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Special Research Article on Health Policy

Strengthening Trade and Health Governance Capacities to Address Non-Communicable Diseases in Asia: Challenges and Ways Forward

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Abstract

Trade liberalisation is a driver of the rising burden of non-communicable diseases in Asia through its role in facilitating the growth of the region's tobacco, alcohol and ultra-processed foods industries while simultaneously restricting the capacities of governments to enact public health regulations. This highlights the need for greater coherence between health and trade policy in the region. Yet there has been little analysis of these topics with regard to Asia. What are the barriers and opportunities for enhancing trade and health policy coherence and strengthening governance capacities? How can health, in particular the prevention of non-communicable diseases through curbing risk commodity markets, be positioned more centrally in trade policy? We draw upon a diversity of literature to outline seven key challenges to governing the health–trade nexus as it relates to risk commodities and non-communicable diseases in Asia, and offer suggestions for strengthening capacities.

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Key words: non-communicable diseases, trade liberalisation, Asia, regulation, governance

1. Introduction

The rate of economic change in Asia over recent decades has been unprecedented. For example, China's share of global gross domestic product (GDP) (purchasing power parity [PPP]) rose from 2.2 per cent in 1980 to 15.6 per cent in 2013, whereas the share of the major advanced economies (Group of 7) declined from 56 per cent to 37.1 per cent (International Monetary Fund 2013). India and China alone doubled economic output per capita in less than 20 years, twice the rate achieved during the industrial revolution in the West (United Nations Development Programme 2013). Millions have been lifted from poverty with resultant gains in living standards and life expectancy. Economic development is likely to continue apace. By 2025, four of the world's largest 10 economies will be in Asia and account for nearly half of global economic output. Seven countries will likely lead this 'march to prosperity': China, India, Indonesia, Japan, South Korea, Thailand and Malaysia (Asian Development Bank 2011).

An important feature of Asia's so-called economic miracle has been trade liberalisation, the systematic reduction in barriers to cross-border trade and investment. It has facilitated the development of the region's

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advanced cross-border production networks, which underlie its status as a 'global industrial dynamo' (Asian Development Bank 2011). In recent decades, and especially since the Asian financial crisis, trade liberalisation has accelerated in both pace and scope through unilateral structural adjustment, accession to the multilateral (that is, World Trade Organization (WTO)) system, and more recently through the proliferation of a 'noodle bowl' of preferential trade agreements (PTAs) at the bilateral and regional levels. Indicative of this PTAs involving at least one Asian country increased from 46 in 1998 to 257 in 2013, of which 132 had been ratified (Baldwin & Thornton 2008).

Despite its triumph as an economic policy idea, trade liberalisation has had rapid[1] and sometimes large-scale negative effects on the health of Asian populations by facilitating the spread and growth of the region's tobacco, alcohol and ultra-processed[2] food industries. Consumption of these commodities is rapidly increasing in the region, especially within the industrialising middle income countries (Baker & Friel 2014; Baker et al. 2014). These industries are, therefore, a key driver of the region's rising burden of non-communicable diseases (NCDs), predominately cardiovascular disease, cancer, diabetes and chronic respiratory diseases. NCDs are the leading causes of death and disability in Asia, accounting for 17 million or 65 per cent of regional deaths in 2008 (Dans et al. 2011; Baker et al. 2014). Alongside still prevalent rates of infectious diseases, NCDs are generating considerable harms for Asian societies through costs to health systems, workforce productivity losses and implications for poverty (Baker et al. 2014).

Trade liberalisation allows transnational risk commodity corporations (TRCCs), those that manufacture, market and distribute risk commodities at a global scale, to more easily move investments, technologies, production capacity, raw materials and final products across borders, and thereby drive risk commodity consumption transnationally (Baker et al. 2014). Attracted by their young and growing populations, burgeoning middle-class consumer base, and rapid economic growth rates, TRCCs have increasingly targeted developing Asian markets. Although trade remains important, market penetration is primarily achieved through foreign direct investment (FDI), whereby TRCCs establish new affiliates or acquire complete or partial ownership of existing firms. Subsequently, FDI inflows are correlated with higher rates of risk commodity consumption and NCDs globally (Stuckler 2008; Stuckler et al. 2012). East and South East Asia together receive more net FDI inflows than any other developing region, equating to nearly half (47.4 per cent) of the world total in 2012 (United Nations Conference on Trade and Development 2013). Many countries are also home to large state-owned risk commodity enterprises, particularly in the tobacco sectors of China, Thailand and Vietnam (Barraclough & Morrow 2010).

