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DRAFT CHAPTER

Bice, S. and H. Sullivan (eds)

*Public Policy in the 'Asian Century': Concepts, Cases and Futures*

**International policy coordination and its impacts**

The traditional dominance of Western nations in global governance is being increasingly counter-balanced by the rise of Asia, whose nations' growing economic power and distinctive values, principles and strategies of international engagement may unsettle existing understandings of the processes, practices, and prospects for policy-making across borders. As Bice and Sullivan (2014) note, the 'Asian Century' is one amongst many manifestations of the globalisation phenomenon regularly identified. However, far from observing the erosion of national political borders and state capacity as proxies for globalisation, studies of international policy coordination in Asia have consistently observed a strong assertion and recognition of sovereignty at the *nation state-level* as a central and defining feature. In terms of international policy coordination, national sovereignty claims are expressed in norms of non-interference in internal affairs by global governance actors, a typical preference for international agreements that are non-binding and lack legal force as well as declarations that do not commit resources.

As a corollary, the general argument is advanced that such tightly held claims of nation state sovereignty in Asia limit international policy coordination. In dealing with the policy problems of growing economic interdependence and policy spillover effects across borders, assertions of nation state sovereignty is argued, in many policy sectors, to cut into the options available for the effective implementation of international governing arrangements (for example, in health, see Stevenson and Cooper 2009, Fidler 2012). Ultimately, the arguments runs, successful international policy coordination relies on undermining national sovereignty and the development of strong, formal institutions at the international level are necessary.

In case study methods terms, Non-Communicable Diseases (NCD) policy is a typical case of international policy coordination in Asia; health is a policy sector where strong norms of national sovereignty tend to operate, and by hypothesis, these would be expected to act as a barrier to the development of effective governing arrangements for international policy coordination. Case allows us to explore the claim that national sovereignty limits the development of international governance for international policy coordination. It limits opportunities for innovation, proscribes certain options for coordination and precludes the establishment of hard, formal authority at the international level. The need for effective international policy coordination is manifest in the multiple disease patterns associated with globalization that cross-cross Asia, novel in the speed, intensity and directions of their pathways. Although the emergence of new infectious diseases in Asia are salient in global health agenda, the increasing burden of Non-Communicable Diseases (NCDs) in poor and middle income Asian countries is the dominant epidemiological transition driven by globalisation. This is both a health challenge and development problem in Asia; macroeconomic effects of chronic poor health and preventable early deaths are significant in Asia and at the level of the household, NCDs may act as a barrier to exit from poverty.

51 The central argument of the chapter is that there is greater capacity for international policy  
52 coordination in Asia in health than implied in the claim that national sovereignty obstruct  
53 effective international policy coordination to protect public health. The argument is developed  
54 first conceptually through an understanding of relationships between formal and informal  
55 institutions in the governance arrangements for international policy coordination in Asia. Next  
56 the argument is illustrated by the NCD case of international policy coordination in terms of the  
57 WHO Framework Convention on Tobacco Control and the ability of Thailand, India, Malaysia  
58 and Singapore to develop informally health related interpretations of formal institutions in  
59 intellectual property rights for medicines. The conclusion reflects on whether this is a health  
60 policy-only case or of more general relevance to thinking about international policy  
61 coordination in Asia.

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#### 64 **International policy coordination: two ideal types**

65

66 As a starting point for the analysis of governing arrangements for international policy  
67 coordination, Ginsberg (2010a; b) posits two ideal types: the *first* is some form of global  
68 constitutionalism, following the EU model of establishing supranational sovereignty, whilst  
69 the *second* is an emerging Eastphalia model constructed in terms of Westphalian sovereignty  
70 (see Krasner 2000 for discussion of mutual respect for the principle of non-interference in the  
71 affairs of another state and the formal equality of states). In an Eastphalia model, the  
72 commitment to state sovereignty is maintained alongside shallow and weakly institutionalised  
73 forms of mutual support and informal cooperation in international policy coordination that will  
74 be explored later in the chapter as the ‘ASEAN way’.

