

Southeast Asian cooperation in health: a comparative perspective on regional health governance in ASEAN and the EU

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Abstract Globalization has led to new health challenges for the twenty-first century. These new health challenges have transnational implications and involve a large range of actors and stakeholders. National governments no longer hold the sole responsibility for the health of their people. These changes in health trends have led to the rise of global health governance as a theoretical notion for health policy making. The Southeast Asian region is particularly prone to public health threats such as emerging infectious diseases and faces future health challenges including those of noncommunicable diseases. This study looks at the potential of the Association of Southeast Asian Nations (ASEAN) as a regional organization to lead a regional dynamic for health cooperation in order to overcome these challenges. Through a comparative study with the regional mechanisms of the European Union (EU) for health cooperation, we look at how ASEAN could maximize its potential as a global health actor. Our study is based on primary research and semistructured field interviews. To illustrate our arguments, we refer to the extent of regional cooperation for health in ASEAN and the EU for (re)emerging infectious disease control and for tobacco control. We argue that regional institutions and a network of civil society organizations are crucial in relaying global initiatives, and ensuring the effective implementation of global guidelines at the national level. ASEAN's role as a regional body for health governance will depend both on greater horizontal and vertical integration through enhanced regional mechanisms and a wider matrix of cooperation.

At the turn of the twenty-first century, the concept of *Global Health* (Woodward et al. 2001) beyond the traditional World Health Organization (WHO) definition of health as “a state of complete physical, mental and social well-being” (World Health

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Organisation 2008), has been extended to encompass all cross-sectoral social determinants of health such as movements of people and products covering issues of trade, travel, food security, etc. at the global levels. Globalization has had such a strong impact on global health (McMichael and Beaglehole 2000), that it has brought a whole new meaning to the term *health governance* (Lee 2001). The erosion of national boundaries and the growing interdependence between nation states has forced global level cooperation (Wamala and Kawachi 2010). Globalization has led to a gradual loss of state sovereignty over policies related to social determinants of health such as trade policy (Kickbush 1999a, b), and inevitably thus a gradual loss of sovereignty over global health policy challenges. Globalization has stirred financial and political commitment and placed health at the center of the global political agenda (Drager and Sunderland 2007). It has also introduced new opportunities for inclusive action with the proliferation of communication channels (Goran 2010). Global health allows us to move beyond the state-centric understanding of health (Hewson and Sinclair 1999). National governments no longer have the sole capacity to guarantee the health of their people as health risks extend across borders and across sectors (Dogson et al. 2002), where health challenges must be addressed beyond the national levels and through cross-cutting, multilevel governance solutions (Duit and Galaz 2008) incorporating all actors: from nation states to United Nations organizations, international nongovernment organizations, the private industry, and civil society.

Global health entails the need to theorize over a new global governance structure for health. *Global governance* may be understood as the “formal and informal institutions through which the rules governing world order are made and sustained”; these institutions can be governmental, nongovernmental private or public, formal or informal, at the global, the regional, the national or the local levels (Held et al. 1999). More specifically, *health governance* concerns the institutions, their actions and means adopted to organize the promotion and protection of the health of populations (Dodgson et al. 2002). Drager and Sunderland thus identify the need to renew the current global health governance (GHG) structure to better facilitate collective action (Drager and Sunderland 2007). A GHG structure must reflect a continuous process of change and adapt to the new health challenges (Rosenau 1995; Duit and Galaz 2008). For this reason, we adopt a transformative approach to GHG explaining how the framework for cooperation on health must evolve and change to reflect the new challenges of the twenty-first century.

What is the best GHG framework for cooperation in Southeast Asia? It has been suggested that a reliable governance mechanism for health may only surface once all actors understand health as a *global public good* insinuating that political and financial commitment should follow not only in times of emergency (a pandemic such as severe acute respiratory syndrome (SARS)) but also in the form of long-term capacity building and sustained cooperation for health (Kickbush 2005). How will sustained cooperation emerge? To answer this question, we turn to *Régime theory*. The concept of régimes for global health governance can be used as a way to collectively operationalize national initiatives at the global level (Kickbush 1999a, b). Régimes may be understood as “sets of implicit or explicit principles, norms, rules and decision-making procedures around which actors expectations converge in a given area of international relations” (Krasner 1983). *Régime theory* can serve as an analytical lens to explore the mechanisms for health policy cooperation in Southeast Asia in a contemporary context. It accounts for the expansion of nonstate actors

and civil society, the increased opportunities for multilevel dialog between stakeholders and the subsequent proliferation of legal instruments (Koehane and Nye 1972, 1974). The emergence of the Framework Convention for Tobacco Control (2003) and the International Health Regulations (2005) as international legal treaties for global health, demonstrates the validity of régime theory for GHG. The incentive for cooperation between actors that are directly or indirectly involved in health at the national, regional, and global levels lies in the common health threats that transcend national borders and require cross-cutting multilevel governance solutions (Duit and Galaz 2008). In sum therefore, cooperation for health governance stems from an “amalgam of mutual interests”, and the number of players involved (Axelrod and Keohane 1985).

