AUSTRALIA–JAPAN RESEARCH CENTRE
ANU COLLEGE OF ASIA & THE PACIFIC
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APEC AND INFECTIOUS DISEASE: MEETING THE CHALLENGE

Joel Gilbourd

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Contents

Figures

Tables

APEC and Infectious Disease: Meeting the Challenge

As globalisation accelerates the international movement of organisms that are capable of carrying infectious diseases, it is becoming clear that global infectious disease management is an issue that demands concerted international action in order to be managed effectively. Health security has, in recent times, featured ever more prominently on the APEC agenda. However, there has been little study done on what specific contribution APEC can make to international infectious disease management. Accordingly, this paper considers how the APEC process, given its institutional characteristics, can help the World Health Organisation in its international infectious disease management efforts.

1 Introduction

This paper considers how the Asia Pacific Economic Cooperation (APEC) process, given its institutional characteristics, can contribute to the efforts undertaken by the World Health Organisation (WHO) against infectious disease (ID). By considering the history of APEC's ID initiatives, this paper will show that there is sufficient interest among APEC's members in using APEC as a health forum for APEC to significantly contribute to the WHO's work in this field. It will then outline the nature of the current international ID threat, what needs to be done to counteract it, and what factors impede effective countermeasures. The measures through which APEC can help the international community to overcome these impediments will then be considered. Lastly, the paper will show that these measures add value to the WHO process and do not duplicate it.

2 APEC: history and structure

Background Conceived in 1989 as a consultative forum between economies on issues of economic integration (Elek 2006: 99), APEC started by holding informal ministerial trade talks in Canberra that same year, with 12 members attending (APEC Secretariat: n.d. c).

In 1993, APEC held its inaugural Economic Leaders Meeting in the United States, where Leaders announced their vision of 'a community of Asia Pacific economies'. In 1994,

APEC Leaders adopted the Bogor Goals, pledging to have free trade and investment in the Asia–Pacific by 2010 for developed economies and by 2020 for developing economies. In 1995, the Leaders adopted the Osaka Action Agenda, naming trade and investment facilitation, trade and investment liberalisation and economic and technical cooperation as the three pillars of APEC.

APEC currently has 21 member economies: New Zealand, Australia, Papua New Guinea, the Philippines, Indonesia, Malaysia, Singapore, Brunei Darussalam, Thailand, Vietnam, China (People's Republic), Hong Kong China, Chinese Taipei, South Korea, Japan, Russia, Canada, the United States, Mexico, Peru and Chile (APEC Secretariat). The table in Appendix A (APEC Secretariat) illustrates its structure: the various working level groups are comprised of member bureaucrats. These groups report to the Senior Officials Meeting (SOM), which is also comprised of members' bureaucratic representatives (see APEC Secretariat). The SOM reports to a range of annual and *ad hoc* sectoral ministerial meetings, including the Trade Ministers' Meetings, which pave the way for the Annual Economic Leaders' Meetings. The APEC Business Advisory Council (ABAC) comprises business representatives from the member economies (APEC Business Advisory Council). It holds discussions directly with the SOM and ministerial meetings in order to advise them on specific areas of cooperation. APEC is served by a secretariat that works from Singapore.

History of health in APEC While ID issues have featured on APEC's agenda for some time, it was members' lack of interest in using APEC as a health forum that rendered its early efforts ineffective. Health was first introduced to APEC through the APEC Industrial Science and Technology Ministerial Meeting in 1995 (APEC Sectoral Ministerial Meeting on Industry Science and Technology Declaration: 1995), and was put under the mandate of Subgroup C of the Industrial Science and Technology Working Group (ISTWG) (APEC 2004f, slide 1). The APEC Strategy on Emerging Infectious Diseases (APEC 2001) was approved by leaders in 2001 (APEC Leaders' Summit Declaration 2001). It proposed six activity categories: electronic networking, surveillance, outbreak response, capacity building, partnering across sectors and leadership (APEC 2001: 10–19). While by 2002, APEC had become involved in 15 health projects (APEC 2002), it failed to make a significant contribution to international management of the 2003 SARS outbreak. Many critics who analyse the international response to SARS do not bother to mention APEC, while others openly deride it.[1] The main reason for this failure, as acknowledged by APEC itself, was the inability of the ISTWG to attract significant interest from members' health ministries in using APEC for a health policy dialogue (APEC 2003a: 2).

APEC senior officials then took measures to give ID issues greater prominence among the APEC forums, yet shied away from giving health the full status that the largely economic-focused Working Groups enjoy. In 2004, an APEC Health Task Force (HTF), which reports directly to the SOM, was established to address 'health-related threats to economies…focusing mainly on…infectious diseases' (APEC Secretariat g; see also APEC 2004a: 3). However, unlike the Working Groups, this was established as an *ad hoc* forum to run on a time-limited mandate to be renewed at the discretion of the SOM (APEC 2003b: 3–4). Unlike the Working Groups, the HTF is not supported by regular sectoral ministerial meetings. Significantly, these limitations were placed on the HTF by conscious design. The SOM did not establish a Working Group on Health because it was considered that this would involve organising regular Health Ministerial Summits, which would need a long-term commitment from health ministries and resources to sustain such a commitment. Thus, the SOM was not prepared to spend resources on a Health Working Group, and member economies were unwilling to provide the extra resources needed. Likewise, the APEC Life Sciences Innovation Forum (LSIF) was established in 2003 in order to 'promote a policy environment to foster the growth of life-sciences innovation and the improvement of public health' (APEC 2004b: 2–3). However, unlike most Working Groups (APEC Secretariat), this forum reports first and foremost to the Committee on Trade and Investment (APEC 2004b: 2–3) rather than to the higher order SOM and Ministerial Meetings.

Yet despite these institutional limitations, there is overwhelming evidence that members are investing great interest in APEC's ID-related activities. The HTF has attracted significant attention from members: one HTF meeting in April 2004 was attended by 36 delegates from 17 members (APEC 2005c), while the recent meeting on avian influenza (AI) was attended by 71 delegates from 21 members, along with six delegates from three non-APEC countries (APEC 2004e). In 2005, the HTF's mandate was renewed until 2007 (APEC 2005: 11). Likewise, ID issues have attracted high-level political attention from APEC's members. In 2003, Leaders launched a separate statement on health titled the 'APEC Health Security Initiative' in which they pledged to pursue efforts to monitor and contain diseases, 'especially those that could have international consequences' (APEC Leaders Summit Declaration: 2003). ID issues have featured prominently in Leaders and Ministerial declarations since.[2] Despite their *ad hoc* nature, sectoral health ministerial meetings have been held frequently in recent times: one was held on SARS in June 2003 (see APEC Secretariat: n.d. f) and another was to be held on AI in May 2006 (APEC Ministerial Meeting on Avian and Influenza Pandemics, 2006). In 2004, there was a ministerial-level dialogue on poultry disease involving representatives from health and agricultural sectors (APEC 2004h: 1). Thus, APEC has

taken steps to overcome the problems that plagued its early health initiatives. It now stands poised to make a serious contribution to international ID management.

3 The nature of the health challenge

The cost of infectious disease States have an important interest in counteracting the spread of IDs. Curson and McRandle, in line with Bower and Chalk, identify six reasons for this (Curson and McRandle 2005: 8–9; Bower and Chalk 2003: 41–49):

i. IDs kill people; ID's have killed over 1 billion people in the last 25 years (Kombe and Darrow 2001: 114).

ii. IDs undermine the normal functioning of the state (Curson and McRandle 2005: 8) by causing panic and by decimating law-enforcement personnel (McInnes and Lee 2006: 16; Shisana, Zungu-Dirwayi, Shisana 2003: 137–157; Cabarello-Anthony 2005: 491).

iii. IDs generate inter-state antagonism (McInnes and Lee 2006: 16). For example, when China was identified as the index country for the 2003 SARS outbreak, Vietnam placed additional troops on the Chinese border to prevent the unchecked entry of infected persons (Curley and Thomas 2004: 23).

iv. IDs damage the international economy (Lee and McKibbin 2003: 25–26) by decimating-work forces,[3] causing import bans (anonymous 2004: 1–3), swings in consumption patterns (anonymous: 2006, p.12), reduced tourism revenue (Cabarello-Anthony 2005: 483; Curson and McRandle 2005: 23) and investment outflows (Overby et al. 2004: 73; Dickie et al. 2003: 10). SARS is said to have cost the world US$30–50 billion (Curson and McRandle 2005: 17).

v. IDs undermine social cohesion in nations (Curson and McRandle 2005).

vi. IDs threaten national security through bio-terrorism (Curson and McRandle 2005: 8).