75

76 There is nothing distinctively Asian about the concept of Eastphalia. For example, one could  
77 plausibly read UK government preferences towards the EU over the last thirty years up to the  
78 Brexit vote of June 2016 as exemplary Eastphalian. However, as Ginsburg (2010a; b) employs  
79 the term, it does help to highlight a countertendency to claims of a global constitutionalism  
80 driving developments in global governance in which the EU model, at least in ideal form, is  
81 the pioneer of establishing formal legal architectures above and beyond states (for example,  
82 Slaughter 2006). In the EU, sovereignty is pooled so that formal legal integration has been able  
83 to underpin a regional governance arrangements in which the European Court of Justice sits  
84 above, and supervenes upon, the policy preferences and actions of the EU member states.

85

86 Without doubting the analytical value of imposing a dichotomy between global  
87 constitutionalism and Eastphalia for a macroscale consideration of new world orders, for the  
88 practical concerns of public policy and international policy coordination these two ideal types  
89 already coexist in practice: policy-making across borders in Asia is typically some mix of  
90 *formal* institutions of supranational authority and *formal* institutions of nation state  
91 sovereignty. This chapter explores how the effects of this mix of formal institutions on  
92 international policy coordination is mediated by a set of *informal* institutions. This chapter  
93 looks, empirically in terms of NCD policy, at the combination of these two types of formal  
94 institutions with coexisting informal institutions and what these may imply for international  
95 policy coordination in Asia

96

97 Although elusive and difficult to reign in analytically, the notion of an ‘ASEAN style’ of  
98 international policy coordination is a useful starting point for describing the hybrid of formal  
99 and informal institutions that govern international policy coordination in Asia. At a minimum,  
100 Fidler (2012) argues it is a preference for non-interference in internal affairs by global

101 governance actors, for weak formal institutions and non-binding coordination solutions. It is a  
102 helpful term here by serving as a convenient label to contrast two policy coordination styles:  
103 an ASEAN way as opposed to a more formalised global governance system, characterised by  
104 trends such as increasing the legalisation of international trade and investment flows (Goldstein  
105 and Steinberg 2008). As Fidler (2012), building on Somers Heidhues (2000), argues: the  
106 ASEAN way is characterised by consensus building rather than discord; pragmatism rather  
107 than higher order principles; and gradualism rather than abrupt change. For our purposes in this  
108 chapter, it also includes the preference for elite level policy negotiations conducted through  
109 informal networks rather than formal and strongly institutionalised regional organizations.  
110

111 Once informality is recognised as a central feature in international policy coordination in Asia  
112 intertwined with the two types of formal institutions, we can state the core contribution of the  
113 chapter: investigating empirically the relationship between informal and formal institutions for  
114 international policy coordination in Asia. For example, although the ASEAN Free Trade  
115 Agreement (FTA) is weakly institutionalised, lacking an effective dispute resolution  
116 mechanism, ASEAN countries also participate regularly in the formal institutions of the WTO  
117 dispute settlement process. The ASEAN Regional Forum has developed as the main security  
118 structure for the region but as Ginsburg (2010a, p.865) argues, it is “...hardly institutionalized  
119 in the sense of its institutional structure having any independent effect on outcomes”. Rather,  
120 it is very much a Westphalian conception of discussions and relational, informal policy  
121 coordination. Yet ASEAN countries are also members of formal institutions within the UN  
122 system (Friedrichs 2012).  
123