Research methodology

Our arguments are based on secondary research analysis of primary documents such as international and regional instruments for health, which includes Association of Southeast Asian Nations (ASEAN) reports, European Union (EU) Directives, and international legal instruments. Our primary research is organized around semistructured interviews conducted with 28 policy makers; members of international organizations, nongovernmental organizations, and regional institutions working on health issues within their respective mandates. Interviews were conducted at WHO offices—both at the headquarters in Geneva and the regional offices of the Western Pacific Region (WPRO) and the European Region (EURO), the EU Commission, as well as civil society platforms such as the European Public Health Alliance or the International Union for Health Promotion and Education.

During our comparative analysis, we bear in mind that both regional contexts are culturally and politically very different. Without making direct comparisons therefore, we explore the strengths and weaknesses of ASEAN in regional health governance while highlighting the potential for a more integrated framework of cooperation by learning from the lessons of the EU’s involvement in health. Our framework of comparison is based on a macro-analysis of the general health mechanisms and strategies for health adopted at the EU and the ASEAN level.

We illustrate our arguments by referring to two examples of regional cooperation in health at the ASEAN and EU levels. The first example is (re)emerging infectious disease (EID) control and the second; tobacco control. Infectious disease control is a successful example of GHG whereby global institutions, regional organizations, nation states, and other stakeholders have been willing to join forces in preventing and controlling the spread of (re)emerging health threats. This was the case during the SARS and H5N1 epidemics in Southeast Asia. EIDs can add to a larger burden on the global economy and as such, stakeholders have been motivated to act out of enlightened self-interests, both by the social and economic costs that epidemics represent. As economic power is gradually shifting towards the Asian continent, Southeast Asian nations must work collaboratively to strengthen their capacity to protect the region against such health threats that impose an important social and economic burden. As for tobacco control, we have analyzed prospects for cooperation in dealing with the challenge of rising chronic diseases linked to tobacco consumption. This provides an

insight into the potential for regional health governance over a non-infectious and longer-term health challenge.

This paper seeks to demonstrate the relevance of regional institutions and civil society organizations to supplement a wider global health governance framework. Regional bodies hold much value as intermediary organization that can assist in the translation of global initiatives to national implementation. We choose to focus on the Southeast Asian region due to its high vulnerability to health threats; such as the epidemics SARS and avian flu, and the high rates of dengue haemorrhagic fever. How can the Southeast Asian region evolve from having greater economic clout into being a bigger political actor? We argue that ASEAN's increased commitment on social issues—such as health—will enhance its position as a global actor in soft power. How may ASEAN, considering its very specific cultural and political context, improve on its existing mechanisms for health cooperation to support an integrative framework for GHG?

To answer the above questions, we must understand the primary challenges poised against effective GHG; notably the barriers of national sovereignty (Dodgson et al. 2002) and the question of leadership and diffuse authority in what is a very ad hoc governance structure (Rosenau 2006). We argue that regional institutions have a role to play in addressing these challenges—and that a network of civil society organizations (CSOs) is an essential element supplementing a GHG framework. CSOs are useful in creating platforms of communication and identifying best practices. Additionally, they help relay the voice of the most vulnerable categories of the population and monitor the implementation of policies at the national and local level (Woodward et al. 2001). Furthermore, an efficient governance structure for health, where health is considered a public good, must be intrinsically linked to development initiatives in the aim of reducing health inequity (Woodward et al. 2001), by addressing all social determinants of health in a cross-sectoral framework (Drager and Sunderland 2007).

In this article, we consider mechanisms that successfully incorporate relevant stakeholders into a cooperative health structure. We suggest that an *open method of coordination* (OMC) may be a useful way to stir political commitment among ASEAN member states towards health cooperation—thus, contributing to a solid institutional framework for health governance—one of increased efficiency, quality, and sustainability. The OMC was introduced by the EU in 2000 for community discussions on sensitive policy areas such as employment policy. It is an adequate method to overcome the barriers of national sovereignty and represents an important first step towards more regional integration. As a “soft law” method for areas where the regional body does not possess any legal competence, the OMC favors increased dialog, the sharing of policy experiences for the improvement of design and implementation, and the establishment of indicators and benchmarks as a first step for policy cooperation (Büchs 2007). The OMC is designed to achieve greater ideational convergence so as to identify areas of community initiatives and to reinforce national action (Regent 2003). It therefore helps identify areas of regional cooperation that could later be supplemented by binding legal agreements.

ASEAN's role in health cooperation depends both on horizontal integration and vertical integration. By horizontal integration, we refer to the regional mechanisms specific to ASEAN member states that contribute to their involvement in health policy. By vertical integration, we refer to a wider matrix of cooperation

encompassing the global and civil society players at different levels by which we can explain how ASEAN works with WHO and other actors and stakeholders in health to promote health in Southeast Asia. This paper explores prospects for regional cooperation in health in Southeast Asia by highlighting the existing mechanisms for regional health policy making within ASEAN, and analyzing how ASEAN fits within a wider matrix of cooperation for regional health governance. In the section “[I—The Association of Southeast Asian Nations—a regional body for governance in health](#)”, this paper provides a comparative study of the EU—highlighting which mechanisms from the EU may feed into the health governance structure of ASEAN, and contribute to the horizontal integration between ASEAN’s policy sectors and member states. Without making direct comparisons, we thus explore which EU mechanisms may be transferable to the Southeast Asian context to supplement the current multilevel framework for health governance. Finally, we explore how ASEAN could build on its strengths and overcome its weaknesses to increase its potential as a leader for regional health governance in Southeast Asia. A global health governance framework sustained by regional institutions and a profuse civil society network is necessary to tackle emerging and future health challenges that cut across national boundaries.