Several 'best-buy' interventions can be used by governments to regulate these industries and attenuate risk commodity consumption, including raising product prices through taxation, marketing restrictions and product labelling controls (Magnusson & Patterson 2014). However, because trade agreements contain rules about how markets are regulated, they can constrict domestic 'policy space', or the 'freedom, scope, and mechanisms that governments have to choose, design, and implement

1. For example, only 1-year after the opening of the Japanese market to US tobacco companies, smoking prevalence doubled from 16 per cent in 1986 to 32 per cent in 1987, with most growth among adolescent girls. Similarly, in South Korea, smoking prevalence increased from 18.4 per cent to 29.8 per cent among adolescent males, and from 1.6 per cent to 8.7 per cent among adolescent females in a 1-year period. This is reflected in tobacco company corporate documents demonstrating the deliberate and strategic targeting of young women.

2. For the purposes of this article, we adopt a definition of ultra-processed foods as substances extracted and purified from unprocessed or minimally processed foods (for example, vegetable oils) and industrially produced ready-to-eat or ready-to-heat food products resulting from the processing of several food substances (for example, snack bars). Examples include foods such as biscuits, confectionary, savoury snacks, processed meats and soft drinks. Because ultra-processed foods tend to be higher in sugar, salt and fat relative to unprocessed or minimally processed foods, such dietary transitions are associated with rising rates of obesity and diet-related NCDs globally.

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public policies to fulfil their aims' (Koivusalo et al. 2009, p. 105). In these ways, the evolving global and regional trade regimes are likely to powerfully influence risk commodity consumption and associated health risks in Asia.

These observations highlight the need for greater coherence between health and trade policy in Asia. We adopt a definition of policy coherence in this regard as 'exploiting positive synergies between health and trade policies, moderating conflicts among the respective policy communities, and minimizing negative inter-sectoral impacts in ways that generate win-win outcomes for . . . development and health' (Organisation for Economic Co-operation and Development 2009). Achieving such coherence requires an understanding of the key issues and governance gaps at the trade–health nexus at the global, regional and national levels, and the strengthening of governance capacity for healthy trade (Smith et al. 2009). Any attempt at analysing such capacity must account for the rising economic and political power of Asian nations and expectations that they will, independently or collectively, play an increasingly important role in global health and trade governance. Key considerations include how they conceive health and trade, how they balance notions of state sovereignty against the need for transnational collective action, how they engage with the international system, and what role they allow for non-state actors including civil society (Lee et al. 2013).

Yet there has been little analysis of these topics with regard to Asia. Important questions are unanswered. What are the barriers and opportunities for enhancing trade and health policy coherence in Asia? How can the prevention of NCDs through curbing risk commodity markets be positioned more centrally in trade policies? How can governance capacity be strengthened in this regard? To address these evidence gaps, we draw upon a diversity of literature to outline seven key challenges to governing the health–trade nexus as it relates to risk commodities in Asia. We offer suggestions as to how governance capacity might be strengthened for healthier trade in the region. The countries we include in this analysis, henceforth termed 'Asia', are the Association of Southeast Asian Nations plus three (ASEAN+3) countries, Cambodia, Indonesia, Laos, Malaysia, Myanmar, the Philippines, Singapore, Thailand and Vietnam (ASEAN), and China, Japan and South Korea (+3). These countries are chosen because of their participation in extensive trade and investment liberalisation activities at the bilateral, regional and multilateral levels. India is also included because of the important contributions it has made to the global governance of risk commodities. However, the challenges and lessons offered are likely to be informative for other countries.

1.1 Challenge 1: Limits to Multilateral Regulatory Processes

Asian nations are members of the two principal multilateral institutions governing health and trade, respectively—the World Health Organization (WHO) and the WTO. Standards and regulations developed by these institutions are likely to be critical to future capacities to address trade in risk commodities and health in Asia. Other institutions whose functions spill over into health, including the UN General Assembly (UNGASS), Food and Agricultural Organization (FAO), Codex Alimentarius (Codex), World Bank, World Intellectual Property Organization, and United Nations Conference on Trade and Development, are also highly relevant (Smith et al. 2009). However, the capacity of this system to address trade in risk commodities in Asia is limited for several reasons.