124 This chapter uses the case of NCD policy to explore the different institutional factors that may  
125 shape, constrain and enable the strategies of Asian countries in international policy  
126 coordination. Four pivotal relationships between formal and informal institutions are identified  
127 to help characterise distinctively Asian features of international policy coordination. The  
128 chapter will discuss the role of Asian nations in international coordination of NCD prevention  
129 policy. This can be divided *a priori* into two sub-cases: (a) tobacco. The development the  
130 Framework Convention on Tobacco Control (FCTC) has been frequently observed as a case of  
131 ‘binding’ international policy coordination; (b) other commodities. The regulation of the  
132 consumption of other commodities which are NCD risk factors, in particular alcohol and ultra-  
133 processed food, have conventionally been contrasted as a case of strong national sovereignty  
134 claims and relatively ineffective international policy coordination. These are employed in the  
135 chapter as illustrative cases of the different ways in which Asian nations might exert their  
136 leadership and influence across formal and informal institutions of international policy  
137 coordination in the coming decades.  
138

139  
140 **Informal and formal institutions: relationships and interactions in international policy**  
141 **coordination in Asia**  
142

143 The key concept that this chapter seeks to reconsider and recast in terms of policy coordination  
144 in Asia is informality in institutional design and practice. The case studies in international  
145 health policy reveal different informal institutions, and their relationship to different formal  
146 institutions, as key aspects of governing international policy across Asia. Informality in  
147 international governance in Asia is most regularly asserted as a set of distinctly Asian norms  
148 and values – including mutual respect for state sovereignty - but for the purposes this chapter  
149 we can interpret the five principles of peaceful coexistence set out by Fidler (2013) as informal

150 institutions that operate in different ways alongside formal institutions in regional collaboration  
151 and international engagement.

152

153 Neo-institutional theory stresses the importance of examining institutions, organisations and  
154 the actors within them and the ways these interact to shape policy and its practice. In public  
155 policy terms, formal institutions refer to official rule-setting and legal obligations with coercive  
156 mechanisms acting as the key driving force for action. They count as *formal* in terms of being:  
157 codified, official, purposefully designed and third party enforced. From this perspective,  
158 behaviour is constrained and regulated formally: organisations act in a certain way because  
159 they have to and not necessarily because they want to. Informal institutions describe values and  
160 norms that not only define goals or objectives but also designate ways to pursue them. We can  
161 call these *informal* on the grounds they are unofficial, uncodified, self-regulated and often  
162 emerge rather than being designed. Like formal institutions, they can impose constraints but  
163 also, at the same time, empower and enable social action.

164

165 New institutionalism allows that formal and informal institutions may be misaligned in certain  
166 contexts, which not only produces confusion and conflict, but may also provide conditions that  
167 are highly likely to give rise to institutional change. In their summary of new institutionalism,  
168 Lowdnes and Roberts (2013) observe a dialectic relationship between the formal and informal  
169 aspects of institutions and place analytical importance on agency in the shaping, bending and  
170 challenging of institutional practices. An emphasis on the interactions and influences of  
171 different institutional norms, culture and actors within a broader context helps gain traction on  
172 the balance of informal and formal institutions in international policy coordination.

173

174 A starting proposition for the study of international policy coordination is that political-  
175 administrative jurisdictions tend to have fixed territorial limits/borders; and these are fixed  
176 even as the territorial scale of economic activity has changed both globally but also variety in  
177 some cases, at regional and urban and local scales. These changing economic geographies  
178 change carry attendant policy problems at those scales which are mismatched with the scales  
179 of political-administrative jurisdictions and national sovereignty as the basis of international  
180 policy coordination.

181

182 Recent research has begun to uncover the role of informal governance in international policy-  
183 making for such problems (e.g. Stone 2013, Kleine 2014). A precise definition of informal  
184 governance in terms of transboundary policy issues remains elusive, however at a minimum  
185 we can say it refers to the unwritten rules, strong norms and/or shared expectations within the  
186 international system that may modify, complement or substitute for formal institutions such as  
187 treaty provisions (Stone 2013). So defined, informalism is everywhere: both within formal  
188 international organizations (IOs), as well as operating separately as informal institutions, and  
189 in a broad array of international policy networks constituted by state and non-state actors.