Prevalence, re-emergence and globalisation: understanding the new threat The modern global ID threat has three particularly worrying features:

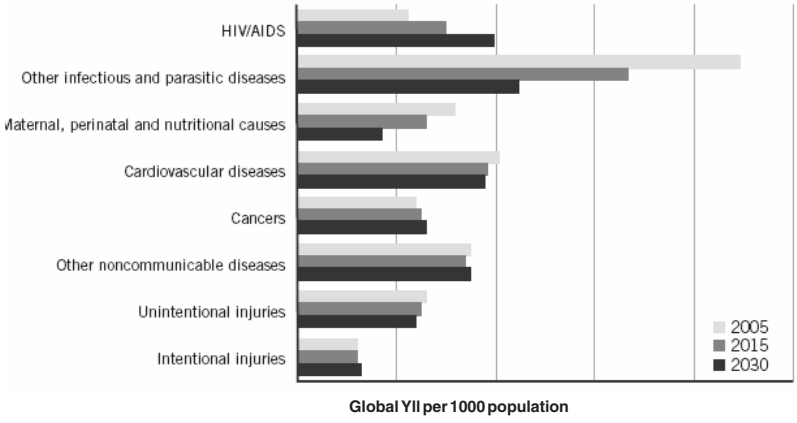
i. ID is extremely prevalent in today's world. ID caused 33 per cent of human deaths globally in 1997 (Kombe and Darrow 2001: 114). The figure below (World Health Organisation 2006: 19), compiled by the WHO, projects the years of life lost for major causes of death worldwide for the years 2005, 2015 and 2030. While the years of life lost to HIV AIDS and other IDs is projected to decline during 2005–2030, however, ID will remain a major cause of death across this period.

ii. Second, new IDs are emerging at an unprecedented rate of one per year (Cabarello-Anthony 2005: 489; Curson and McRandle 2005: 14). One particularly worrying cause of emergence, however, is zoonosis, whereby animal-borne diseases jump the species barrier to infect humans. Probably as many as 75 per cent of IDs to have emerged in the last 40 years did so through zoonosis (Curson and McRandle 2005: 15).

iii. Indeed, SARS only took 24 hours to infect five countries on two continents (Bishop 2005: 1181). Moreover, while SARS broke out in China, it infected cases in Canada, Singapore, and the EU, thus proving that good sanitation and infection control would not protect the developed world from global outbreaks (Asamoah-Bahh 2004: 15).

However, while ID is a global threat, it retains a regional dimension. This is because human air travel is regionally concentrated. These figures go some way in explaining why 99 percent of the world's probable SARS cases occurred in APEC economies (APEC 2003: 2).

Figure 1 Years of life lost (YLL) per 1000 populations for major causes of death, all ages, world projections for 2005, 2015 and 2030



Causes It is a fact of science that IDs are immediately caused by pathogens and the scientific processes through which pathogens move between hosts. Yet these processes are not objective acts of God, entirely beyond the influence of mankind. It is for this reason that pathogens can only be thought of as the *immediate* cause of ID. Indeed, there are various underlying social, environmental and other conditions that can catalyse the emergence and spread of ID. Further, these conditions can be counteracted and prevented through effective public policy supported by the necessary resources. Therefore, effective policy can counteract the emergence and spread of ID (Kickbush 2006: 6). By extension, the spread and emergence of IDs, and the general degradation of public health, can be understood as the product of bad governance, of resource constraints, or a combination of the two (Kickbush 2006).

For example, zoonosis is an important *immediate* cause of ID re-emergence. Zoonosis is the scientific process that sees animal-borne diseases jump the species barrier to infect humans. Probably as many as 75 per cent of IDs to have emerged in the last 40 years did so through zoonosis (Curson and McRandle 2005: 15). The process of zoonosis is a natural biological process that has been occurring for eons, yet it is not beyond the influence of mankind. Indeed, zoonosis is catalysed through the keeping of different animal species close to each other and to humans (Karesh et al. 2005: 1001). This practice is especially prevalent in Asian traditional farming methods (Curson and McRandle 2005: 20) and Asia's wildlife markets (Enemark 2006: 46; Karesh 2005: 1001). The prevalence of these dangerous practices in several Asian countries is, in turn, the result of poor agricultural regulatory policy and resource constraints. Therefore, zoonosis, has been as much a product of poor policy choices and resource constraints—factors which are well within the influence of mankind—as it has been the product of 'objective' biological processes. By implication, the re-emergence of ID though, is also the result of these factors that man can control.

The policy areas which have influence over ID, and global public health generally, are numerous, and many of them are not, strictly speaking, medical (Kickbush 2006: 6). It is beyond the scope of this paper to describe how each policy area has the potential to affect the global ID situation. It will suffice, by way of example, to look at merely the policy domains that are among the more influential in this regard.

Agricultural regulation continues to be of primary concern, not exclusively within the context of zoonosis. For instance, in the late 1990s where rising living standards in China, supported by new economic growth, generated greater consumer demand for meat (Curson and McRandle 2005: 14). Much was of this new demand being met through an increase in domestic intensive agricultural practice, which saw China's total animal product triple during 1986–96. Unsupported by a co-requisite increase in regulation and quality control of the meat industry, these new levels of production became a serious ID risk factor for China.

Intellectual property regulation, both at national and international levels, can also affect public health (Westerhaus and Castro: 2006, p.1230). Some critics are concerned that patent law, because of its role in determining drug prices, can make it difficult for developing nations to procure the counter-ID medication that they need, while doing little to encourage development of new counter-ID drugs (*ibid*, p.1232). Of particular concern to these critics is the Trade Related Aspects of Intellectual Property Rights (TRIPS) agreement in the WTO and its implications for international access to counter-ID medicine (*ibid*, p.1230).

The incentives that governments offer to undertake research into ID and ID-related issues also has important implications for ID. In recent times, governments around the world have been found wanting in this regard. Indeed, while not exactly *causing* re-emergence, the inaccessibility of drugs is certainly making suppressing the ID threat ever more difficult (Thomas 2001: 20). Pharmaceutical companies dedicate only a fraction of their resources to the development of anti-ID vaccines and medication (Kombe and Darrow 2001: 119). Anti-ID drugs are often too expensive for citizens of the developing world, this being where ID is most prevalent (Thomas 2001: 20). Moreover, the developed world often corners the ID drug market (Curson and McRandle 2005: 26).

Immigration and social integration policy also have considerable consequences for ID. Indeed, recent times have seen a move away from thinking public health problems in purely medical terms towards a broader conception of public health in terms of social determinants (Kickbush 2006: Irwin *et al*: 2006; 749; Graham and Kelly 2004: 2). This approach considers a range of demographic determinants and how such factors correlate with the health problems faced by a population. It thus tries to identify which social categories are at greatest risk in terms of health. Ethnic origin, for instance, is one such 'determinant': in 2003, Australia's overseas-born population had an ID infection rate of 22 times higher than that of the Australian-born population (Curson and McRandle 2005: 17). Gender can be another important determinant: in recent times, the global number of women who are self-employed, working part-time, or doing seasonal jobs has increased; this has seen a correspondence in their engagement in transactional sex-work as a means of augmenting their low earnings and this has rendered women in some parts of the world particularly susceptible to sexually transmissible IDs (Sicchia, Maclean 2006: 70). An individual's socio-economic position has been noted to be an important health determinant, and some critics have also spotted a more general positive relationship between disease prevalence and poverty (Cabarello-Anthony 2005: 495). Moreover, some critics have suggested that even modifiable risk factors that contribute to an unhealthy lifestyle, such as smoking, should be considered the product of structural patterns such as social exclusion rather than as in individual lifestyle choices (Irwin et al: 2006: 0749).

Transport and customs policies also have important implications for the international spread of ID. Indeed, owing to the massive increase, in recent times, in the speed (Forrest 2000: 158; Curson and McRandle 2005: 23) and patronage levels of international air travel (Curson and McRandle 2005: 21–22), IDs spread around the world further and quicker than in the past. Across the 1945–2004 period, the number of passengers carried by airlines per year grew from 9 million to 1.6 billion, and it is predicted that well over 2 billion passengers will fly each year within the next decade (*ibid*: 21). SARS only took 24 hours to infect five countries on two continents (Bishop 2005: 1181). Moreover, while SARS broke out in China, it infected cases in Canada, Singapore, and the EU, thus proving that good sanitation and infection control would not protect the developed world from global outbreaks (Asamoah-Bahh 2004: 15).

It is important to clarify, however, that while ID is a global threat, it retains a regional dimension. This is because human air travel is regionally concentrated. In 2004, 80.9 per cent of travel was conducted intraregionally and it is predicted that this figure will be 75.8 per cent in 2020 (World Tourism Organisation 2005: 9–10). There is good reason to suspect that there is more intra-APEC than extra-APEC travel currently going on. Intra-APEC traveller arrivals outstripped extra-APEC arrivals in Australia during 2005 (World Tourism Organisation 2006, Table 6B), in PNG during 2003 (PNG Tourism Promotion Authority: 2004), in Japan (ASEAN–Japan Centre: n.d.), New Zealand (Statistics New Zealand 2005), the United States (United States Office of Tourism and Travel Industries: n.d.) and the APEC–ASEAN block (that is, APEC plus Myanmar, Cambodia and Laos) (ASEAN–Japan Centre: n.d.a) during 2004, as well as in China during 1996–2000 (China National Tourist Office: n.d.). These figures go some way in explaining why 99 per cent of the world's probable SARS cases occurred in APEC economies (APEC 2003: 2).