The first is the limited capacity of these institutions to develop, independently and in unison, effective international regulations addressing trade in risk commodities. This stems partially from the divergent roles and powers of WHO and WTO. Although it has enabling constitutional powers to make legally binding rules that could in principle regulate risk commodity trade, in practice WHO is a largely technical and normative agency that shapes national health policy through its power to convene national health ministries and to develop technical standards and guidelines. The WTO in contrast institutionalises a set of

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binding trade rules (that is, General Agreements on Tariffs and Trade (GATT) and subsequent WTO agreements) supported by enforcement panels, and engages more powerful ministries of finance and trade (Holden & Lee 2009; Magnusson 2010). Provisions in GATT/WTO agreements designed to protect health (the so-called flexibilities) have been interpreted very narrowly to date. Health regulations are, therefore, subject to trade regulations much more so than trade is to health.

There is, however, potential to utilise and strengthen existing capacity within the multilateral system through contributions by Asian actors. Most Asian countries, as former members of the GATT, became members of the WTO upon its establishment in 1995. Others, concerned with the protection of domestic industries from foreign competition, proceeded with a more cautious approach to determining the depth and timing of trade liberalisation, acceding to the WTO until considerably later: China in 2001, Cambodia in 2004, Vietnam in 2007 and Laos in 2013 (Baker et al. 2014). Although the GATT/WTO agreements prohibit governments from adopting measures (policies and regulations) that discriminate between foreign and domestic goods and investments, and between the goods and investments of different countries, trade restrictive measures are permitted if they are non-discriminatory, not used as disguised barriers to trade, and when the content of those measures is consistent with international standards, including those developed by WHO (McGrady 2011).

In this regard, the 2003 *Framework Convention on Tobacco Control* (FCTC) (adopted under Article 19 of the WHO constitution) is a legally binding treaty that can be used to uphold domestic tobacco legislation in trade disputes. This was demonstrated recently in arguments used by Australia to defend its plain packaging legislation in response to the WTO dispute arbitration and in a dispute bought by the tobacco company Philip Morris under the Hong Kong–Australia Free Trade Agreement (Commonwealth Government of Australia 2011). Providing WHO with financial and political support to develop stronger multilateral risk commodity standards, alongside the adoption of ‘enabling legislation’ at the national level, is a key potential opportunity for addressing risk commodities in the region.

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

The *power* of Asian nations to influence the development of international standards in favour of public health presents another challenge. Some, such as Thailand and India, played important supportive roles in the development of the FCTC. Their role in strengthening future risk commodity standards is, however, uncertain but likely to be constrained by several factors. Evidence suggests that Asian governments have engaged in global health negotiations in a largely individualistic manner rather than through regional configurations (Lee et al. 2013). This state centrism reflects the diverse political and economic positions of the countries and may limit their capacity to act collectively in this regard. At present, Asian nations make only small contributions to the financing of multilateral organisations governing health and trade. This is likely to weaken their capacity to influence the respective agendas, especially when the largest TRCCs are domiciled in the United States and European Union (EU), the most powerful UN donor member countries, which have at times

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hindered the development of risk commodity standards. A much improved understanding of the potential for Asian nations is needed in this regard, especially given their increasing influence in global health and trade governance more generally (Lee et al. 2012, 2013).

Many Asian nations are also at a disadvantage in using the WTO rules due to existing asymmetries in bargaining power and the resources available to governments to initiate or defend disputes. We have demonstrated that this is evident in historical WTO arbitration records. Of the 26 WTO trade disputes made against Asian nations pertaining to agriculture, alcohol, tobacco and pharmaceuticals between 1996 and 2013, 21 were made by the United States and EU alone, and of these nine were against developing countries. Disputes pertaining to alcohol were most common. To the contrary, only five claims were made by developing Asian countries against the United States and European Commission (Baker et al. 2014). These difficulties are accentuated when the delegations of the United States and EU are backed by deep-pocketed TRCC lobbyists and extensive legal teams (Shaffer 2003).