I—The Association of Southeast Asian Nations—a regional body for governance in health

In the section on “[Research Methodology](#)”, we highlight the potential of ASEAN for horizontal and vertical integration; working towards the convergence of health systems among its ten member states. What are the specific mechanisms for health improvement in ASEAN? What is ASEAN’s modus operandi for health policy making and subsequently, how may those mechanisms be improved to build capacity and enhance cooperation for health among and within ASEAN’s ten member states (Brunei Darussalam, Cambodia, Indonesia, Laos, Malaysia, Myanmar, Philippines, Singapore, Thailand, and Vietnam). In sum, we look into ASEAN’s potential for increased systematic cooperation within a complex world order (Rosenau 1992). ASEAN, as a young regional institution, experiences a certain degree of resistance from member states towards regional governance reforms that might impede on their sovereignty (Fidler 2007). Nevertheless, this regional body has a moral obligation to support the international framework for health improvement and this support may come in the form of an open method of coordination. For the Southeast Asian context, such a method of cooperation might be a good way to work around a rigid decision-making process.

ASEAN and health governance mechanisms

ASEAN is faced with important health challenges due to demographic and epidemiological transitions of the region, and the double burden of diseases typically present in developing countries with a continuous threat of infectious diseases or the growing needs of chronic diseases. Globalization has affected working environments and consumption patterns leading to changes in lifestyles and well-being. Additionally, climate change along with recurrent natural disasters pose major health threats to the

region. The main obstacle to health cooperation in Southeast Asia lies in the economic, cultural, and political differences between its ten member states. To overcome these disparities and tackle common health challenges as collective, Southeast Asian nations must look beyond national policy and towards the potential of ASEAN as a regional institution. Health is still largely considered as a national concern that is related to domestic issues. However, there is relevant scope for regional intervention to achieve common standards, as in the form of training and capacity building of health policy makers or the health workforce.

The conventional “ASEAN Way” has caused the decision-making process to be often slow, and highly politicized. The primacy of national sovereignty, the prevalence of national interests over the common good, and the culture of rule by consensus have been the main limitations to collective action among ASEAN nation states. With regards to the ratification of the Framework Convention on Tobacco Control (FCTC) for example, Indonesia continuously refuses to sign the convention due to the high revenues generated from taxes on tobacco and the close cooperation between the Indonesian government and multinational tobacco companies. This causes the whole region to lag behind in tobacco control. To overcome this prevalence of national interests over the common good which acts as a limitation to ASEAN’s involvement in health improvement, member states must be prepared to pool their sovereignties further regarding health interests—hence, pushing the movement for regional integration forward.

The SARS epidemic (2003) was a turning point for ASEAN’s involvement for health in the region. The common threat of a potential epidemic forced ASEAN member states to cooperate on cross-border surveillance and screening procedures, for example. Despite the continuous lack of infrastructure in terms of EID control, the response to SARS has had positive implications for the development of regional policy making in health. The series agreements and declarations at the ASEAN level (such as the Joint Declaration of the Special ASEAN Leaders Meeting on SARS 2003) testify ASEAN’s intention to strengthen cooperation to curb the SARS epidemic and subsequently the H5N1 epidemic (leading to the Declaration of the 8th ASEAN Health Ministers Meeting; “ASEAN Unity in Health Emergencies” 2006)

The ASEAN charter and ASEAN engagement for health and social policy cooperation

The ASEAN Charter of 2007 granted ASEAN with a *legal personality*¹ and greater legitimacy as a global actor. The charter redefines ASEAN institutions and instigates a rule-based approach to policy making, allowing for more systematic planning in all policy fields. The Charter created an ASEAN Socio-Cultural Community (ASCC) pillar focusing on health as well as the environment, education, welfare, and development. Among these new priorities, ASEAN seeks to “enhance the well-being and livelihood of the peoples of ASEAN by providing them with equitable access to

¹ Definition of legal personality: an institution with legal personality is one that possesses all “*the totality of international rights and duties recognized by international law*” (as for nation states) (Egmont Royal Institute for International Relations, Working Paper on the legal personality of the EU, 2007)

opportunities for human development, social welfare and justice” (Tran 2011) striving towards the creation of an *ASEAN Community* by 2015. This is a clear sign of ASEAN’s progressive involvement in health governance for the region whereby it recognizes that the region’s capacity for development depends first and foremost on a healthy community achieved through collective effort. The ASCC blueprint establishes a strategic framework on health and development (2010–2015) to guide action in health governance and focuses on access to adequate and affordable healthcare, medical services and medicines, and promotion of healthy lifestyles. It seeks to improve the capability to control communicable diseases and pays a new attention to food quality control. The birth of the ASCC pillar and blueprint create the potential for a more integrative health governance framework in Southeast Asia. Nevertheless, the current structure of cooperation and governance in health for Southeast Asia remains an emergent policy space that has not reached a stable institutional profile (Bradford and Linn 2007). It is challenging at this stage to track clear policy responses with nation states that reflect the blueprint recommendations directly.