190

191 Importantly, whilst Stone (2013) argues that the informal may well complement or substitute  
192 for the formal, there remains an important possibility that has been neglected by current  
193 scholarship: a much more tense and problematic relationship where the formal can upset and  
194 even destroy informal institutions with severe and adverse consequences. For example,  
195 knowledge-based critiques of formal institutions argue that knowledge is necessarily  
196 fragmented and dispersed (and in large part tacit) which means that any attempt at ‘command  
197 and control’ or central planning is likely to be inimical to the informal because the ‘all knowing’  
198 policy-maker and institutional designer is impossible. Conversely, and again ignored in the  
199 international governance literature, the work of Stinchcombe (2001) develops an argument in

200 favour of formalism: when a formal institution is designed to correct and update itself over  
201 time in response to feedback, it can be successful in adapting and learning formally about  
202 processes which are in essence informal.

203 This chapter argues that it is in the different interactions between formal and informal  
204 interactions that we may explore the claim that national sovereignty undercuts effective  
205 international policy coordination. As noted, most institutionalist work in international policy  
206 tends to see the formal and informal as substitutable and existing in a coordinate relationship;  
207 for example, Stone (2013) describes the growing informality of international governance where  
208 non-state actors perform important functions in advocating for, implementing provisions  
209 within and reinforcing the legitimacy of formal treaty arrangements. In other literatures, the  
210 informal develops in the shadow of the formal, and a symbiotic relationship develops to ensure  
211 efficacy and stability of the formal.

212

### 213 **Background to case of international NCD prevention policy coordination in Asia**

214 An important feature of Asia's rise in economic power has been trade liberalization, the  
215 systematic reduction in barriers to cross-border trade and investment. It has facilitated the  
216 development of the region's advanced cross-border production networks that underlie its status  
217 as a 'global industrial dynamo' (Asian Development Bank 2011). In recent decades, and  
218 especially since the Asian financial crisis, trade liberalization has accelerated in both pace and  
219 scope through unilateral structural adjustment, accession to the multilateral (i.e. World Trade  
220 Organization) system, and more recently through the proliferation of a 'noodle bowl' of  
221 preferential trade agreements (PTAs) at the bilateral and regional levels.

222 Amongst its many social and economic consequences, trade liberalization has been identified  
223 with some large-scale negative effects on the health of Asian populations by facilitating the  
224 spread and growth of the region's tobacco, alcohol and ultra-processed<sup>2</sup> food industries.  
225 Consumption of these commodities is rapidly increasing in the region, especially within the  
226 industrializing middle-income countries (Baker, Kay et al. 2014). Thus, by way of the  
227 commodities they produce, advertise and distribute, these industries have been identified as a  
228 key driver of the region's rising burden of non-communicable diseases (NCDs), predominantly  
229 cardiovascular disease (CVD), cancer, diabetes and chronic respiratory diseases. NCDs are the  
230 leading causes of death and disability in Asia, accounting for 17 million or 65% of regional  
231 deaths in 2008 (Dans, Ng et al. 2011, Baker, Kay et al. 2014). Alongside still prevalent rates  
232 of infectious diseases, NCDs are generating considerable harms for Asian societies through  
233 costs to health systems, workforce productivity losses, and implications for poverty (Baker,  
234 Kay et al. 2014).

235 Trade liberalization allows transnational risk commodity corporations (TRCCs) to move  
236 investments, technologies, production capacity, raw materials and final products more easily  
237 across borders and thereby drive risk commodity consumption transnationally (Baker, Kay et  
238 al. 2014). Attracted by their young and growing populations, burgeoning middle-class  
239 consumer base, and rapid economic growth rates TRCCs have increasingly targeted developing  
240 Asian markets. Although trade remains important, market penetration is primarily achieved  
241 through foreign direct investment (FDI) whereby TRCCs establish new affiliates or acquire  
242 complete or partial ownership of existing firms. Subsequently, FDI inflows are correlated with  
243 higher rates of risk commodity consumption and NCDs globally (Stuckler 2008). Among  
244 developing countries East Asia was the recipient of more net FDI inflows than any other region  
245 since 1990, equating to 64.5% of the world's total in 2013 (World Bank 2014). Many countries