1.2 Challenge 2: Limits to Multilateral Program Capacity

Another challenge is generating program capacity within the multilateral system. In 2006 the World Health Assembly adopted a resolution on trade and health, calling for engagement with trade policy-makers to 'take advantage of the potential opportunities, and address the potential challenges that trade and trade agreements may have for health' (World Health Organization 2006). The WHO *Global Action Plan for the Prevention and Control of Non-Communicable Diseases 2013–2020* (GAPNCD) further recognises the role of WHO in offering technical assistance to governments to mitigate the impact of trade agreements on health. The GAPNCD also calls on the FAO to '[s]upport ministries of agriculture in aligning agricultural, trade and health policies', and on the WTO to '. . . support ministries of trade in coordination with other competent government departments (especially those concerned with public health), to address the interface between trade policies and . . . noncommunicable diseases' (World Health Organization 2013, p. 74). Such assistance may be critical to addressing the proliferation of risk commodity industries in developing Asian countries with limited institutional capacity.

Programs have been established within the WHO to this end. A program on globalisation, trade and health was initiated in 2000 'to strengthen knowledge, develop analytical methods, and produce training materials for supporting member states in addressing trade and health issues'. This led to some collaboration with the WTO staff, including a joint report on trade and health, although further commitments and activities have been vague (Holden & Lee 2009). This work later merged into the WHO program on global health diplomacy, which offers executive training including on trade and health. Health diplomacy is likely to be a key force in achieving health and trade policy coherence for attenuating risk commodities as it already has for access to medicines under the WTO's TRIPs agreement (Aginam 2010). This includes building leadership capacity within the health community, and skills for advocating public health principles and methods in trade policy-making and implementation (Holden & Lee 2009; Magnusson & Patterson 2014). WHO has, in the past, provided critical assistance to Asian governments during risk commodity trade disputes. For example, Thailand successfully defended a 1990 GATT dispute, bought by the US Trade Representative on Thailand's tobacco import restrictions, partly due to scientific evidence provided by WHO officials (Drope & Lencucha 2014).

The future of such programs is, however, uncertain. Political pressures from powerful donor countries, particularly from the US and EU countries which are home to some of the largest TRCCs (Holden & Lee 2009), alongside increasing industry engagement (tobacco excepted), have led to reluctance from within WHO to tackle issues likely to cause confrontations with powerful industries (Holden & Lee 2009; Magnusson & Patterson 2011).

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WHO is also challenged by significant structural changes in global health governance more broadly. This includes the proliferation of new state and non-state actors in global health governance, the so-called third-way norms and an expanded role for economic actors through public–private partnerships, philanthrocapitalism and the financing/disciplinary power of international financial organisations. At present, many of these actors, particularly the most powerful, give little priority to financing or supporting the prevention or control of NCDs (Sridhar & Batniji 2008). The support of Asian governments, ideally through financial commitments, may significantly contribute to strengthening such programs.

1.3 Challenge 3: Regionalism on the Rise

Possibly the most significant challenge to the effectiveness of the multilateral system is ‘regionalism on the rise’, referring to the proliferation of bilateral and regional PTAs in recent decades. Today, regional PTAs with investment provisions are most economically significant (United Nations Conference on Trade and Development 2012). Emerging regionalism can be explained by several trends in global trade governance. Trade negotiations within the multilateral system have stalled since the Doha Development Round in 2006, and PTAs have provided an alternative institutional mechanism for high income countries to achieve accelerated trade liberalisation. Initial agreements may also trigger a domino effect as other countries initiate further PTAs to retain trade competitiveness (World Trade Organization 2011).

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

Further, while the multilateral system provides aforementioned flexibilities on public health grounds, these can be excluded from or highly restricted within PTAs. In the WTO system, trade disputes are also made by one government against another, whereas the inclusion of investor–state dispute settlement (ISDS) provisions in many PTAs provides the opportunity for private investors to pursue arbitration directly against governments to recuperate losses resulting from the adoption of domestic regulations, including those designed to protect public health. Investors are increasingly utilising this mechanism; the number of cumulative ISDS cases increased from almost none in 1995 to more than 500 in 2012 (United Nations Conference on Trade and Development 2014). Finally, PTA negotiations are usually ‘closed door’, therefore lacking the greater transparency of multilateral negotiations and the checks-and-balances that come from closer scrutiny by civil society (Friel et al. 2013; Baker et al. 2014). These observations underpin the importance of Asian governments acting unilaterally and collectively to protect regulatory space in such agreements.

1.4 Challenge 4: Asia’s Institutional Diversity

Emerging regionalism accentuates the need for regional-level trade and health policy coherence.