There is a range of other policy areas that have important implications for ID and public health. Urban planning and environmental policy, for instance, are among these (Forrest 2000: 158). One unintended outcome of deforestation in Africa, for instance, has been the rise of the bush meat trade in Africa: as roads built by logging companies have penetrated into previously inaccessible areas of rainforests, commercial hunters are finding it easier to kill apes and sell the meat in some African cities (Pearce 2003: 92). This trade, is generally subjected to little public health inspection, and so is potentially dangerous in its capacity to spread food-borne IDs (Pearce 2003: 92). Media and public communications law is another policy area that can have significant ramifications for public health. Some critics suggest that private, corporate control over mass media channels can impede governments' capacities to inform their citizens about the true nature of harmful goods such as tobacco and alcohol, and to communicate other health related information (Wiist 2006: 1370).

Treatment and prevention: a recipe for effective ID management It is dangerous to generalise about what makes good counter-ID policy. ID is not monolithic: diseases and outbreak conditions will vary from situation to situation, and so will the policies that are appropriate to each. It is beyond the scope of this paper to prescribe specific measures to counter specific diseases or outbreaks. However, while a 'one size fits all' approach to counter-ID policy is indeed inadequate, there are a few comments about what makes such policy effective in general that are worth making.

First, all counter-ID efforts must be supported by a cross-sectoral policy approach. It has already been shown how numerous public policy domains outside health can inadvertently affect public health and ID, and some critics have even suggested that 'most' of the factors that impact health are to be found *outside* the spheres of medical knowledge (Swedish National Institute of Public Health 2003: 6). Any public health or ID management policy package, therefore, must draw on a whole of government approach, with agriculture, transport, media, community services, science and other bureaucracies acting alongside health ministries.

An effective recipe for international management would involve, importantly, two sorts of efforts: *treatment* and *prevention*. *Treatment* policies are taken in reaction to an ID outbreak. They largely involve measures such as dispensing appropriate care to those who have been infected by the outbreak, but could also involve measures such as quarantine. *Treatment* should generally address the following four general aspects of ID management.

i. **Capacity development:** Governments should have strong surveillance capabilities which will allow for early detection of ID outbreaks (Prescott 2003: 217). Governments must also develop surge capacity within their public health systems to be able to treat large numbers of patients during pandemic outbreaks (*ibid*).

ii. **National planning:** Governments need to prepare plans for dealing with pandemic outbreaks (Karesh and Cook 2005: 41; Cabarello-Anthony 2005: 491).

iii. **Transparency:** Countries to need be honest about their ID outbreaks and about their capacity to deal with them (see World Health Organisation 2005: 10). This allows other countries to contain the spread of the disease through measures such as the issuing of travel advisories and tighter screening and regulation of the inflow of imports and people.

iv. **Connectivity and coordination:** All of the above actions need to be supported by 'connectivity' (*ibid*). This refers to the setting-up of international communication channels for the rapid sharing of ID intelligence and for the coordination of national and international ID initiatives.

Prevention involves measures that are taken proactively in order to avoid an outbreak occurring in the first place. On one level, *prevention* would involve policies such as public education campaigns to discourage people from engaging in dangerous practices that are conducive to the spread of ID. It would also involve public immunisation campaigns. Yet significantly, *prevention* should go beyond this 'medical' level. As discussed above, *prevention* must not only address the pathogenic and medical causes of disease, it must also address the underlying social conditions which are associated with ID and bad health (Swedish National Institute of Public Health 2003: 5–6; Wanless 2004: 24).

The distinction between *treatment* and *prevention*, admittedly, is to some degree semantic and artificial. Some counter ID measures, such as the culling of infected livestock to prevent zoonosis, can be said to belong to both categories of ID policies. Such culling is a *treatment* measure because it is reacting to an ID outbreak measure within the animal population. However, it is also a preventative measure, in that it inhibits ID from spreading to humans. The two categories of policy clearly overlap, and there is no need to emphasise a clear-cut distinction between the two. On the contrary, it is important to realise that *treatment* and *prevention* policies are not mutually exclusive. Practicing one sort of policy does not 'crowd out' the other sort. Effective counter-ID strategies will invariably involve elements of both *treatment* and *prevention*.

4 Impediments to effective international ID management

The following section considers the main impediments to developing and implementing a concerted strategy to tackle the ID problem.

Unwillingness *Unwillingness* refers to a government appreciating the danger of the ID threat, but being *unwilling* to take the necessary countermeasures. Crucially, governments' *unwillingness* to report their ID outbreaks undermines the transparency of international ID control. Such *unwillingness* occurs for the following reasons:

i. Reporting an outbreak can seriously damage a country's economy. For instance, import bans imposed on poultry from AI infected countries by the EU and Japan (anonymous 2004: 3), combined with consumption swings caused by media saturation of AI issues (*ibid*: 2–3), are putting 1 million and 1.25 million jobs at risk in Thailand (Perlez 2004: W.1) and Indonesia (anonymous 2004: 3) respectively (anonymous 2006: 12). Likewise, the SARS outbreak stunted China's intake of foreign investment: Southern Guangdong's Canton Trade Fair was cut short in April 2003, having signed less than 20 percent of the value of contracts signed during the 2002 event (Overby et al.: 2004: 73; see also Dickie et al: 2003: 10).

ii. Reporting ID outbreaks can ferment social unrest, and put a government into a position where it is required to do things that will make it unpopular. Undemocratic nations are not immune to this problem (anonymous 2004: 2). For instance, the WHO has recommended that chicken flocks that have sustained AI casualties must be culled (Cohen et al. 2004b: 30–33,31). This is causing popular angst in countries such as Thailand and Vietnam, where governments can only afford very low levels of compensation (anonymous 2004: 3; see also Bradsher and Lawrence 2004). During the 2003 SARS outbreak, rumours that the government was going to establish SARS patient isolation wards caused riots in several parts of China (Enemark 2006: 485).

iii International law provides little incentives for countries to report outbreaks. The International Health Regulations (IHR), adopted by the international community through the WHO, is currently the only international code governing states' conduct with regard to ID (WHO 2005a). However, the WHO does not have a means of enforcing compliance with the IHR: it does not have the right to impose punitive measures (Bishop 2005: 1197; Taylor 1998: 1121) and this renders its dispute resolution mechanism of little use (Taylor: 2000, p.1354). In effect we have a bizarre situation whereby reporting a disease is more likely to result in import bans and thus causing, in the short term at least, more harm than covering it up.

However, contrary to what some critics have suggested (Bishop: 2005), significant incentives to report outbreaks do exist:

i. Reporting outbreaks can qualify countries for international assistance to stop the spread of the disease. Indeed Australia recently announced an AU$141 million AI aid package to Indonesia (Curson and McRandle 2005: 27). The United States has pledged over US$334 million in grants to countries threatened by the virus (US Agency for International Development 2006). In 2000 Canada committed CA$90 million in bilateral assistance to African countries to fight HIV/AIDS, with another CA$100 million announced in 2003 (Canadian International Development Agency n.d.).

ii. The announcement of ID outbreaks and ID policy responses can generate domestic political capital for governments. The announcement of an outbreak generally does not bring governments political loss of face, because it is the pathogen and not the government that is causing the trouble (Forrest 2000: 158). In this way, discussing the threat of an outbreak can be used to reinforce the image of the government as a dedicated protector of its people. Speaking about AI, George Bush, for instance, publicly said that 'we are likely to face another pandemic' before outlining a US$7.1 billion program to combat the disease (Grigg 2005: 19).

iii. Countries understand that, as far as outbreak reporting is concerned, they are faced with a prisoner's dilemma: if everyone hides their respective outbreaks, it will ultimately be to everyone's detriment. Accordingly, countries understand that if they are to expect other countries to report their outbreaks, they must also report their own. This is reinforced by the fact that even if the government does not report an outbreak, there is still an appreciable chance that the international community will find out about it. In the modern age of globalised communications, non-governmental whistleblowers who have witnessed the outbreak first-hand can bring the disease to the attention of the international community. The WHO is allowed to accept outbreak information from such sources (WHO n.d.: Article 8) and about 40 per cent of ID outbreaks identified by the WHO are first recognised by scouring the internet for rumours of emerging diseases (Prescott 2003: 220). There is also the possibility that the disease will spread to another country where it will be reported and traced back to the country of origin. This is what happened with China and SARS (Curley and Thomas 2004: 23).

It is ultimately difficult to ascertain whether forces against reporting disease are ultimately outweighed by incentives to report. Admittedly, China initially classified its SARS outbreak in late 2002 as a national secret (Bishop 2005: 1181), and there were AI related cover-ups in Thailand and Indonesia in 2004 (Bradsher and Lawrence 2004). By 20 April 2006, however, no less than 56 countries (including China, Thailand and Indonesia) had reported AI outbreaks to the International Organisation for Animal Health (OIE) (World Organisation for Animal Health (OIE): 2006), and the WHO recently stated that political commitment to AI outbreak reporting was 'strong' throughout the Asia Pacific (Mason: 2006).