The ASCC pillar and its blueprint gave rise to a small *Health and Communicable Diseases Division*, currently consisting of five employees including the head, one senior officer, two technical officers, and one secretary. This is a first sign of institutionalized cooperation for health improvement in Southeast Asia. At the present stage however, the Health Division is understaffed to tackle all the priorities listed under the blueprint. It is apparent that to increase ASEAN’s capacity to govern health for the region, this Health Division would need more human resources.

Regional mechanisms for health cooperation—the ASEAN Health Ministers’ Meetings

The ASEAN Health Ministers’ Meetings (AHMM) is an important mechanism for high-level decision making on the priorities for health improvement in ASEAN. These meetings are preceded by Senior Officials Meetings (SOM) which oversees the operational decision-making processes for health policy making. SOMs are prepared through the advisory work of numerous technical working groups that identify the evidence-based health priorities for the region. ASEAN’s ability to guide regional action on health matters is thus limited by a decision-making process that is highly compartmentalized and bureaucratic. Furthermore, the long lapses of time between each stage of the decision-making process highly compromise its efficiency. Nevertheless, we may note that AHMMs have led to numerous declarations on health since the early 1980s. After the SARS epidemic, health was acknowledged by ASEAN as an essential element in promoting social development.

As early as 2002, ASEAN put together a “Healthy ASEAN 2020” vision and established a *Regional Action Plan on healthy Lifestyles 2020*, promoting the improvement of social determinants of health (Association of Southeast Asian Nations 2002). This first strategy aims to establish a number of relevant regional mechanisms for governance in health such as high-level policy forums, a network of exchange in expertise, partnerships for technical capacity improvement, the involvement of the educational sector for health literacy, as well as multisector engagements to secure the determinants of health (Association of Southeast Asian Nations 2002). This regional

action plan mentions the establishment of *leadership development programs*, for key government and nongovernmental bodies, built around needs that are relevant to the ASEAN Member Countries (Association of Southeast Asian Nations 2002) and to develop capacity for health governance among member states.

This regional action plan also calls for more intersectoral links between departments of ASEAN in labor, economic or cultural cooperation, thus gearing internal governance towards dealing with global health challenges at large. This recommendation is reflected with the new structure of the ASEAN sociocultural community pillar, whereby the health division is placed under the umbrella of the Cross-Sectoral Cooperation Directorate. This suggests that solution to health threats must be solved in parallel to other areas of attention under the sociocultural community pillar of ASEAN namely social and education policy, environmental sustainability, and disaster management. While the declarations that emanate from ASEAN official meetings are not legally binding, they do bear a lot of political pressure on the ten member states. The regional action plan as an example of a nonbinding cross-cutting strategy thus calls for the establishment of relevant mechanisms for GHG, encouraging an open method for cooperation.

The main limitation to cooperation for health is a lack of economic commitment and thus resources for ASEAN to act on its ASCC blueprint and priorities in health. This lack of economic resources ultimately stems from a lack of political commitment to tackle health threats as a collective. In order to solve the collective action problem and achieve the best outcome for health development across the ten member states, ASEAN must adopt a method of negotiation and policy making that is adapted to the ASEAN leaders' attachments to sovereignty and rule-by-consensus. Through an open method of coordination, "the objective is not to prescribe uniform rules or to deliver policy outcomes. Instead, it organises a learning process in order to promote the exchange of experiences and best practices" (Regent 2003). By promoting dialog on policy making as a first step, it might be possible to convince and pressure countries such as Indonesia to ratify the FCTC and abide by tobacco control measures.

In order to achieve a higher level of horizontal integration, the ASEAN community must allow more regional integration altogether. To achieve a greater level of health equity and work to reduce the disparities in health status between the lower-income countries including the countries Vietnam, Cambodia, Laos, and Myanmar and the other six ASEAN members, capacity building and a political commitment to help one's neighbor will be essential.

ASEAN member states must shift their understanding of health threats from a security issue to a global public good. As Kaul, Grundberg, and Stern explain, public goods are understood as non-excludable and nonrival. In other words, no one can be stopped from consuming "better health" and "health" can be consumed by many without being depleted (Bettcher and Lee 2002)—legal frameworks such as the FCTC or even immunization programs and epidemic surveillance are all intermediate public goods that aim to achieve one final public good: improved health for all (Bettcher and Lee 2002). Ultimately, pooling resources and working towards further cooperation will serve to guarantee this intermediate public good for the ASEAN community. By promoting further dialog and working towards a common ASEAN Strategy for Health Improvement in line with the ASCC blueprint—ASEAN could pool resources that might be redirected towards countries in greater need and

accompanied by effective training and capacity-building programs. The establishment of an ASEAN training center for capacity building might be yet another efficient mechanism for the harmonization of health systems across ASEAN.

Another challenge for ASEAN is the quality of data collection and analysis. A centralized data collection system such as a Health Metrics Network (Waldman 2007) would be of great support to an ASEAN health governance framework. This initiative might be possible by pooling ASEAN member states' resources and creating a centralized data collection system—but also by relying further on the help of civil society organizations—as we will see in the next subsection.