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Yet Asia lacks well-institutionalised organisations like the EU. It has evolved instead a melange of institutional and semi-institutional arrangements, reflecting the region's unparalleled economic, social and political diversity. In economic terms, for example, there is a 55-fold difference in gross national income per capita (Atlas method) between Japan and Cambodia (World Bank 2014). Politically, the region accommodates Marxist–Leninist communism in Laos and Vietnam, a unitary authoritarian parliamentary system in Singapore, and the world's largest parliamentary democracy in India. This diversity in Asia creates particular challenges for collective action.

Regional institutions governing trade include the ASEAN and the Asia-Pacific Economic Cooperation (APEC) forum. Both are, respectively, central to the two competing institutional pathways towards regional integration. The first, the Regional Comprehensive Economic Partnership (RCEP) consolidates the multitude of ASEAN+1 agreements centred on the ASEAN Economic Community (AEC), and includes China and the other ASEAN+6 members (Asian Development Bank Institute 2014). The second, the US-led TPP, involves only four of ASEAN's 10 members (Lewis 2013). In recognition of the diversified needs of members, the RCEP requires less stringent and more flexible commitments than the TPP with few 'behind-the-border' measures, although it is unclear to what extent it includes flexibilities on health grounds. Both are potential precursors to a proposed Free Trade Agreement of the Asia Pacific involving all 21 APEC member countries (Asian Development Bank Institute 2014).

Regional institutions governing health include ASEAN, APEC, the offices of WHO, as well as bilateral agreements for health (Lee et al. 2012; Fidler 2013). The effectiveness of these institutional arrangements in global and regional health governance has been variable. During negotiations of the FCTC for example, ASEAN and WHO regional offices served as important platforms for consolidating a regional position. They have, however, been ineffective at generating regional consensus in other areas, including negotiations of the International Health Regulations and pandemic influenza response (Lee et al. 2012). For historical reasons, WHO has divided East Asia into two regions, a significant challenge for building cohesion and coordination (Lamy & Phua 2012). Although ASEAN has played, at times, an important role in facilitating regional cooperation for health, its role has been hampered by the so-called ASEAN way, the predominance of national sovereignty over collective action and highly politicised decision-making processes (Fidler 2013). Particularly problematic is that one of ASEAN's key members, Indonesia, is yet to ratify the FCTC.

Despite these challenges, these institutions will play increasingly important roles in governing trade and health. APEC and ASEAN have recently demonstrated increased commitment to addressing regional health issues, although this has centred largely on infectious disease threats (Lamy & Phua 2012). APEC is not a negotiating body but a high-level forum for non-binding discussions and information sharing, as well as the development of guidelines and shared principles for consideration in trade negotiations. It may have significant potential to facilitate discussions on trade and health issues that are too sensitive for ASEAN negotiations (Lim et al. 2012). Its Health Working Group formulated the Healthy Asia-Pacific 2020 initiative, endorsed by APEC health ministers at the High-Level Meeting on Health and the Economy in 2014. This includes NCDs as a priority area and proposes a 'health in all policies' approach to action (Asia-Pacific Economic Cooperation 2014).

In 2002, the ASEAN Health Ministers Meeting endorsed the *Regional Action Plan on Healthy ASEAN Lifestyles*, which included the development of policies to address the impacts of trade on health (Association of Southeast Asian Nations 2002). Since then, under the ASEAN Strategic Framework on Health Development, a working group was established for NCDs and regional tobacco control, but not for nutrition or alcohol (Association of Southeast Asian Nations 2012). In a joint statement in 2012, ASEAN+3 Health Ministers recognised the region's growing NCD burden and affirmed their commitment to implementing the *Political Declaration on the Prevention and Control*

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of Non-Communicable Diseases of the UN General Assembly (Association of Southeast Asian Nations 2012).

The establishment of the AEC in 2015, and potentially RCEP, will significantly strengthen ASEAN's role in regional governance (Asian Development Bank Institute 2014). Increased cooperation on social issues through ASEAN, including health, is also likely to strengthen its 'soft power' as a regional and global actor. However, weak financial commitments (approx. US$16 million) and human resource capacities (approx. 300 person secretariat) may limit an ASEAN-led response (Asian Development Bank Institute 2014). Such capacity could be expanded through technical collaboration between WHO and ASEAN, by achieving greater financial and technical commitments from China, Korea and Japan through the ASEAN+3 framework, and through stronger engagement with regional non-government organisations and epistemic communities working to address risk commodities (Lamy & Phua 2012). The work of the ASEAN consumer protection program may also be expanded beyond product safety (ASEAN Committee on Consumer Protection 2015) to include cooperation with relevant national and regional groups for improved consumer education and product standards.