Inability *Inability* refers to governments not being able to effectively counteract IDs due to factors that are largely beyond their control. The main causes of inability are resource constraints, which render some countries *unable* to develop the requisite counter ID capacity. The OIE (Reuters 2006), the UN (Xinhua News Agency 2006) and the WHO (Grudgings 2005), have all acknowledged that many developing countries lack the communications infrastructure and expertise needed for rapid detection of disease outbreaks. This, in turn, renders countries *unable* to contribute to international ID transparency in an optimal way. Lack of treatment capacities, such as hospital ventilators and drug stockpiles, is another issue (Grudgings 2005; Hill & Associates Risk Consulting 2005: 6). Of particular concern for APEC is the prevalence of such capacity constraints among its poorer Asian members.[4]

Irrationality *Irrationality* refers to governments' adoption of irrational policies towards ID management. It generally takes two forms:

i. First *irrationality* stops governments from appreciating the full danger of the ID threat. This, in turn, prevents governments from dedicating adequate attention to their national ID planning and from directing sufficient resources to ID capacity development. This is reflected in the low priority given to primary health care by the many governments who spend more money on defence (see Table below) (Cabarello-Anthony 2005: 493). In October 2005, Hill & Associates, a private consultancy firm, analysed the AI preparedness situation in various nations. It rated the 'official response to date' as 'unsatisfactory' for Thailand and Pakistan (Hill & Associates Risk Consulting 2005: 9). It seems that even if these countries had the resources to develop an effective counter-ID capacity, they would have higher priorities in other areas and would spend these resources elsewhere.

ii. Where governments do appreciate the dangers of ID, *irrationality* can cause such governments to misconceive the nature of the threat, and to pursue counteractive policies under the misconception that such policies are effective. One example of such policies has been the imposition in 2004 by Japan, the United States and the EU of import bans on chicken meat from AI infected countries (Brasher and Lawrence 2004). These bans are irrational because they do not enhance the safety of people living in the banning countries, given that the WHO explicitly stated that there is no evidence that chicken meat can cause illness (*ibid*). What the bans do, however, is create economic pains in poultry exporting countries (see above at Section 3). This, in turn, gives poultry exporting countries a disincentive to report further disease outbreaks (Prescott: 2003: 216; Bishop 2005: 1193).

Table 1 Government health and defense expenditure in 1995 in selected ASEAN countries

	Health (% of GDP)	Defense (% of GDP)
Brunei	2.2	5.5
Cambodia	0.7	5.9
Indonesia	0.6	1.3
Malaysia	1.5	2.7
Philippines	1.3	1.4
Singapore	1.3	4.7
Thailand	1.4	2.2
Vietnam	1.1	7.2

Source: Cabarello–Anthony 2005: 494.

Fragmentation *Fragmentation* refers to absence of connectivity and coordination in international ID management. There is an increasing number of health-related initiatives being taken outside of the WHO through bilateral channels and through other international organisations such as UNESCO, the World Trade Organisation (WTO), the World Bank and the G-8 (Yamey 2002: 1295). The lack of coordination between these efforts is leading to increasing evidence of duplication and inconsistency in the realm of international public health (Yamey 2002: 1295; Taylor 2004: 504). There is also a lack of communication between human and animal health authorities: in 2004, James Hughes, an official of the US Centre for Disease Control and Prevention stated: 'we don't come to their meetings and they don't come to ours' (Cohen, McKay 2004: A11). Of particular concern for APEC, has been the lack of cooperation shown by mainland Chinese health authorities to those of Taipei and Hong Kong (Cessar 2006; Parry 2003: 130).

5 Should APEC do anything?

There are two arguments that suggest that ID issues should not be incorporated into APEC's agenda. First, some argue that APEC should not deal with non-trade related issues because these dilute APEC's focus on trade (Gyngell and Cook 2005: 6; Krongkaew 2005: 4) and 'crowd out' progress in trade liberalisation (Krongkaew 2005: 4). Second, it might be argued that to establish yet another health forum outside the WHO in APEC would only further *fragmentise* international ID management.

The first of these concerns is inconsistent with APEC's evolving agenda. Indeed, with most countries failing to move towards the Bogor Goals any further than they are bound to by their WTO Uruguay Round commitments, many commentators suggest that in the area of trade liberalisation, APEC has bitten off more than it can chew.[5] While trade policy is likely to remain a dominant concern for APEC, APEC will also need to explore other areas in which it can carry out its community-building vision (Elek 2006: 116). ID management offers a good area for this: while there is much to be gained from cooperation (see below at Section 6), ID management also retains an important trade-related dimension (see above at Section 3); its inclusion into APEC's agenda would not significantly dilute APEC's trade focus. APEC itself has acknowledged this (APEC 2003: 6–49). Conversely, in limiting the APEC agenda to *purely* trade-related issues, members might miss out on other opportunities to fulfil APEC's community-building purpose (Elek 2005: 38).

The second concern can also be dismissed. Certainly, the WHO remains the world's main vehicle for international ID cooperation (Bishop 2005: 1174; Jones 2005: 178). However, the global significance of APEC's membership in itself discourages one from one considering APEC in the context of *fragmentation*: APEC economies account for approximately

40 percent of the world's population, approximately 56 per cent of world GDP (APEC Secretariat: n.d. h) and include 3 UN Security Council Permanent members as well as Japan. Hence, provided that the APEC process can channel cooperation between its members into initiatives that complement rather than duplicate the WHO, APEC will counteract *fragmentation* rather than worsen it. APEC itself has recognised this factor (APEC 2001: 10; APEC 2004a: 7–8; APEC 2005b: 1). The following chapters will discuss how APEC's processes of consensus building and information sharing can help members to overcome the impediments to effective ID management in ways that the WHO cannot.

6 What can APEC do?

Profile APEC itself has recognised the leadership value of its high profile Leaders' Meetings in the area of ID (APEC 2001: 18). A strong collective statement made by a weighty group of countries generates international interest in ID issues and pushes countries to understand the gravity of the ID threat. This causes countries to overcome *irrationality,* and to dedicate higher levels of attention and resources to national ID planning and ID capacity development. The high level of political commitment given to HIV/AIDS at the 2001 G-8 Summit, for instance, led to higher levels of investment throughout the world to counter HIV/AIDS (*ibid*). Statements like the 2003 APEC Health Security Initiative are posed to have a similar effect. Indeed, when APEC Leaders speak, the world listens. When, in 1993, the United States hosted the inaugural Leaders' Meeting, this was a clear signal to the EU that the United States was willing to create its own trading framework if the EU failed to make concessions in the WTO (Petri 1999: 6). Consequently, the EU made additional concessions, and the Uruguay Round was concluded shortly afterwards (*ibid*).

Socialisation APEC can encourage governments that are impeded by *irrationality* to overcome this impediment and to *prudently* engage the ID threat. APEC can do this through its process of socialisation: by exposing member governments to iterated pressure from other members, APEC can lead them to redefine their sense of identity (Ravenhill 2000: 161; Garofano 1999: 78–79 and Wendt 1999: 10). This can catalyse convergence between members' policy goals (Aggarwal and Lin 2001: 180–181). Critics have acknowledged pressures of socialisation, exercised through APEC, as having contributed to the East Asian governments' move from import-substitution to trade liberalisation (Ravenhill: 2000, p.152; Aggarwal and Lin 2001: 181), and towards greater privatisation (*ibid*). It is difficult, as yet, to discern tangible outcomes of APEC's socialising process on its individual members' approach to ID management. However, the growing attention paid to APEC's health initiatives by its members (see above at Section 2) suggests that APEC is catalysing the growth

of members' interest in ID issues and increasing their awareness of the full extent of the ID threat.

Consensus building APEC is an effective avenue for the building of consensus, which can be useful to the ID effort in various ways:

i. First, members can use APEC to establish standard procedures in aspects of their national ID related policy. This makes states act more predictably, relieves uncertainty (Drysdale 1988: 27), and contributes to better coordination of international ID efforts. For example, APEC Trade Ministers recently pledged to work collectively to develop protocols for continuity of essential services and trade during ID emergencies (APEC 2005: 2).

ii. Second, members can agree on communal policy benchmarks that can be used to measure progress (McKay 2003: 11–12) towards ID related goals. This can accelerate national ID planning: APEC members recently agreed to work individually to develop national pandemic preparedness plans by November 2006 (APEC 2005: 1). In non-politically sensitive areas (see below at Section 6), these benchmarks signify genuine commitment which brings tangible results. In 2001, APEC members agreed to reduce trade-related transaction costs within the APEC region by 5 percent by 2006 (Gyngell and Cook 2005: 9; see also Elek 2005: 39). A recent review found that members were well on their way to achieving this goal (*ibid*).

iii. Third, APEC members can mutually acknowledge the various impediments to an effective international ID response. For example, members have recognised that 'importing countries have adopted trade restrictions…[which] are often inconsistent with the recommendations of international standard setting bodies' (APEC 2005a: 9). Such consensus paves the way for the gradual, long-term socialisation and convergence of values discussed above, and thus helps governments to overcome *irrationality*.