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

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

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

272

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

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

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

291 guidelines. The WTO in contrast institutionalises a set of binding trade rules (i.e. General  
292 Agreements on Tariffs and Trade (GATT) and subsequent WTO agreements) supported by  
293 enforcement panels, and engages more powerful ministries of finance and trade (Lee, Sridhar  
294 et al. 2009, Magnusson 2010). Provisions in GATT/WTO agreements designed to protect  
295 health (so-called ‘flexibilities’) have been interpreted very narrowly to date. Health is therefore  
296 subject to trade rules much more so than trade rules are subject to health regulations.

297 There is, however, *potential* for Asian states to use informal institutions to strengthen policy  
298 capacity within the formal institutions of trade governance. Most Asian countries, as former  
299 members of the GATT, became members of the WTO upon its establishment in 1995. Others,  
300 concerned with the protection of domestic industries from foreign competition, proceeded with  
301 a more cautious approach to determining the depth and timing of trade liberalization, acceding  
302 to the WTO considerably later: China in 2001, Cambodia in 2004, Vietnam in 2007 and Laos  
303 in 2013 (Baker, Kay et al. 2014). Although the GATT/WTO agreements prohibit governments  
304 from adopting measures (policies and other regulations) that discriminate between foreign and  
305 domestic goods and investments, and between the goods and investments of different countries,  
306 trade restrictive measures are permitted if they are non-discriminatory, not used as disguised  
307 barriers to trade, and when the content of those measures is consistent with international  
308 standards including those developed by the WHO.

309 In this regard, the 2003 *Framework Convention on Tobacco Control* (FCTC) (adopted under  
310 Article 19 of the WHO constitution) is a legally binding treaty that can be used to uphold  
311 domestic tobacco legislation in trade disputes. This was exemplified recently in arguments used  
312 by Australia to defend its plain packaging legislation in response to WTO dispute arbitration  
313 and in a dispute brought by the tobacco company Philip Morris under the Hong Kong-Australia  
314 FTA (Commonwealth Government of Australia 2011). In this way, formal institutions can  
315 provide a legal mandate for Asian countries to protect domestic regulatory space to address  
316 risk commodities in trade disputes. However, developing informal institutions alongside the  
317 formal to help provide WHO with financial and political support to develop stronger  
318 multilateral risk commodity standards is a key potential opportunity for addressing risk  
319 commodities in the region.

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

331 The second challenge concerns the *power* of Asian nations to influence the development of  
332 international standards. Some, such as Thailand and India played important supportive roles in  
333 the development of the FCTC. Their role in strengthening future risk commodity standards is,  
334 however, uncertain but likely to be constrained by several factors. Evidence suggests that Asian  
335 governments have engaged in global health negotiations in a largely state-centric and  
336 individualistic manner rather than through regional configurations (Lee, Pang et al. 2013). This  
337 reflects the commitment to state sovereignty discussed earlier and related lack of sense of



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

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

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

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

385 The future of such programmes is uncertain, however. Political pressures from powerful donor  
386 countries, particularly from the US and EU countries which are home to some of the largest  
387 TRCCs (Lee, Sridhar et al. 2009), alongside increasing industry engagement (tobacco  
388 excepted), has led to reluctance from within WHO to tackle issues likely to cause  
389 confrontations with powerful industries (Lee, Sridhar et al. 2009, Magnusson and Patterson  
390 2011). WHO is also challenged by significant structural changes in global health governance  
391 (GHG) more broadly that weakens its capacity to govern responses to risk commodities. This  
392 includes the proliferation of new state and non-state actors in GHG, so-called ‘third-way  
393 norms’ and an expanded role for economic actors through public-private partnerships,  
394 philanthrocapitalism, and the financing / disciplinary power of international financial  
395 organizations. At present many of these actors, particularly the most powerful, give little  
396 priority to financing or supporting the prevention or control of NCDs (Sridhar and Batniji  
397 2008). More broadly, these contemporary changes in GHG significantly constrain the capacity  
398 of WHO and its regional offices in Asia (SEARO and WPRO), to enhance responses to risk  
399 commodities at the health-trade nexus.