Aside from improving horizontal mechanisms for regional cooperation in health, we must analyze ASEAN's potential to support a wider framework of cooperation for health governance—in cooperation with WHO and CSOs at large—a process of vertical integration.

An ad hoc regional cooperation structure between ASEAN and WHO regional offices

The World Health Organization as the specialized technical agency of the United Nations for health has often been considered as the leader in global health policy (Waldman 2007). Yet its capacity to act has been largely reduced to its inefficient and bureaucratic structure. In addition to well-needed reforms, it is essential for WHO to build upon partnerships between the regional and country offices of the WHO. In the case of Southeast Asia, ASEAN and WHO work on a very ad hoc cooperation structure. The rare cooperation between both structures translates into WHO representatives' participation at the yearly ASEAN preparatory meetings to the AHMM as well as at the ASEAN Regional Forum. There are noticeable instances of cooperation between both institutions through emergency response programs such as during the H5N1 epidemic. Furthermore, ASEAN is part of the WHO Pacific Strategy for emerging infectious diseases (World Health Organisation Western Pacific Office 2005). This ad hoc cooperation structure, however, does not extend substantively beyond the emergency of an epidemic. There is no long-term cooperation mechanism in place between ASEAN and WHO regional offices.

The first limitation to an institutionalized cooperation is the fact that ASEAN member states are split between the regional offices of WHO South-East Asia Regional Office (SEARO) and WHO WPRO. This structural disadvantage does not set the right context for continuous and structured dialog. An institutionalized form of cooperation, however, might be useful in preventing the duplication of health programs at the regional level; it would also contribute to the effective use of technical resources and expertise through a more constant channel of knowledge sharing. Both institutions could benefit from an institutionalized cooperation as they are complementary in nature. At the EU level for example, WHO provides the credibility of the content while Directorate General for Health and Consumers (DG SANCO) provides the tools by monitoring implementation through close scrutiny on national action and implementation plans. ASEAN, as an intergovernmental body, has the necessary tools to stir political commitment among its ten member states. Furthermore, ASEAN possesses the cross-sectoral value of a diplomatic entity with direct contact with all

sectors of government in its member states, as well as with CSOs and the private sector. As a regional intergovernmental institution, it is a better candidate for identifying the specific needs of the Southeast Asian people and bridging the gap between WPRO and SEARO. WHO on the other hand, could bring in the technical expertise (the medical know how and data collection capacity) that ASEAN has not yet harnessed to its full potential.

The necessity to work towards an inclusive framework for cooperation on health

An inclusive regional matrix for cooperation in health does not limit itself to institutionalized cooperation with WHO but includes the ability to work with an extensive civil society network. ASEAN operates through a system of *dialog partners* which includes, among others, the EU and the United Nations, Australia, China, or the USA (Severino 2011). This governance mechanism allows for cross-institutional communication and facilitates technical cooperation between global, regional, and national entities. To support a regional framework for health governance, ASEAN should work to develop its potential as an international actor. The *Action Plan on Healthy Lifestyles 2020* for example, suggests that ASEAN must increase its visibility on the global scene by presenting case studies and research at international meetings. Furthermore, ASEAN might benefit from the development of the ASEAN Plus Three framework as a relevant structure to support the regional health governance structure. The combined economic power and technical expertise of China, Japan, and Korea could add significant value to ASEAN's involvement in health improvement programs at the international level.

In addition to the network of *dialog partners* and the ASEAN Plus Three framework, ASEAN possesses a small network of affiliated NGOs including organizations such as Medical Association of Southeast Asian Nations. In effect, however, this CSO network remains small, and there is little contact and reporting between ASEAN and affiliated NGOs. Informing policy making from the bottom-up in ASEAN is a largely ad hoc and rather difficult process. The communication channels between epistemic communities and the Southeast Asian governments for example, also remain rather limited. ASEAN could benefit from greater synergy between CSOs, the private sector, and other global/regional institutions involved in health governance. CSOs including community organizations, nongovernmental organizations, foundations, etc. represent the voice of the people. They are essential in focusing health policy making towards the community, and to the benefit of the most vulnerable in particular. CSOs are direct contributors to GHG through their research and advocacy work. They help to identify needs and promote best practices, highlight inequities, and inform policy priorities at the governmental level. They also monitor the efficient implementation of new health policy guidelines. Similarly, public–private partnerships for health are a crucial element of efficient global health governance (Waldman 2007). For example, financing solutions have been worked out by pooling the resources of companies such as pharmaceutical companies to support new initiatives for global health. An illustration of such a partnership is the UNAIDS and the *Global Fund for*

AIDS, Tuberculosis and Malaria (Waldman 2007). Certain NGOs such as the Bill and Melinda Gates Foundation—with an annual budget of US\$ 2 billion—provide considerable financial resources to global health initiatives. Additionally, the Health Barometer (Edelmans 2011)—a survey conducted on a pool of 15,000 in 12 countries on health behaviors and expectations—suggests that 82 % agree that businesses have an important role to play in improving the health of the public—starting with their employees. GHG thus extends over all sectors of activity, public or private, working together towards one common goal: improving health. This reinforces our argument on the need for a cross-sectoral multi-actor cooperation framework to supplement ASEAN's involvement in global health. It also implies the undeniable importance of a strong CSO network to support an ASEAN global health governance network.

