoption of the Global Health Strategic Framework 2016–2020, which seeks to strengthen Thailand's leadership and role in agenda-setting at the regional and global levels (Ministry of Public Health, 2017).

1.3.5   The contested space for civil society engagement

CSOs – referring to those organizations that operate outside of the State and the market (Lee, 2010) – play an important role in regional governance

for health. This group of actors is highly diverse (Youde, 2012). For example, in Bangladesh, CSOs range from large-scale organizations with multimillion-dollar budgets that employ thousands of people to local-level grass-roots organizations (Clayton, Oakley and Taylor, 2000). Despite this diversity, some common roles for this group include advocacy, policy-making, strengthening accountability, service provision, and bridging the gap between regional governance and local implementation (Nodzenski et al., 2016). The world's largest NGO in this area, BRAC based in Bangladesh, has contributed substantially to health improvement in rural communities throughout Bangladesh and has become a critical component of the country's health-care delivery system (Chowdhury et al., 2013). Other examples at the national level include networks and organizations of people living with HIV in Cambodia and Thailand, which have had a prominent role in response efforts and in ensuring that the rights of those affected by HIV/AIDS are promoted and protected (Wells-Dang and Wells-Dang, 2011); indeed, civil society's contribution was key to scaling up access to antiretroviral therapy to meet universal coverage in Thailand (Tantivess and Walt, 2008). At the regional level, Solidarity for Asian People's Advocacy (SAPA) aims to enhance communication, cooperation and coordination among NGOs working in Asia, engaging key regional actors such as ASEAN (Nodzenski et al., 2016). At the local level, CSOs in Asia have been particularly effective in service delivery for vertical programmes, but have delivered fewer results in more horizontal programming, largely due to their reliance on external donors that favour disease-specific approaches (Wells-Dang and Wells-Dang, 2011). CSOs have also been particularly important health-care providers in Asia, sometimes working in partnership with governments (Zaidi et al., 2017). An example of this type of collaboration that has made a considerable impact is the Heartfile Lodhran cardiovascular disease (CVD) prevention project in Pakistan, which is jointly delivered by Heartfile – an NGO aimed at improving health systems to progress towards UHC in Pakistan and in other LMICs (Heartfile, n.d.) – and the National Rural Support Program in Lodhran district, which implemented a community-based CVD primary prevention project to train "lady health workers" as a means to reach populations that would otherwise be excluded (Nishtar et al., 2007).

Despite some collaboration between governments and civil society in Asia, it has been argued that the influence of CSOs in governance in the region has been relatively limited, and that cooperation between national and regional bodies and civil society has not been institutionalized (Lamy and Phua, 2012a; Nodzenski, 2012; Nodzenski et al., 2016). By contrast, Asian governments could draw on the unique position of civil society to gain legitimacy and political support to influence both regional and global governance for health (Gostin, 2013).

1.3.6 The expansion of the private for-profit sector

Alongside CSOs, a wide range of privately owned for-profit institutions and individuals are playing an increasing role in the health architecture in Asia. Health services have become an important industry with a mix of formal and informal, private and public providers, together with a growth in medical tourism and international trade in health services (Chongsuvivatwong et al., 2011). The private for-profit sector has traditionally played multiple roles, which vary across countries and include service delivery in both the formal and informal sector, technical expertise and capacity-building, research and development activity, manufacturing and distribution of pharmaceutical products, developing new medical technologies, and financing global and regional activities. The private sector's role in health-care delivery is heterogeneous in the region. In India, for example, the private sector dominates service provision, with a high private share of health expenditure and a low ratio of public spending to gross domestic product (GDP); whereas in Thailand, public sector spending supports a universalist public sector that is complemented by private sector investment and activities (Mackintosh et al., 2016). As these examples show, the private sector has engaged in service provision alongside the public sector in many countries, expanding health-care coverage; however, concerns have been raised that private for-profit providers divert doctors and nurses from the public health sector, exacerbating shortages in human resources. In addition, the for-profit private sector is often weakly regulated across Asia (Florini, 2014); regulation of the private sector should seek to ensure that service provision is fair and equitable, and aligned to national and regional strategies (Morgan, Ensor and Waters, 2016). Medical tourism is another area that the private sector has promoted in countries such as

Singapore and Thailand, capitalizing on their comparative advantage to sell health services and other recreational packages to "wealthy foreigners" (Chongsuvivatwong et al., 2011). Finally, the region is home to some of the most innovative forms of public–private mix in health services (Chongsuvivatwong et al., 2011) and there is growing recognition of the importance of public–private collaboration to achieve regional health goals, although there is a need for new mechanisms to harness the positive developments and to address the remaining challenges.