400

401

402 *Informal institutions complementing formal institutions: trade rules and NCD prevention policy*

403 Notwithstanding the US withdrawal from the Trans-Pacific Partnership (TPP), the proliferation  
404 of bilateral and regional preferential trade agreements (PTAs) in Asia, alongside various  
405 investment provisions and treaties, is the salient feature international economic policy  
406 coordination (United Nations Conference on Trade and Development 2012). Trade  
407 negotiations within the multilateral system have stalled since the failed Doha Development  
408 Round in the mid-2000s and PTAs have provided an alternative institutional mechanism for  
409 high-income countries to achieve accelerated trade liberalization. Initial agreements may also  
410 trigger a domino effect as other countries initiate further PTAs to retain trade competitiveness  
411 (World Trade Organization 2011).

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

427 Further, while the multilateral system does provide aforementioned flexibilities on public  
428 health grounds these can be excluded from or highly restricted within PTAs. In the WTO  
429 system trade disputes are also made by one government against another, whereas the investor-  
430 state dispute settlement (ISDS) provisions in many PTAs enable corporate investors to enact

431 proceedings directly against governments to recuperate losses resulting from the adoption of  
432 domestic regulations (including health regulations). Finally, PTA negotiations are usually  
433 ‘closed door’, therefore lacking the greater transparency of multilateral negotiations and the  
434 checks-and-balances that come from closer scrutiny by civil society (Friel, Gleeson et al. 2013,  
435 Baker, Kay et al. 2014). These observations underpin the importance of Asian governments  
436 acting unilaterally and collectively to build informal institutions to protect regulatory space in  
437 such agreements.

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439

440 *Informal institutions undermining formal institutions: the challenge of policy coherence in*  
441 *NCD prevention*

442 Growing economic integration in Asia brings the need for regional-level trade and health policy  
443 coherence. Yet in Asia, relative to the process of European integration, there has been an  
444 evolution of a hybrid mixture of formal and informal institutional arrangements that govern  
445 health and trade relations, reflecting the region’s economic, social and political diversity. In  
446 economic terms, for example, there is a 55-fold difference in Gross National Income (GNI) per  
447 capita (Atlas method) between Japan and Cambodia (World Bank 2014). Politically the region  
448 accommodates Marxist-Leninist Communism in Laos and Vietnam, unitary authoritarian  
449 parliamentary systems in Singapore and Indonesia, and the world’s largest parliamentary  
450 democracy in India. Unlike in the EU and North America, regional economic hegemony is also  
451 contested. This is evident in the two competing opportunities towards further regional  
452 economic integration, the first led by China, the Regional Comprehensive Economic  
453 Partnership (RCEP) involving the ASEAN+6 countries, the second involving the United States,  
454 the Free Trade Agreement of the Asia Pacific (FTAAP) to which the TPP is a pre-cursor (Lewis  
455 2013).

456 This institutional diversity in Asia creates particular challenges for collective action to address  
457 trade in risk commodities. Regional institutions governing trade include the Asia Pacific  
458 Economic Cooperation forum (APEC), the East Asia Summit (EAS), and the Association of  
459 South East Asian Nations (ASEAN). Regional institutions governing health include ASEAN,  
460 and the offices of the World Health Organization (SEARO and WPRO) as well as bilateral  
461 agreements for health (Lee, Kamradt-Scott et al. 2012, Fidler 2013). The effectiveness of these  
462 institutional arrangements in global and regional health governance has been variable. During  
463 negotiations of the FCTC for example, ASEAN and WHO regional offices served as important  
464 platforms for consolidating a regional position. These same organizations however, have been  
465 particularly ineffective at generating regional consensus in other areas including negotiations  
466 of the International Health Regulations and pandemic influenza response (Lee, Kamradt-Scott  
467 et al. 2012).