II—Transferable mechanisms for health cooperation in Southeast Asia—a comparative analysis of ASEAN and the EU

The EU experience in health cooperation at the regional level offers some material for comparison with the current situation in ASEAN. We do not, however, turn towards the EU example to take the European-level mechanisms for an absolute solution. Both institutions are at a very different level of integration. Rather, we examine the EU structure to understand what may be useful to ASEAN. Another apparent difference between the EU and ASEAN is the financial strength and the legitimacy of the EU as a *sui generis* organization. The EU has reached a level of regional integration which accounts for its highly developed health governance structure. Nevertheless, over the last 44 years, ASEAN has developed into less of a trade organization and into an all-encompassing institution—widening its competences to other fields including health. Similarly to the European Commission, ASEAN has a role to play in ensuring the sharing of best practices, in coordinating forums for dialog and exchange of information, and in the use of statistics for harmonization of data collection across the ten member states. From our observations of the EU's partnerships for health improvement, its interactions with the WHO and its framework of cooperation with CSOs, we have highlighted various mechanisms that could feed into a Southeast Asian health governance framework.

The example of the European Commission's (EC) DG SANCO established in 1999, is a useful element for comparison with the newly established ASEAN health division. DG SANCO for example, encompasses over 120 employees working on health for Europe and representing the voice of the EU as a whole. DG SANCO's mandate is to “complement national action on health” rather than duplicate national initiatives. Developing the Health Division of ASEAN closer to the model of DG SANCO would allow the creation of specialised sections dealing with infectious disease or noncommunicable disease and also trade regulations (e.g., to deal with cases of illicit medicine trade). Such a division could oversee the creation of a stronger system of health indicators for the ASEAN community—to allow for more successful harmonization of data collection and measurements, for example (European Commission, Together for Health 2007).

European mechanisms—a potential template for regional cooperation in health

Additionally, to improve its potential as a leadership institution for health governance however, ASEAN could work on the development of a more *general strategy for health*. The EU general health strategy for example was designed to improve health security (health preparedness, health promotion) by tackling health inequalities related to social determinants of health and by disseminating health knowledge and information. The general European Health strategy works through annual priority work plans—and operates through an Executive Agency for Health and Consumers. Supplementing this European strategy is the *Statement on Fundamental Health Values* by the EC—aimed at improving the coherence of the strategy by aligning member states on a similar value system for health improvement (European Commission Together for Health 2007). As such, we may suggest that ASEAN's potential in health governance could be improved by the creation of a more complex health division, more regular SOM and AHMM meetings, as well as a more resourced executive structure working towards the implementation of a general strategy for health, and supported by an ASEAN-specific statement on health values.

The EC's Together for Health 2008–2013 strategy tackles the challenge of an aging population, and of continuous threats to public health security such as pandemics. It is based on the principle of shared values—on access to quality healthcare and on solidarity. Such a strategy helps to improve the coherence of policy recommendations between all actors for health in the EU and works to reinforce the regional institution's role as a global actor in health governance. The “Together for Health” strategy also incorporates the *Health in All Policies* principle which calls for more synergy between the NGO sector, the industry, academia and the media. Now that ASEAN has integrated *health* as one of its priorities within the ASEAN sociocultural community pillar—the next step towards incorporating health as a cross-sectoral priority could be to adopt an approach similar to *Health in All Policies* as clear mechanisms for cross-sectoral horizontal integration. The Reform Treaty of the EU (Article 9) reinforces this initiative by categorizing *public health* as one of three overarching objectives for the EU. All sectors of policy making at the national and regional levels must consider public health as a prime objective—from social and regional policy, to taxation policy, environment policy, education policy, and to research. This is an example of horizontal integration—as it promotes a whole-of-government and whole-of-society approach (Kickbush 2011)—with the intent of reaching all levels of the governance spectrum. This change of approach is primordial to effective collective action.

Comparative examples through emerging infective disease and tobacco control

As demonstrated through our two examples (EID and tobacco control), ASEAN could benefit from a more comprehensive health strategy. In the case of emerging infectious disease control for example, ASEAN operates through numerous frameworks and disease-specific agreements. This leads to a less coherent approach to EID control. ASEAN's political commitment in EID control is apparent through the numerous working groups and task forces that were set up over the last 10 years.

However, ASEAN does not benefit from a comprehensive surveillance mechanism (Coker et al. 2011) such as the European Centre for Disease Control that coordinates EID control activities with the EU commission and WHO EURO. ASEAN's sustained capacity to prevent and combat EIDs could depend on the creation of a clearly defined health strategy for the region. With regards to tobacco control, the EU provides strong leadership through the European coordination mechanisms which draw the link between FCTC requirements, WHO EURO initiatives and EU commission activities in tobacco control. ASEAN currently operates through its focal point on tobacco control set up in 2007. However, it could benefit from a more comprehensive and integrated strategy for tobacco control, to ensure greater coherence between WHO SEARO and WPRO initiatives and national government efforts towards tobacco control. Additionally, ASEAN involvement in tobacco control could largely contribute to reducing the disparities in health status between Southeast Asian nations as tobacco-related diseases account for the highest rate of preventable deaths across the region. From a development perspective therefore, a coherent strategy for tobacco control transposing the FCTC provisions to the national level via a regional initiative is essential.