The WHO regional offices, the South East Asia Regional Office (SEARO) and the Western Pacific Regional Office (WPRO) are also likely to play important roles. The WPRO is developing an evidence base to inform regional trade and health policies in the Pacific. The SEARO recently led an inter-country consultation on tobacco and trade (Asia 2012). Yet neither appears to have engaged with the same topics in regard to alcohol and nutrition in Asia. More research is needed to understand the potential for APEC, ASEAN, the WHO regional offices and other regional bodies to act collectively for strengthened health and trade governance.

1.5 Challenge 5: Norm Divergences

There are several normative considerations important to understanding health and trade policy coherence in Asia. Norms, in the first instance, refer to the understandings of appropriate behaviours, values and objectives held by the respective trade and health communities (Drope & Lencucha 2014). There is potential for health actors to view trade only as a threat to population health, taking a 'harm-minimisation' approach, with little consideration for trade objectives. Trade actors, conversely, may view health regulations as barriers to cross-border commercial flows and economic growth (Smith et al. 2009). Trade and health debates have the potential to pivot, therefore, around norms of 'anti-trade' and 'open-trade', for example between an international tobacco control norm on the one hand and open tobacco trade on the other (Drope & Lencucha 2014). In the second instance, certain norms also govern the way international policy is made across Asia. Often asserted is a set of distinctly Asian values, the five principles[3] of peaceful coexistence, that characterise regional collaboration and international engagement. Among these values, the principle of mutual respect for state sovereignty is paramount (Fidler 2013).

Asian nations differ considerably in how they sought to balance the above norms in regulating risk commodity consumption. For example, during the FCTC negotiations, Japan and China took steps to weaken the binding nature of adopted measures, making assertions of 'protecting sovereignty'. In contrast, Thailand and India demonstrated considerable leadership in building regional consensus towards a strong tobacco control treaty, alongside their adoption of enabling legislation at the national level. Thai delegates explicitly emphasised the need to achieve a strong treaty with provisions that take priority over trade rules (Lee et al. 2012).

These observations suggest that norm divergences can potentially undermine collective action on risk commodity control in Asia. This is not given, however. Polemics of anti-trade

3. The five principles of peaceful coexistence are (i) mutual respect for territorial integrity and sovereignty; (ii) mutual non-aggression; (iii) mutual non-interference; (iv) equality and mutual benefit; and (v) peaceful coexistence.

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vs. open-trade do not reflect the more nuanced views of many public health and trade actors; trade agreements are neither inherently good or bad for public health—it largely depends on the final provisions of the agreement and the characteristics of the trade partners. Trade agreements can benefit health when, for example, they facilitate the dismantling of powerful tobacco State-Owned Enterprises (SOEs), thereby removing the conflict of interest arising from the state as both producer and regulator (although admittedly to be replaced by TRCCs) (McGrady 2011). The positive examples of Thailand and India in the FCTC process demonstrate the potential for regional leadership. The sovereignty principle can also be invoked in the public health interest. This has been done by India, Malaysia and Thailand to challenge intellectual property rules governing access to essential medicines, and by Indonesia to challenge perceived inequities in rules governing access to vaccines (Lee et al. 2012; Kamradt-Scott et al. 2013). Although these are different issues, strong assertions of sovereignty may have potential utility when it comes to protecting domestic policy space for risk commodity control.

1.6 Challenge 6: Productivism

Divergent country positions are also reflections, at least partly, of the political economy of their respective risk commodity industries. Holliday has proposed that East Asian nations demonstrate a characteristic 'productivist welfare capitalism' model when it comes to balancing social protections against economic growth. In this regard, 'social policy is an extension of economic policy, and is subordinated to and defined by economic objectives' (Holliday 2005, p. 148). Although the productivist model has been critiqued, it may explain why in several countries, including China, Thailand and Vietnam, the state plays a significant but also conflicting role as both tobacco producer and regulator (Barraclough & Morrow 2010).