Admittedly, there are two factors worthy of consideration that might limit APEC's capacity to build consensus:

i. First, APEC's greatest failure in its dealing with the SARS crisis was the time-lag in its response (Curley and Thomas 2004: 28): while the first WHO alerts on SARS came out in mid-March 2003 (McInnes and Lee 2006: 9), it was not until 27 May that SARS first appeared on APEC's agenda (APEC 2003c: 1). Critics suggest that this problem was caused

by APEC's institutional structures, emphasising APEC's lack of in-house analytical capability as the main problem (APEC International Assessment Network (APIAN) 2002: 5; Curley and Thomas 2004: 28). Indeed, with a slim staff of approximately 50 people (Gyngell and Cook 2005: 7), comprised mainly of foreign affairs generalists (APIAN 2002: 5), APEC has neither the numbers nor the expertise needed 'to identify and address new and emerging issues' (*ibid*). However, while fostering an in-house analytical capability would certainly improve APEC's quick-reaction capacity, the above-mentioned critics have a limited appreciation of APEC's current response capabilities. Indeed, the APEC Leaders' meeting has been able to facilitate the resolution of pressing problems of the day such as East Timor's independence and China's entry into the WTO (Gyngell and Cook 2005: 8; McKay 2005: 30). Furthermore, the regularity of the SOM, which meets three to four times a year (see APEC Secretariat n.d.), allows for a rapid response to arising issues. APEC's lag in responding to SARS was not really a structural problem. As discussed above (see Section 2), it was the result of members' lack of interest in using APEC to address ID challenges and this level of interest has since shown signs of improving.

ii. Second, APEC does not compel members to adopt and implement politically difficult policy commitments. APEC operates on consensus, eschews exerting direct pressure on its members and has no authority to bind agreements (APIAN 2000: 4). This is not helpful when it comes to overcoming domestic political impediments: governments cannot justify unpopular policy on grounds that they are bound by international law (Ravenhill 2000: 160). For this reason, many of the cooperative promises made in politically sensitive areas through APEC are vague and insubstantial. In his analysis of the Osaka Action Agenda, which supposedly sets the principles along which APEC would travel to the Bogor Goals, Ravenhill concludes that it is 'highly ambiguous…and ridden with escape clauses' (2000: 155–157). Moreover, the absence of a formal dispute resolution mechanism denies APEC an authoritative voice in rule interpretation and makes it hard to resolve such ambiguities (*ibid*: 163). Similarly, APEC does not have the capacity to authorise punitive actions against its members (APIAN 2000: 4). Thus, even where politically painful, concrete commitments are made, members often have little inducement to adhere to them. We have already seen how members have failed to move towards the Bogor Goals beyond their Uruguay Round requirements. For these reasons, APEC has difficulty with giving countries incentive to overcome problems of *unwillingness* and *irrationality*. Indeed, it has been surprising to see APEC members pledge to restrict ID-related import bans to those that are scientifically justifiable (APEC 2005: 2), given that the United States continues to ban poultry meat imports from AI affected countries (US Department of Health and Human Services Centre for Disease Control and Prevention 2006).

Information sharing APEC is also a useful forum through which economies can share information (McKay 2005; Ravenhill 2000: 161). Even if it does not bring about consensus, information sharing is still useful for three reasons:

i. First, information sharing can contribute to *transparency* and build trust (*ibid*: 145). Interview-based studies of APEC officials by the APEC International Assessment Network (APIAN), a group of independent academics, found that APEC information sharing efforts on trade-related questions have contributed to transparency (APIAN 2000: 8). APEC has created a number of valuable guidebooks and databases on regulations governing business in the region and business-people have found these useful (Ravenhill 2000: 170; Senate Committee on Foreign Affairs, Defence and Trade 1997: 31; Chiang 2000: 201). Likewise, 13 countries made presentations in the HTF on aspects of their national ID policy,[6] 10 of which have presented detailed data on their outbreaks situation.[7] Thailand, China, and Vietnam, who have in the past failed to disclose their ID outbreaks (Bradsher and Lawrence 2004: A11; Reuters 2006), are included in this number. In 2004, the United States conducted, through the HTF, a survey of APEC health ministry officials (APEC 2005n). At September 2004, 11 APEC economies had completed the survey (*ibid*). Although the results did not name specific members, the survey gave important information about the current status of national pandemic plans in the region (see Table below).

   Furthermore, the HTF has set itself up as a transparency mechanism in itself, which members can use to gauge each others' level of ID threat awareness. When a member

Table 2 Current status of national pandemic plans

Plan status	APEC	Non-APEC
Plan completed and approved	5*	1
Plan completed; approval pending	2	1
Draft plan completed	3	1
Planning group developing draft	0	2
Decision to plan; activity pending	1	0

Note * Australia; Chinese Taipei; Hong Kong; New Zealand; Philippines.
Source: APEC Document 2005n: 2.

announces their ID policy in the HTF, they are not only sharing data; they also set an important example for other members to follow (see I-Ways 2005: 47), subtly impelling them to announce their respective national ID policies and situations. Should the eight members who have not publicised their ID policies in the HTF continue not to publicise them, this might suggest that these members might be suffering from a degree of apathy towards the ID threat. Indeed, with 13 members, including Russia, China and the United States having announced their ID policy in the HTF, the pressure on the remaining members to do likewise is not insignificant. In continuously not publicising their ID policies, therefore, these eight members would be ignoring this pressure and this might suggest they might benefit from some help in raising their awareness of the ID threat. Indeed, in continuously not publicising their ID policies, these eight members would be passing up the opportunity offered by the HTF to reassure a very weighty group of economies that they have developed strong policies to tackle their ID woes, and that their economies are safe to invest in and to import from. Alternatively, they would be passing up the opportunity offered by the HTF to admit to any ID capacity gaps they might have, and to ask for international assistance. In this way, the HTF is able to identify which members might benefit from some encouragement in dedicating more attention to ID issues.

ii. Second, information sharing in APEC can contribute to quality national ID planning. APEC allows its members to learn from one each others' experience in policy development (McKay 2005: 7; Ravenhill 2000: 161). Interview-based studies of officials representing members in APEC confirmed that members do learn from each other (APIAN 2000: 8; APIAN 2002: 3). The 13 above-mentioned presentations on members' ID policies shared, in good detail, ideas concerning the use of IT communication technologies (APEC 2006k), the management of national drug stockpiles (APEC 2006d) and the establishment of cross-sectoral communication channels within governments (APEC Document: 2006a).

Moreover, APEC allows for particularly good policy discussion, in that it brings together a diversity of viewpoints. APEC combines countries that have had success and experience in modern pandemic management with countries that have had little of either. Thailand, for instance, has run a particularly effective campaign against HIV/AIDS (Ahlburg and Flint 2001: 9; Curson McRandle 2005: 24), while Vietnam engineered a very effective policy response to SARS (Curley and Thomas 2004: 23; Prescott 2003: 218). Russia, on the other hand, is struggling with its rising rates of HIV prevalence (Upton 2004: 74), as is PNG (Curson and McRandle 2005: 32). Furthermore, one of the HTF's purposes is to engage in dialogue with international health organisations (APEC 2003b: 3–4). This

allows such organisations to contribute to discussion and national ID policy development in the HTF. Indeed, one 2005 HTF meeting was attended by representatives from the WHO, the World Bank, International Red Cross, the UN Food and Agriculture Organisation and the OIE (APEC 2005c).

iii. Third, information, in the form of advice, can act as 'non-coercive' influence (Knorr 2003: 4–5). Indeed, information has been shared through the HTF about the world ID situation, and the threat that ID poses to members (see, for instance, APEC 2001: 1–5, APEC 2005p: 405; APEC 2004g: 3). This can contribute to socialisation, in that it raises members' awareness of ID and impels them to devote greater attention to their ID policies.

However, APEC also has two crucial institutional characteristics that imply certain limitations for its information sharing processes.

i. First, APEC members, being governments, are naturally adverse to undertaking activities in APEC that might embarrass them (Krongkaew 2005: 12)—and APEC's broader structures do little to change this. Just as APEC provides its members with few incentives to take on politically difficult agreements, APEC has difficulty in compelling its members to disclose sensitive information. In APEC's traditional trade-related areas, the main internal monitoring mechanism is the Individual Action Plan (IAP) Peer Review process. In this process, members formulated IAPs that outlined the measures they plan to take to reach the Bogor Goals. Certain members then 'swapped' these IAPs with one another for mutual review (Woo 2003: 5). This process, however, is voluntary, and has been criticised in lacking a consistent methodology (*ibid*: 7).

ii. Second, there is a lack of institutionalised dialogue with external, independent experts; efforts to embed such experts into the APEC framework have also met little success. For instance: The APEC Eminent Persons Group (EPG) was established within APEC in 1993 to advise Leaders on APEC issues. The EPG tried to introduce greater policy transparency into APEC as a means of embarrassing governments into action (Ravenhill 2000: 166). East Asian economies did not like this and successfully pushed for the abolition of the group in 1996 (*ibid*).