1.4   The complexity of the regional health architecture

As discussed in the preceding sections, the regional health architecture in Asia is characterized by its complexity. Citing Simon (1962, p. 468), Koenig-Archibugi (2013) highlights that complex systems can generally be defined as those "made of a large number of parts that interact in a non-simple way". As with global governance for health more broadly, complexity in the regional health architecture is related to the unstructured nature of health cooperation and the plurality of actors operating in this space (Koenig-Archibugi, 2013). In Asia in particular, the diversity of political, cultural, religious, linguistic and economic arrangements across countries poses a significant barrier to generating collective action (Lamy and Phua, 2012; Lee, Pang and Tan, 2013). So too does the primacy of the non-interference principle in the region and the associated lack of willingness in some contexts to contribute to regional health collaboration, which in turn relies on the challenge of sustaining donor funding. Health services are uniquely complex in Asia as they have become a lucrative industry in the region with, for example, a growing market for medical technologies, medical tourism and trade in health services, alongside a mix of public and for-profit providers that are often weakly regulated (Chongsuvivatwong et al., 2011). This lack of regulation and unique landscape of health-care markets makes governing health in the region particularly complex. The regional architecture is therefore characterized by a low level of communication, data-sharing and best practices management between the various actors, and cooperation appears ad hoc rather than strategic (Nodzenski et al., 2016). To add to this complexity, health programming in the region is highly decentralized, with multiple overlapping initiatives that are often underpinned by different normative frameworks, timeframes and objectives

(Liverani, Hanvoravongchai and Coker, 2013). Similarly, the institutional landscape in the region, as with the global health landscape more broadly, lacks the necessary coherence to address cross-sectoral health issues (Lee, Pang and Tan, 2013), as shown by the example of tobacco control.

1.5 Regional cooperation and communicable disease control in Asia

The case of communicable disease control in Asia further illustrates the complex dynamics of regional health governance. As previously discussed, the prevention and control of communicable diseases has been a key area for regional health cooperation in different Asian contexts. In South-East Asia, early initiatives were developed during the 2000s, in recognition of the transnational nature of endemic and emerging diseases and the need for collective action between neighbouring countries to address common health threats. For example, the Mekong Basin Disease Surveillance (MBDS) network, established in 2000, has been a pioneering and ambitious attempt to create a regional infrastructure for infectious disease control in South-East Asia, involving Cambodia, China (Yunnan province), Lao People's Democratic Republic, Myanmar, Thailand and Viet Nam (Phommasack et al., 2013). Based on equal participation, rotating leadership and mutual learning, the MBDS network adopted a distinctive governance model in which each member country is responsible for the management and coordination of one specific programme component: cross-border cooperation (Lao People's Democratic Republic), human–animal sector interface and community-based surveillance (Viet Nam), human resources development (Thailand), ICT capacities (Cambodia), risk communication (Myanmar) and laboratory capacities (China). Further, MBDS has developed an extensive regional network for the cross-border sharing of expertise, epidemiological data and information, from the local communities to the provincial and central levels. Similarly, the Middle East Consortium on Infectious Disease Surveillance (MECIDS) was established in 2003 to facilitate public health cooperation between Israel, Jordan and Palestine – a prominent reminder that a concern with shared health issues can bridge political disputes and promote the pursuit of the common good (Leventhal et al., 2006).

Over the past two decades, other regional programmes for the prevention and control of infectious diseases have been established in Asia, either focused on specific diseases such as HIV (Sharma and Chatterjee, 2012) and avian influenza (ADB, 2014) or "horizontal" in scope such as the MBDS and MECIDS networks. In addition, specific initiatives have been developed to support malaria control at the regional or subregional level, including the Asia Pacific Leaders Malaria Alliance (APLMA), an advocacy forum for high-level engagement and regional coordination, and the Strategy for Malaria Elimination in the Greater Mekong Subregion (GMS) (2015–2030). In the GMS, the identification of artemisinin resistance at the Cambodia–Thailand border – and subsequent reports of widespread cross-border transmission (Ashley et al., 2014) – has also prompted the adoption of a regional emergency response (WHO, 2013). To deal with the resurgence of malaria in the region, especially threats posed by artemisinin-resistant strains in the Mekong Basin, the Australian DFAT and the Gates Foundation have established the APLMA with the objective of malaria elimination in the region by 2030 (APLMA Secretariat, n.d.).

Individual countries have also taken the lead in promoting regional information and data-sharing. Given the continuing problems with dengue in all countries of the region, Singapore has shown leadership in establishing the UNITEDengue initiative, which aims for timely and open sharing of epidemiological and virological surveillance data on dengue between countries in the region (UNITEDengue, n.d.).

As described earlier, organizations for political and economic cooperation have also provided institutional platforms to support regional public health programmes and strategies. To different degrees, the prevention and control of infectious diseases has been on the agenda of the ASEAN Plus Three, the ADB, SAARC and APEC, in joint action with the WHO Regional Office for South-East Asia and the WHO Regional Office for the Western Pacific. For example, as part of the ASEAN work programme in the health sector (2016–2020), the ASEAN Secretariat coordinates a wide range of activities for the prevention and control of infectious diseases, including continued support to existing disease surveillance networks, preparedness through joint simulation exercises and the establishment of regional mechanisms to supply less-resourced countries with drugs/vaccines in

the event of outbreaks, and the ASEAN Field Epidemiology Training Programme (FETP), led by Thailand (ASEAN, n.d.-b).