China, as the region's tobacco epicentre, offers an example. There, 1.2 million smokers die every year, a figure expected to rise to 3.5 million by 2030. It is the world's largest tobacco producer, with an output of 2.5 trillion cigarettes in 2012, accounting for approximately 43 per cent of global tobacco production (Baker et al. 2014). The market is monopolised by the state-owned enterprise China National Tobacco Corporation (CNTC), which generated 7.5 per cent of the government's tax revenue total in 2007. It is regulated by the State Tobacco Monopoly Administration, with strong participation by the CNTC officials (Hu et al. 2010). External justifications for this policy incoherence usually centre on poverty alleviation (that is, tobacco provides jobs and income, and promotes economic development) (Barraclough & Morrow 2010). Representatives from these organisations played a key part in shaping China's attempts to weaken the FCTC (Lee et al. 2012). Thus, a weak FCTC and domestic regulations may be seen as instrumental to economic growth by Chinese policy-makers. Addressing this conflict of interest of the state is likely to be critical to achieving stronger domestic tobacco control as well as regional cooperation.

However, given its large state-owned tobacco monopoly, the productivist model does not explain Thailand's leadership role in the FCTC. This may reflect a stronger assertion of public health norms by Thai policy-makers, representation by civil society in trade and health policy-making, and recognition of the enormous economic costs tobacco imposes on the society (Lee et al. 2012). Undoubtedly, civil society networks and non-governmental organisations are likely to play a key role by exerting political pressure, in sensitising policy-makers to the relevant issues, and in mobilising public opinion on the relevant health and trade issues (Smith et al. 2009). As Fidler notes, however, despite the recent proliferation of non-state actors in global health governance, they are likely to have a more limited role in Asia, where norms of 'non-interference' and state-led policy-making are paramount (Fidler 2013). However, in some countries, such as Thailand and India, strongly coordinated civil society actions have played important roles in shaping tobacco control regimes in those countries as well as transnationally.

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1.7 *Challenge 7: The Capacity to Engage, Monitor and Protect*

Increasing participation in trade agreements requires countries to strengthen their capacity to evaluate the costs and benefits of entering into trade agreements, to ensure compliance with their international obligations when they do, and to ensure adequate protections for domestic regulatory space (Walls et al. under review; Baker et al. 2014). Doing so is, however, a significant challenge for poorer countries, which may struggle to develop the required scientific and legal expertise, as well as institutional capacities (Drahos 2003; Walls et al. 2015). We have already emphasised the importance of multilateral programs, particularly those of WHO and WTO, in providing technical support and capacity-building in this regard.

Given the multilateral and regional challenges outlined earlier, potentially the greatest opportunity for Asian nations to attenuate risk commodity consumption is through unilaterally regulating their domestic markets. A suite of synergistic policy interventions are given in the relevant WHO policies (World Health Organization 2013). 'Best buy' interventions include raising product prices through taxation, restrictions on product marketing, promotion and sponsorship, and product labelling controls (Magnusson & Patterson 2014).

By reducing tariff revenues and imposing significant compliance and negotiation costs, trade agreements can also reduce the resources available to governments to fund policies and programs addressing risk commodities. Consumption taxes, such as those on tobacco and sugar-sweetened beverages, are a key strategy for off-setting such losses, and can therefore be adopted for both revenue-raising as well as public health reasons. Additional revenues generated from consumption taxes can be used to fund universal access to health services and essential NCD medicines (Magnusson & Patterson 2014). Asia is home to 'light-house' countries that have struck this balance in the public health interest by unilaterally regulating their risk commodity markets. Thailand, for example, has one of the most comprehensive tobacco control regimes globally (Chantornvong & McCargo 2001). It has implemented a hypothecated 2 per cent tax on alcohol and tobacco to fund its Thai Health Promotion Foundation (Casswell & Thamarangsi 2009).

Policy space for such interventions should be protected in future trade agreements. However, a significant legal risk stems from a government 'tying its own hands with respect . . . to regulation in the process of seeking to attract investment' (Thow & McGrady 2014). Increasing trade liberalisation ultimately enhances the power of TRCCs to achieve regulatory concessions[4] from governments because they must increasingly compete with one another to attract and retain the investments and jobs they provide (Farnsworth & Holden 2006), especially when such companies are among the largest operating in developing countries. This creates a difficult paradox for government regulators who must balance the investments and thus opportunities for economic development TRCCs provide and the public health and welfare implications of those investments (Hawkes 2005).