The outside sources that do exist, however, are inadequate (Krongkaew 2005: 12). The APEC Study Centres Consortium was established as a result of the first informal Leaders' Meeting in 1993. Its purpose was to unite independent academics from the member economies that would study and debate APEC related-issues (*ibid*). The Consortium,

however, does not have direct links with the APEC process through the Senior Officials Meeting and relies on small and often irregular support from governments. APIAN does not have regular or core funding from *any* organisation, and has to look for funds every time it wants to do research (*ibid*). The precursor to APEC, the Pacific Economic Cooperation Council (PECC), is a forum that unites government, business, and academic representatives from Australia, Japan and the United States. The governments that support PECC, however, are currently under pressure to reduce funding, and government sensitivities have disallowed PECC to publish data on individual economies, and the participation of government officials in these negotiations has solidified these limitations (*ibid*).

These factors imply two key limitations for APEC's information sharing efforts:

i. First, APEC has a limited capacity to contribute to transparency regarding its members' ID outbreaks and their capacity to deal with them. Indeed, in a recent HTF meeting, participants have explicitly 'cautioned against reporting that identifies economies that…do not have pandemic preparedness plans' (APEC 2005l: 2). While, as discussed above, some members have made significant strides towards transparent information sharing in the HTF, of the 13 countries that have presented on their ID policies, only Vietnam has admitted to ID capacity constraints and asked for assistance (APEC 2005i: 3)—even though it is known that serious capacity constraints plague China, Thailand (Hill & Associates Risk Consulting 2005: 9), Korea, Indonesia and the Philippines (Grudgings 2005).

ii. Secondly, it implies that in areas where all members espouse irrational policies, or espouse policies that are irrational in the same way, then APEC can do little to help APEC overcome this inadequacy: indeed, a forum of blind men cannot teach one another to see. The institutionalisation of an active dialogue with 'seeing men', such as NGOs and independent academics, would go some way making APEC less likely to succumb to such institutional 'blindness'.

Capacity building APEC can help members overcome *inability* by facilitating international aid efforts that assist capacity development its in poorer members. Admittedly, capacity building efforts conducted *through* APEC have had limited impact. APIAN surveys established this in 2000 (APIAN 2000: 13–16; Lu and Taylor 2001: 104–105) and several critics have reaffirmed this conclusion more recently (McKay 2005: 26–27; Krongkaew 2005: 6). This has been the case for at least two reasons:

i. First, the total resources dedicated to capacity-building initiatives in APEC are tiny (Elek 2006: 103). Substantial links have not been developed with the major funding agencies such as the Asian Development Bank (Krongkaew 2005: 7).

ii. Second, APEC's already small resources are finely scattered across too many different areas, and there is frequent overlap and lack of coordination (APIAN 2000: 15). APEC's consensus-based decision making process makes priorities hard to set (Elek 2006: 102; APIAN 2000: 15): each APEC member has their pet projects which, when multiplied by 21, quickly accumulate into a 'laundry list' (APIAN 2000: 15). Again, its secretariat has neither the numbers nor the expertise to evaluate the various projects (APIAN 2002: 5) or to meaningfully coordinate between forums (Krongkaew 2005: 8). While the Budget and Management Committee (BMC) has the power to evaluate and approve projects submitted by the Working Groups, in practice, it acts 'more like a spreader of APEC funds than a screening body…for high quality projects' (Krongkaew 2005: 10–11). Likewise, APEC's forums do little to evaluate projects sponsored by its individual members, and the SOM does little to evaluate the work of the Task Forces and Working Groups (APIAN 2002: 5). Most individual project reports submitted to the HTF have no 'lessons learnt' section,[8] and the same can be said for most HTF reports submitted to SOM.[9]

Hence, large capacity building projects that are likely to have a high impact cannot be administered through APEC (Elek 2006: 103). However, APEC has the capacity to assist the various bilateral and regional projects, which its members are undertaking outside APEC, in two ways:

i. First, APEC can be used as a probing device to find out where such aid efforts are most needed. We have already seen how the HTF in itself acts as a useful transparency mechanism that allows members to gauge each others' level of ID awareness. Initiatives such as the above-mentioned survey (see above at Section 6), allow APEC members to pinpoint areas of weakness in the regional ID architecture and to channel their efforts to rectify those weaknesses. In the following tables, taken directly from this survey, economies indicated what they felt were the greatest barriers to effective ID planning, where international collaboration and assistance would be most welcome and which modality of international cooperation would be preferable.

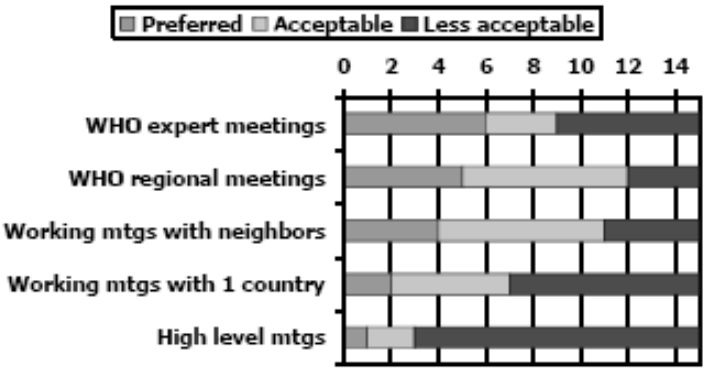
ii. Second, APEC can act as a laboratory where individual members 'test run' potential bilateral projects on a smaller scale. For instance, a substantial piece of Australia's AU$141,000,000 aid package to Indonesia involves training for Indonesian Health

Table 3 Barriers to pandemic influenza preparedness

Category	Barrier	Greatest barrier
Lack of guidance	7	2
Lack of interest by MOH	6	3
Lack of interest by other Ministers	11	4
Lack of interest by government leaders	4	1
Preparedness a low healthcare priority	4	3
Preparedness a low national priority	5	2
Lack of funding	11	7

Note: Other barriers: Lack of vaccine; lack of antiviral drugs.
Source: APEC 2005n: 5.

Figure 2 Relative preferences for types of international collaboration in pandemic planning



Source: APEC 2005n: 2.

Officials (Curson and McRandle 2005: 27). In preparation for this training, Australia could run a pilot of the training courses through APEC to ensure their quality and make any necessary improvements. This much was done by the United States when it ran, as an APEC HTF project, a Public Health Emergency Preparedness Course for officials from its various member economies. In its report on the course to the HTF, the United States noted 'suggested course improvements' from course participants, such as the need for more

Table 4 Topics for International Collaboration and assistance in pandemic planning

Topic	MOH Official (n=15)	Planner (n=14)
Surveillance	13	8
Containment	10	5
Strategies to decrease international spread	14	9
Clinical patient management	6	5
Vaccine supply	12	11
Vaccine use	5	8
Antiviral supply	11	10
Antiviral use	9	8
General emergency preparedness	8	8
Info. sharing/Risk communication	12	11

Source: APEC 2005n: 2.

opportunity to comment on delegation presentations and for more regional examples of problems (APEC 2005n: 3). Again, as discussed above (See above at Section 6), the diversity of APEC's membership and the inclusion of international health organisations in its meetings ensure a good variety of feedback on such pilot projects.

Personalised network building APEC's forums have intrinsic value (Gyngell and Cook 2005: 11) in that they encourage personalised interaction between the various bureaucracies of its members.

i. First, human interactions between domestic bureaucracies can induce domestic agencies to absorb new norms, which in turn are reflected in changes to their standard operating procedures (Ravenhill 2000: 149). This can help members to overcome any *irrationalities* that they might have in their national ID operating procedures.

ii. Second, personalised interaction allows people to gain experience in working together as a team. This improves connectivity, in that it allows for smoother communication between governments in times of ID crises (APIAN 2000: 6)—the HTF has itself acknowledged this (APEC 2004: 9; APEC 2004a: 7–8).

7 APEC: a one-way process?

During the writing of this paper, a concern arose about the degree to which APEC has targeted a *treatment*-based policy response to the ID challenge, and whether this has compromised its capacity to encourage a *prevention*-based response. This issue is discussed in this section.

As a preliminary point, one must ask: is it really suitable to speak of APEC as an organisation that is capable of collectively 'targeting' a specific policy approach to a particular policy challenge? One must ask this question because, as discussed in the previous section (see 'Consensus Building'), APEC is a 'soft' institution, which has difficulty compelling members to adopt and implement politically difficult policy commitments. This places limitations on the idea that APEC can 'target' a specific policy approach to a particular challenge: APEC is limited in its capacity to compel members towards a specific policy approach to a certain problem; it cannot coerce its members into adopting particular types of counter ID policies—be these *prevention* or *treatment* related. However, as discussed above, coercion is not the only way in which international organisations can move members to adopt certain policies. Indeed, through its processes of socialisation, APEC can, over time, convince its members towards agreeing on what is the best policy approach to be adopted in dealing with a certain challenge. Thus, the question stated at the beginning of this question becomes narrower: does APEC, through its process of socialisation, encourage a *treatment*-based policy response to the ID challenge among its members, and does this compromise its capacity to encourage a *prevention*-based response?