An integrated cooperation with WHO and related organizational structures

As we have seen in the first section “[Research methodology](#)”, one of the main challenges for health cooperation in Southeast Asia is the lack of a coherence data collection mechanism. The Organisation for Economic Development and Cooperation (OECD) collaborates with the EU on Health and may be considered as the third partner for health governance in Europe along with the EC and WHO EURO. As a potential equivalent to the OECD, the Asia Pacific Economic Cooperation forum (APEC) might be an interesting partner supplementing an ASEAN regional health governance framework, by supplying for example, the resources for improved surveillance. From the perspective of EID control, for example, working in closer synergy with APEC would allow ASEAN to harness the private sector stakeholders for EID control. We may note that APEC has previously worked to empower business leaders in the region by advising them on how to cope with the influenza virus through business continuity plans. This is a clear example of how APEC may supplement ASEAN's mechanism for EID control, or supplement a more general health strategy for the region in the near future.

WHO and ASEAN communicate via the WHO Indonesia Country Office in Jakarta; however, from a global governance point of view, this has little potential for regional integration. The EC on the other hand, cooperates with the WHO Headquarters in Geneva and the WHO EURO office separately as both bureaus have set up an office in Brussels. Additionally, DG SANCO has a representative stationed in Geneva for continuous exchange of information and expertise. Executive Directors of both DG SANCO and WHO EURO meet twice a year in January and May to discuss priorities in health security for the region, health information and solutions to health inequalities in the EU. In order to reinforce the cooperation between ASEAN and WHO regional offices therefore, both WHO WPRO and SEARO would ideally combine efforts to support a WHO regional office or unit based at the ASEAN

headquarters in Jakarta. To implement a more systematic structure of cooperation, ASEAN may choose to work towards a joint agreement with WHO WPRO and SEARO, calling for more policy dialog. In order to elaborate on a complex matrix of cooperation—WHO EURO and the EC have agreed on the need to include all EU delegations and WHO country offices in EU member states as direct partners on their health programs. This is an interesting idea for ASEAN and the WHO country offices. An integrated cooperation with WHO would allow the establishment of a single integrated information system for a uniform and efficient surveillance and alert mechanism, for example. The European region is currently working on such a system which will be based on standardized definitions and methods for data collection—reducing the burden of data collection on member states. This would be highly valuable to Southeast Asia to overcome inefficiencies in data surveillance.

Furthermore, both WHO EURO and the EC have aligned their health strategies for improved coherence as another benefit of their cooperation for health governance. WHO EURO implements projects and general strategies that are directly in line with EU health policy. The Health 2020 Strategy established by WHO EURO at its 61st Committee Session (September 2011) presents the regional directors' proposals on the "scope, vision, and values ... related to the new European policy for health" (WHO EURO 2011). The alignment of regional strategies for health at the ASEAN level would be a great opportunity for added coherence in health policy making for the region. Moreover, WHO EURO contributes to regional health governance for Europe through additional mechanisms such as the South Eastern European Health Network—a forum for cooperation among health ministries, International Organisations and the Council of Europe to guide the reconstruction and stabilization of the East European Region and reduce disparities in health. Such networks of complex partnerships would be a useful model for Southeast Asia in the region's attempt to minimize health inequity and to provide specific help to less developed countries such as Myanmar, Lao PDR, or Cambodia.

We may illustrate the above points by drawing further recommendations from cooperation in EID control and tobacco control. WHO Global oversees the harmonization of infectious disease control and prevention tools. The FCTC and the International Health Regulations serve as a template on which WHO regional offices and regional institutions may base their region-specific strategies for infectious disease and tobacco control. Regional offices of the WHO have taken the lead in establishing region-specific technical programs to strengthen national capacity. As we can see, WHO EURO works in a tripartite partnership with the EC and the European Centre for Disease Control for EID control. It is unfortunately much more difficult to impose such a structured framework for Southeast Asia due to its divided WHO membership. Although SEARO and WPRO have joined forces through the *Asia Pacific Strategy for Emerging Diseases*—ASEAN would benefit from an institutionalized center for prevention and surveillance (such as the ECDC) to facilitate cooperation between its health division and the WHO regional offices. Furthermore; WHO EURO established a European Strategy for Tobacco Control and includes the EU as a main partner for this strategy. In contrast, the Tobacco Free Initiative (TFI) by WHO WPRO only includes ASEAN and WHO SEARO as *collaborators*. ASEAN would benefit from having a more integrated role in a cooperation framework where ASEAN, WHO WPRO, and SEARO all work together as partners in the TFI.