This diverse range of initiatives has contributed to intensification in various forms of collaboration between Asian countries, including the exchange of epidemiological data and information between regional partners for routine disease surveillance or in the event of emergencies. Additionally, the increase in regional meetings, the close collaboration through cross-border health committees and workshops has promoted the sharing of expertise, experiences and good practices among health professionals, policy-makers and other stakeholders. Gradually, these collaborations build and sustain trust among local front-line public health workers and local policy-makers, which foster close collaboration.

Despite these achievements, key challenges remain. Regional public health cooperation and information-sharing is crucial to infectious disease control, particularly in transnational disease "hotspots", such as the GMS, where cross-border population mobility, the regional ecosystem and trade may facilitate disease emergence and transmission. However, the achievement of effective regional cooperation requires convergence and communication between different public health systems (including systems for the collection and dissemination of epidemiological data), which are variably shaped by national governance structures, capacities, rules and practices (Liverani et al., 2018).

The nature of institutional and legal arrangements in place is another important variable that may affect the practice of international cooperation. Asian countries are bound to the provisions in the IHR (2005), which require health authorities to report to WHO and Member States health threats of international concern within 24 hours of detection. However, national capacities to implement the IHR are variable and, consequently, so are their abilities to report disease outbreaks to neighbouring countries and global health organizations. In addition, virtually all regional health programmes in Asia have been established through non-binding "soft law" agreements such as memoranda of understanding; thus, they provide weak legal bases to support collective action, especially for complex interventions that require clear rules and operating procedures, such as joint outbreak

investigations. Regional organizations such as ASEAN and SAARC have the potential to support regulatory convergence, common rules and standards in collaboration with WHO, given their well-established institutional profile. However, as noted earlier, these organizations have historically been influenced by consensus in decision-making and a strong sensitivity towards national sovereignty, limiting their power to develop and enforce provisions in sensitive areas such as regional (health) security (Liverani, Hanvoravongchai and Coker, 2012; Pattanaik, 2010). Lastly, the implementation of regional programmes for infectious disease control in both South and South-East Asia has benefited from the financial assistance of donor countries, private philanthropists such as the Rockefeller Foundation, the Global Fund and development finance institutions such as the ADB (Coker et al., 2011). This large flow of donor funds has undoubtedly contributed to building an infrastructure for regional public health cooperation. Yet, funding is usually provided to support stand-alone programmes, raising concerns about the integration of these programmes in the wider national health systems and their sustainability in the long term.

1.6   Conclusions

This chapter provides an overview of the regional health architecture in Asia and its governance, with examples from different contexts. It has shown that the health architecture in Asia is characterized by its complexity. While a sense of solidarity and a shared vulnerability to health threats has encouraged collective action in the region, regional governance for health remains a complex and demanding task, requiring convergence and communication between different health systems, as well as diverse political, economic, social and cultural arrangements. The unique nature of health services, which have become a lucrative industry in the region – particularly in the context of an expanding market for medical technologies, medical tourism and trade in health services – alongside the mix of public and private providers present distinct challenges for governance (Chongsuvivatwong et al., 2011). Case studies from Cambodia and the Philippines illustrate how insufficient coordination between donors and their sponsored programmes throughout Asia has resulted in a lack of synergies across health initiatives, as well as the prioritization of vertical disease programmes that may not necessarily reflect national health needs.

However, the examples also show how Asian states are developing new mechanisms to promote coherence across programmes at the national and regional levels.

To overcome some of these barriers and improve health cooperation in Asia, regional organizations such as ASEAN and SAARC are in a good position to promote regulatory convergence, common rules and standards, given their well-established institutional profiles but not without their own challenges. Increased investment will be important to facilitate greater cooperation between states and to improve coherence across sectors.

Lastly, amid shifting political and economic influence from the West to the East, a so-called "Rising Asia" presents an important opportunity to strengthen regional cooperation and improve global health capacities to contribute more firmly as a region to global governance for health (Yeling, Lee and Pang 2012). Case studies from Thailand and Japan show that regional actors are gaining prominence in this space and are increasingly committed to taking the lead on coordination roles and on global health agenda-setting. One key area of opportunity would be for Asian actors to capitalize on growing political and economic power to lead more South–South collaborations and gradually become "rule-makers and game-setters". Looking ahead, given the rise in relevance of global health in Asia, and the associated expansion of the regional health architecture, actors throughout the region have a critical opportunity to generate greater dialogue, synergies and commitment to regional governance for health and to lead more firmly in the global health space.

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