In approaching this issue, it is practical to begin by examining it from an empirical standpoint. The ideal empirical approach to the above question would necessarily involve an analysis of the connection between APEC initiatives and the domestic counter-ID policies of its individual matters: can it be said a specific APEC initiative *caused* a member to adopt a certain counter-ID policy, or is the connection between the policy and the initiative merely one of coincidence? To undertake such an analysis, however, would be too ambitious a task for this paper. Accordingly, the empirical analysis undertaken here will simply seek to ascertain how prominently the *prevention* approach has featured in APEC's ID-policy discussions. In undertaking this approach, two sorts of empirical evidence will be considered: joint statements made by APEC members (whether through the HTF, the SOM, the Ministerial Meeting, or the Leaders' Summit) will provide insight into whether APEC members are collectively coming to favour a particular counter-ID approach; materials presented for discussion by individual members to the HTF will show whether APEC members are pushing the collective body towards a specific policy approach.

Undertaking this analysis, it is clear that the *prevention* approach features rather insignificantly in APEC's counter-ID policy discussions:

i. The term 'prevention' has rarely featured in APEC's joint statements, which have given reactive, *treatment*-related measures a far more prominent role. For instance, in the 2003 Ministerial Meeting Statement, Ministers 'emphasised the need for continued implementation of the Action Plan and the APEC Infectious Disease Strategy, especially with a view to *mitigating* the impact of future outbreaks of infectious diseases' (APEC Meeting of Ministers Responsible for Trade Declaration 2003; emphasis added). Likewise, in discussing counter-HIV/AIDS policy in 2004, Ministers placed primary emphasis on accessibility of retro-viral medication (APEC Meeting of Ministers Responsible for Trade Declaration 2004).

   In the rare instances that the term 'prevention' does appear in statements of joint declaration, it does so only in very general terms; notions such as 'health determinants' and health inequalities are almost never mentioned. At the 2005 Ministerial Meeting, for instance, 'Ministers underscored the importance of timely and accurate reporting and capacity building efforts to enable adequate, systematic and well-coordinated prevention' (APEC Meeting of Ministers Responsible for Trade Declaration 2005). Likewise, in 2003, Leaders proclaimed that they 'will work to strengthen our public health infrastructure to detect, respond to, and prevent bio-terrorism and naturally occurring disease outbreaks' (APEC Leaders Summit Declaration: 2003). The APEC Strategy on Fighting HIV and other Infectious diseases, elaborated in 2001 and reaffirmed in numerous ministerial and Leaders' statements since (APEC Leaders Summit Declaration: 2004, 2005, 2006; APEC Meeting of Ministers Responsible for Trade Declaration: 2004; 2005, 2006) also mentions prevention but does not discuss social determinants of health (see APEC 2001).

ii. *Prevention-related* measures, not to mention social health determinants, also occur rarely in the presentations made by individual members to the HTF. Most of these presentations deal primarily with *treatment*-related issues, such as animal culling and disinfection (see, for example, APEC 2005e, APEC 2005r), outbreak management (see for instance, APEC 2005f), drug stockpiling (see, for instance, APEC 2006d). A few individual presentations do deal with prevention. However, these presentations conceive *prevention* in narrow, medical terms such as vaccination; they do not conceive of *prevention* in the broader context of social equity (see, for instance, APEC 2006c, APEC 2005g).

However, the degree to which the discussion of *prevention-related* measures is absent from APEC discussion should not be exaggerated:

iii. Primarily, it must be acknowledged that many of the counter-ID ideas that are promoted in APEC are too broad to be classed as exclusively *treatment* or *prevention* related measures; these ideas could lend themselves to either policy approach. For example, one idea that has been often promoted to the HTF has been the use of modern communications technology to monitor ID (see especially APEC 2001, see also 2006e and 2006k). It is true that the presentations that have promoted such technologies have never described how such technologies could aid the rectification of health inequalities (*ibid*). Indeed, the technologies could well be used for other purposes. Nevertheless, the fact remains that these technologies could also be used in collecting data on, and fighting against, health inequalities. Hence, presentations on such general counter-ID policies, which form an important portion of APEC's ID-related dialogue, cannot be said to be encouraging *treatment*-based counter-ID measures among its members. Indeed, the presentation of such ideas, inadvertently perhaps, could well be encouraging its members to adopt more effective *prevention* mechanisms.

iv. Furthermore, in recent times, prevention-related notions of health determinants and health inequalities have begun to rear their heads at various levels of the APEC discourse. At the working level, there has been some discussion of identifying social groups that are particularly vulnerable to ID and of addressing the social inequalities that cause this vulnerability. In a recent presentation to the HTF by the United States, 'poverty and social inequality' are listed among the 'factors contributing to the re-emergence of infectious disease' (APEC 2006). Presentations have also been made about addressing work-related gender inequalities (see APEC 2005s, 2006o) and improving migrant workers social status (see APEC 2006g) as a means of addressing the HIV/AIDS problem. The recommendations made in these presentations have gained the support of the Ministerial Meetings (APEC Meeting of Ministers Responsible for Trade Declaration 2006).

Yet empirical analysis cannot, in itself, provide a satisfactory answer to the concern mentioned at the start of this section: to conclude that APEC does favour a particular counter-ID approach begs the question of *why* it does so. It begs this question in two ways. First, it assumes that there is a relationship of mutual exclusivity between *treatment* and *prevention*, and that the sole reason why APEC has come to underplay the value of a *preventative* approach is that it has focused on a *treatment*-based one. Second, it assumes that APEC's encouraging of primarily *treatment*-based counter-ID measures is the inevitable result of APEC's institutional processes; it assumes that APEC is somehow 'hardwired' to encourage its members towards a *treatment* and not *prevention* of ID.

The first of these concerns is unfounded because, as discussed in Section 3, *treatment* and *prevention* are not mutually exclusive. Developing *treatment* policies and capacities does not compromise a government's capacity to undertake *prevention*-based efforts as well. Not developing effective *treatment* capacity will not, in itself, necessarily, lead to more focus on *prevention*. By extension, it cannot be argued that, by encouraging its members towards more effective *treatment* measures, APEC is discouraging its members from undertaking *prevention*. Indeed, as stated in Section 3, a comprehensive solution to the ID problem will necessarily involve a combination of both *treatment* and *prevention* measures.

The second concern raises a more profound question. If one is to suggest that APEC processes and structures, in themselves, cause APEC to emphasise *treatment* and not *prevention*, one would have to explain why this is the case. One explanation, perhaps, can be found in the suggestion that developed countries underplay the value of international *preventative* counter-ID efforts. Indeed, many critics have criticised the 'fortress mentality' entertained by the developed world towards global ID management, which focuses on dedicating large resources on isolating themselves from developing world IDs, without doing enough to prevent the emergence of such diseases in the developing world (see, for example, McInnes and Lee 2000: 11). Hence, it could perhaps be suggested that APEC's wealthier members are 'using' the APEC process to socialise its other members towards a reactive approach to ID management, and to dedicate most of their resources towards containing outbreaks rather than at preventing them. This raises a broader question concerning the nature of APEC's socialising processes: do APEC's socialising processes flow one way, that is, are these processes exclusively a case of the developed members socialising the developing members? Or is it a broader process where every member gets equal opportunity to influence and socialise their fellow members?

Formally and structurally, of course, APEC's institutional process of socialisation does *not* favour its wealthier members. In practice, of course, members do not get an absolutely equal chance to have their say and to influence APEC outcomes. Naturally, it is the larger and more aggressive governments that have the most impact—*if they choose to have it*. This, however, is all part and parcel of the normal interaction between governments—whatever power imbalances exist between member economies outside APEC, APEC does not exacerbate these in any way. Indeed, APEC is a neutral dialogue process that is open to all members.

To argue the contrary, and to suggest that APEC's socialising processes are 'one way' would be patronising to APEC's developing members: these members' representatives can talk and listen as well as those of developed countries—for indeed, talking and listening is the essence of the APEC process; APEC is a forum, not a legislative assembly (see Section 9). It does not have institutions such as the Security Council of the United Nations, which give

some members higher profile and greater privilege than others. APEC is a soft institution that has neither the power to bind nor the power to enforce its agreements. The pressure that its members exercise on each other, therefore, is non-coercive; it is a process of discussion and leading by example. There is little, save resource constraints, to make some members more capable of exercising this sort of pressure than other members. Resource inequalities do, of course, have some impact on developing members in this regard: APEC's poorer members have less bureaucratic resources to devote to their APEC engagements and this means that APEC's richer members devote more time, effort and brain power to the issues. At least on ID issues, however, where developing countries needs were greater, and it behove them to act more energetically, resource constraints do not seem to have significantly constrained their capacity to do so: many of the presentations made by member economies on ID issues have been made by developing countries.