The role of civil society in ASEAN regional health governance

Ultimately, ASEAN needs a stronger civil society network at the local, national, and regional levels in order to build on its potential for more regional integration in health governance. For CSOs, it is easier to influence one body representing ten member states rather than lobbying for change in ten different countries at once. The European Public Health Alliance (EPHA) for example, acts as a platform for all health CSOs to relay information to the European institutions. EPHA supports the flow of information on health promotion and public health policy developments among all players: politicians, civil servants, NGOs, stakeholders, and the public. EPHA trains, mentors, and supports NGOs and health actors to engage with the EU. This CSO platform therefore helps create the link between government and business and regional organizations. Having such a platform of CSOs would help to draw the link between health and social justice. Before such a platform can be created in Southeast Asia however, there needs to be a flourishing CSO landscape. The richness of the CSO landscape depends largely on the political structure and philosophy behind the governments of each member state. Governments of Southeast Asia have a role to play in facilitating the legal registration of CSOs in health. Developing on the CSO framework would allow governments to go beyond the complex bureaucratic and political compromises of ASEAN and to reach out to the ASEAN community more efficiently—building on the *ASEAN Community* principle.

From an institutionalist perspective, CSOs create the bridge between regional, global, and governmental bodies. The EC has set up various consultation mechanisms to integrate CSOs in the governance framework for health. It organises *residential seminars* to promote interconnectedness between the institutions consulting with the EU and EU delegations on health policy making—promoting synergy for effective implementation. Furthermore, DG SANCO organises *Global Health Policy Forums* once a month in Brussels for the network of CSOs to share their ideas and projects with the EC. The *Civil Society Contact Group* is yet another example of a forum in health in which CSOs meet to discuss the implementation and evaluation of health policies in the EU region. CSOs influence policy formulation and policy implementation from bottom up and from top to bottom—they are thus essential to a fully inclusive GHG framework. A flourishing CSO framework is a predetermining factor that would support ASEAN in the creation of a sustainable and integrated health governance framework by creating synergy between all levels of the governance spectrum.

Conclusion

ASEAN possesses much potential to strengthen health governance in Southeast Asia. ASEAN's potential can be improved by reinforcing its existing mechanisms to support a stronger and more coherent regional health governance framework. Ultimately, pushing for more integration can pave the way towards a more inclusive ASEAN—pooling the resources and expertise of a civil society network together towards the reduction of health inequities and to meet the health challenges of the twenty-first century.

We have argued that ASEAN member states may cooperate more effectively through an open method of coordination in which actors and stakeholders for health interact in a complex matrix of shared interests. Such a model involving soft agreements and more regular interactions may be a good structure to move progressively towards more integrated frameworks for cooperation. The OMC does not imply a transfer of competences from the national to the regional level, yet it still empowers regional institutions with certain specific tasks central to the governance process (Regent 2003). The OMC is of particular relevance in dealing with socio-economic issues of high sensitivity such as health (Borras and Jacobsson 2004). As such, it would be a relevant governance structure for ASEAN to enhance its framework for cooperation in health.

As Illona Kickbush explains, the main challenge of global health governance today is the need to *harness creativity, energy and resources for global health*. This means instigating the notion of “health responsibility” in all institutions that have an impact on health—such as businesses, employers, school teachers etc. The greatest challenge is getting non-health actors to act consciously for health—such as the energy, food, or transport industries (Gostin and Mok 2009). As such, the OMC would be a catalyst for increasing CSO activity in Southeast Asia. It is through the creation of community movements and other such grassroots initiatives, for example, that monitoring the implementation at the national and local levels for tobacco control and EID control will become feasible.

As we have seen, EPHA successfully harnesses the potential of CSOs to supplement a wider matrix for cooperation in health, and to openly contribute to an open framework of cooperation. This platform of CSOs fosters a health-promoting economic framework and social framework favoring a cross-sectoral perspective on health challenges. CSOs can create the link with industrial policies, and corporate behavior, or with issues of poverty and discrimination that have repercussions on health governance. This demonstrates the value of a CSO network for ASEAN to become a noticeable actor in global health. Governance is not only about exchanging technical information; it is also about interchange of values, expectations and accountability. CSOs thus have an important role to play in relaying the expectations of global citizens (Bloom 2007).

Regional bodies such as ASEAN are useful mid-way organizations relaying the engagements of international agreements to the region—ensuring respect and adequate implementation of all international agreements for health improvement within their member states. However, ASEAN should demonstrate equal political commitment towards both short- and long-term health challenges. Although political commitment to cooperate is apparent in times of a pandemic, a similar engagement would be required from member states to tackle the costly threat of noncommunicable diseases (NCDs) linked to tobacco usage for example. The challenge of NCDs may be heightened by the creation of an ASEAN Economic Community, hence the need for a regional answer to tackle long-standing health risks.

The examples of EID control and tobacco control demonstrate the need for stronger horizontal and vertical integration at the regional level. A regional institution takes time to develop and expand. Its integration must be progressive and organic and will have to be accompanied with increasing human capital and financial resources. These will trickle down from heightened political commitment by member states.

Greater regional integration may stir political commitment. And with deeper political commitment comes financial commitment, ultimately increasing ASEAN's capacity to act as a global health actor. With more elaborate regional mechanisms for health cooperation and a wider network of global/regional/societal partnerships, an ASEAN-style and context-specific framework for regional health policy making can evolve organically. By doing so, Southeast Asian representatives will be able to harness ASEAN's potential to act as a stronger global actor for health cooperation

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