468 For historical reasons, WHO has divided East Asia into two regions, a significant challenge for  
469 building cohesion and co-ordination (Lamy and Phua 2012). Although WPRO is developing  
470 an evidence base to inform regional trade and health policies in the Pacific, neither SEARO  
471 nor WPRO appear to have engaged with the same topics in regards to Asia. Although ASEAN  
472 has played, at times, an important role in facilitating regional cooperation for health its role  
473 been relatively minor, and ASEAN health ASEAN Post-2015 Health Development Agenda  
474 exhibits the characteristics described by Fidler (2013): the predominance of national  
475 sovereignty over collective action, a culture of consensus-building rather than open conflict,

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

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

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

501

502

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

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

512 Asian nations have differed considerably in how they have balanced the above norms as they  
513 relate to addressing risk commodities. For example, during the FCTC negotiations, Japan and  
514 China took steps to weaken the binding nature of adopted measures, making assertions of  
515 'protecting sovereignty'. In contrast Thailand and India demonstrated considerable leadership  
516 in building regional consensus towards a strong tobacco control treaty, alongside their adoption  
517 of 'enabling' legislation at the national level. Thai delegates explicitly emphasised the need to  
518 achieve a strong treaty with provisions that take priority over trade rules (Lee, Kamradt-Scott  
519 et al. 2012).

520 These observations tend to suggest that norm divergences serve to misalign informal  
521 institutions and thereby threaten the potential to undermine any collective action to coordinate  
522 policy on risk commodity control by Asian nations. Conversely, state sovereignty has also  
523 been invoked in the public health interest: by India, Malaysia and Thailand to challenge  
524 intellectual property rules governing access to essential medicines, and by Indonesia to  
525 challenge perceived inequities in rules governing access to vaccines (Lee, Kamradt-Scott et al.  
526 2012, Kamradt-Scott, Lee et al. 2013). Although these are different issues strong assertions of  
527 sovereignty may have, therefore, potential utility when it comes to protecting domestic policy  
528 space for risk commodity control. Overcoming anti-trade vs. open-trade debates is also another  
529 path forward. Such debates often ignore the potential for trade agreements to promote health.  
530 The liberalization of the tobacco sector, for example, could potentially result in the dismantling  
531 of powerful state-owned enterprises SOEs thereby removing the conflict of interest arising  
532 from the state as both producer and regulator (although admittedly to be replaced by TRCCs)  
533 (McGrady 2011).

### 534 **The future: Emerging Asian varieties of international policy coordination**

535

536 The chapter has explored the argument that assertions of national sovereignty and the primacy  
537 of formal national level political institutions in policy-making tends generally to undermine  
538 international policy coordination in Asia. The NCD prevention policy case presents some  
539 suggestions that there is greater international policy coordination capacity in Asia than this  
540 argument implies. In addition to challenging the scholarly utility of an ideal type dichotomy in  
541 international policy coordination of the EU and Eastphalian models in which the latter is seen  
542 as an immature and weaker version of the former, this case study casts light on the importance  
543 of informal institutions and their intersection and articulation with formal institutions in  
544 international policy coordination. This latter insight is developed conceptually in the chapter  
545 through sketching some possible simple relationships between formal and informal institutions.

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

555 Options identified by the WHO for attenuating risk commodity consumption include raising  
556 product prices through taxation, restrictions on product marketing, promotion, and sponsorship,  
557 and product labelling controls (Magnusson and Patterson 2014). This necessitates informal  
558 institutions to establish collaboration between health and trade policy-makers to protect policy  
559 space in future trade agreements (Thow and McGrady 2014). By reducing tariff revenues and  
560 imposing significant costs associated with compliance and negotiation, trade agreements may  
561 also reduce the resources available to governments used to fund policies and programmes to  
562 address risk commodities. Consumption taxes are a key strategy for off-setting such losses, and  
563 can therefore be adopted for both revenue-raising as well as public health reasons.

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

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

584

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