Policy incoherence is likely when there is 'collaborative vacuum' between health and trade policy-makers (Smith et al. 2009), necessitating new institutional structures that bridge the divide. Absent inter-ministerial consultation, for example, has been flagged as a common issue for regional tobacco control (Asia 2012). Thailand is also a world leader in establishing novel institutional designs in this regard. It has a dedicated international trade and health program established within the Ministry of Public Health through which it collaborates with WHO (World Health Organization Country Office for Thailand 2011). Its Trade in Health and Social Services committee brings together officials from ministries of industry, public health, food and agriculture, as well as various professional groups to investigate how trade agreements affect health, to advocate for the inclusion of health

4. See Thow and McGrady (2014) for example. The Laotian Government committed to fixing excise taxes on tobacco for a 25-year term under the conditions of its sale of its state-owned tobacco monopoly to a foreign investor.

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in trade negotiations, and to coordinate action between concerned agencies (Smith et al. 2009).

Other governments in the region may consider the establishment of their own ministerial level and intergovernmental bodies with a mandate to address trade and health-related issues. As Blouin notes, such institutional mechanisms can take many different forms from informal to formal, and may include or exclude industry and civil society representatives. Principally, such mechanisms incentivise collaboration and eventually help build trust between the two communities (Blouin 2007). Cooperation between countries in order to share such lessons could be important to strengthening governance responses to NCDs across the region.

Finally, the monitoring of the health impacts of trade agreements is currently inadequate. Yet tools to do so have been developed, including health impacts assessments (HIAs) conducted retrospectively or prospectively (Lee et al. 2007). As others have noted, the WTO's trade policy review mechanism offers a potential model for WHO to follow in regularly analysing and reporting on the health impacts of trade agreements on individual countries (Holden & Lee 2009). Civil society and academic networks are likely to play a critical role in establishing an information infrastructure for monitoring and evidence-sharing (Smith et al. 2009). A recent HIA of the proposed TPP agreement by Australian researchers offers an example (Hirono et al. 2015). Scholars are also paying increasing attention to the role of Asia in global health governance (Lee et al. 2013). The expansion of this scholarly community, coupled with growing linkages into regional and international organisations, may significantly advance regional governance capacities and would ideally include collaborations on trade and health (Wrigley & Lowe 2010).

2. Conclusion

From a public health perspective, trade and investment liberalisation has the potential to bring considerable benefits to Asia's 3.6 billion inhabitants through stimulating economic growth and development and by promoting access to health-promoting goods and services. Simultaneously, it has the potential to do great harm when it facilitates the growth of the region's tobacco, alcohol and ultra-processed food industries while restricting the policy space and capacities of governments to regulate in the public health interest. Given their rising economic and political power, Asian nations are likely to have considerable influence in future global health governance and collective action efforts to address risk commodity trade and consumption. In this article, we have described key challenges for strengthening trade and health governance to address risk commodities. Six proposed opportunities for strengthening governance in Asia are summarised below:

1. Strengthen institutional capacity for healthy trade: Provide financial and political support for trade and health programs within multilateral and regional organisations with mandates to provide technical assistance to governments, to build leadership and skills capacity within the public health and trade communities, to develop best-practice guidelines and health impact assessment methods, and to advocate for healthy trade policy. At the national level, establish or strengthen high-level inter-ministerial structures for health and trade, consistent with a health in all policies approach.
2. Make 'regionalism' and new trade agreements work for health: Utilise the strengthened institutional capacities to act unilaterally and collectively to protect policy space in future negotiations of trade agreements, particularly those of significant regional importance, such as the RCEP and TPP. Collective action efforts are likely to require concerted leadership from individual countries.
3. Strengthen regulatory instruments: Provide financial and political support for the development of stronger multilateral regulatory instruments targeting risk commodities. Enact 'enabling legislation' and regulate risk commodity markets at the national level by adopting best-buy interventions, including consumption taxes,

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marketing restrictions and product labelling controls. This will require overcoming productivism and addressing the conflicts arising from governments acting as both tobacco producers and regulators.

4. Develop trade and health monitoring systems: Develop systems for monitoring the impacts of trade agreements on health, and mainstream health impact assessments into trade policy processes.
5. Build deeper collaborations with non-state actors and researchers: Foster civil society collaborations for healthy trade and facilitate their participation in trade and health policy processes. Provide sustained funding for research on trade and risk commodities, including research on strengthening governance, policy and regulation.

Ultimately, strengthening governance for healthy trade will come about through synergistic efforts at the multilateral, regional and national levels, and through concerted leadership both within and outside of government. This will play a crucial role in stemming the tide of NCDs in Asia.

11 May 2015.

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