APEC's capacity building processes, likewise, are not skewed in favour of its wealthier members. Rather than allowing developed members to impose a *treatment*-based policy approach to ID management upon APEC's poorer members, APEC's capacity building processes actually encourage APEC's developed members to be more sensitive towards the needs of the poorer members. As the paper suggests, the primary value of 'APEC' capacity building projects is one of education and socialisation: APEC can catalyse accord and convergence between member's policy goals. APEC is a device through which members can consult other members on what kind of assistance is most needed. It can also be used as a 'laboratory' in which members can 'test run' future expensive bilateral capacity building projects on a smaller scale, so as to gain feedback from the other members. It is by giving feedback on various projects run through APEC, that member countries have an opportunity to influence their wealthier peers. Conversely, it is in this way, APEC encourages its wealthier members to better tailor their more ambitious assistance projects (which are executed outside APEC, often through bilateral channels) to the true needs of their developing peers.

There is another way through which it could be argued that APEC's 'targeting' of sub-optimal, or incomplete policy approaches is the result of structural factors. The previous section dealt with the concept of 'institutional blindness': if all of APEC's members espouse irrational policies, especially policies that are irrational in the same way, then APEC can do little to help them. The previous section acknowledged that, to an extent, this flaw in the APEC process is unavoidable as it is hard-wired into APEC's structures. Hence, there is a possibility that the sparsity of *prevention*-related discussion in APEC's policy discussions is explained by institutional blindness: if all of the health bureaucracies of APEC's individual members underplay *prevention,* and do not appreciate how important it is to tackle the social causes of ID, then APEC can do little to change this. The issue that arises thus is: can we really say that APEC individual members are all unaware of the value of ID *prevention*?

To definitively ascertain whether this is really the case, one would have to undertake an in-depth analysis of all of the domestic counter-ID policies of all of the APEC members. This, again, is too ambitious a task for this paper. It should be noted, however, that the extent to which APEC suffers from institutional blindness should not be exaggerated. The likelihood of APEC's members being collectively blind is low. As the previous section suggested, this is because APEC brings together a good diversity of viewpoints among its membership. Admittedly, input from NGOs and other non-APEC bodies has not yet been 'rooted' into the APEC process; they do not hold permanent observer status in the APEC Health Task Force (HTF). However, as the previous section states, the HTF mandate does require it to engage in dialogue with a range of non-governmental and international organisations bodies, and the HTF has done quite well in this regard, albeit on a non-permanent basis.

Ultimately, it cannot really be said that APEC has 'targeted' *treatment*, nor that this has impeded its capacity to encourage *prevention*. From an empirical standpoint, perhaps the better part of APEC's policy discussion does concert *treatment*-based counter-ID measures. However, this fact cannot be held to compromise APEC's capacity to encourage *prevention,* because *treatment* and *prevention* measures are not opposed to one another. Moreover, this empirical evidence could well be the result of coincidence rather than of structural factors. Indeed, APEC's processes are not 'one way'. While, from time to time, some members will be more influential than others, on the whole, influence in APEC does not flow exclusively from its wealthier to its poorer members; it cannot be said that the wealthier members are using APEC to encourage its poorer members to underplay the value of *prevention*. Perhaps APEC's underplaying of *prevention* is explainable through the concept of institutional blindness—such blindness being a structural weakness of APEC. This explanation too, however, seems unlikely.

8 Why do such APEC capabilities add value to the WHO?

The *membership* difference The various membership differences between APEC and the WHO allow APEC to add value to the WHO process in several ways:

i. First, the WHO has 192 members drawn from the global community of nation states (World Health Organisation: n.d. d). APEC has 21 members, all of which are concentrated in the Asia Pacific. This allows APEC to focus more on Asia Pacific ID issues and, to this end, to engage exclusively regional resources (Jones 2005: 174). Indeed, in the recent APEC agreement on AI, members pledged to enhance regional response capabilities by engaging the expertise of the Regional Emerging Disease Intervention (REDI) Centre

(APEC 2005: 3). REDI is an organisation with an Asia Pacific focus (Ministry of Health Singapore 2004).

ii. Second, Chinese Taipei and Hong Kong, are separately represented in APEC (Gyngell and Cook 2005: 10) but not in the WHO (WHO: n.d.d). This allows for these economies to partake in APEC's various ID efforts and goes some way in overcoming the *fragmentation* of international ID cooperation.

iii. Third, the WHO, apart from its 192-member international headquarters, also has a series of Regional Offices (ROs), which unite regionally clustered subsets of the WHO membership (Minelli 2003: Section 3.2; WHO: n.d. f, Article 50). APEC, however, incorporates members from three ROs (see WHO: n.d.a; WHO: n.d. b, n.d. c). This renders APEC a fundamentally different, non-duplicative network of economies when compared to the WHO. It also puts APEC in a position to counteract the *fragmentation* of international ID cooperation, as there exists little coordination between the ROs (Brundtland 1999; Minelli, E: 2003 Section 3.3; Yamey 2002a, p.1111; Jones 2005: 175).

The *interstate* difference In two ways, APEC provides for a fundamentally different mode of interaction between its members, compared to that offered by the WHO:

i. First, interaction in APEC is driven by its members, rather than by a supranational secretariat. Indeed, in contrast to APEC's slim secretariat, which 'does little more than service APEC meetings' (Gyngell and Cook 2005: 7), the WHO's Secretariat employs over 8,000 people (WHO 2006, Table 2) and has a budget of approximately US$8.8 billion (WHO 2005b, p.3).

In APEC, members interact with each other directly; in the WHO, members generally interact through the central Secretariat (APEC Document: 2001b, p.3). The World Health Assembly (WHA) is the part of the WHO that brings together representatives from each of its member states (World Health Organisation: n.d; Minelli: 2003, Section 2.1). The WHA archives show that individual states do not make presentations to the WHA; presentations are made by the Secretariat or on behalf of Committees comprised of several states (World Health Organisation: n.d. e). A similar situation occurs within the ROs: in Regional Committee Meetings (RCM), this being the element of the ROs which unites member states' representatives, individual members do not make presentations to the RCM (see for example, World Health Organisation Regional Office for South East Asia:

n.d.). In APEC meetings, by contrast, the majority of presentations are made by the members themselves (APEC Secretariat: n.d.a). At the recent APEC Symposium on Emerging Infectious Diseases, held in 2006, 23 of 27 presentations made were made by member economies.[10]

Likewise, all technical activities undertaken through the WHO, whether through Headquarters or through the ROs, are administered by supranational secretariats (see Minelli: 2003, Sections 2.3.1–2.3.2 and 3.2–3.3). Many technical projects undertaken through the HTF, by contrast, are sponsored and administered by individual members (see, for instance, APEC 2005q: 6).

ii. Second, APEC, unlike the WHA, offers a forum for members to discuss each other's national ID policies. We have seen how many of the presentations made in the HTF concern members' national ID situations and policies. The primary purpose of these presentations, clearly, is to stimulate discussion of these policies: the presentations neither concern collective HTF projects, nor do they directly push for certain recommendations to be made to the higher order forums. The role of the WHA, by contrast, is not to provide a discussion forum but to act as a 'legislative' body (Minelli 2003, Section 2.1.3; see WHO n.d. f, Articles 18, 19, 21, 23): it collectively decides the strategic direction of the WHO's Secretariat, determines the WHO's policies and creates international law in the form of conventions and resolutions (*ibid*). A similar situation occurs within the RCMs, the purpose of which is to formulate WHO policies on matters of an exclusively regional character and to supervise the activity of the Office Secretariat (*ibid*).

The combination of these two differences allows APEC to add to the WHO process in the following ways:

i. First, it allows members to have a different, additional source of information for policy development. In the WHO, members learn technical information from the Secretariat (Minelli 2003, Sections 2.3.1–2.3.2, 3.2); in APEC, states learn from each other.

ii. Second, APEC allows its members to exert a diplomatic influence on each other that they could not exert through the WHA. As discussed above (see above at Section 6), information shared in the HTF by a member regarding their national ID policies subtly impels other members, in turn, to share information on their respective national ID situations. In the WHO, by contrast, policy guides are developed and administered by the supranational Secretariat (*ibid*), and so do not have this exemplary, diplomatic effect.

iii. Third, APEC's state-driven nature allows it to assist bilateral and regional capacity building initiatives in ways that the WHO cannot. As all capacity-building initiatives in the WHO are administered by supra-state authorities, APEC members cannot use the WHO to 'test run' initiatives which they themselves wish to administer outside the WHO.

iv. Fourth, it allows APEC to counter *fragmentation* by bringing non-state agencies into its state driven dialogue. The inclusion of organisations such as the WHO and the World Bank in HTF meetings (see above at Section 6) acknowledges that international ID management involves many actors and initiatives outside the WHO. This allows the various players of international health, both state and supra-state alike, to better coordinate their efforts. Importantly, it allows the WHO, with its experience and its expertise, to comment on the national and bilateral initiatives that members are engaging in (*ibid*). Countries do not present on such initiatives in the WHA and so the WHA does not allow the WHO Secretariat to comment on them in this way.

The *comprehensiveness* difference In the following ways, APEC allows for a more comprehensive interstate dialogue than does the WHO:

i. First, APEC allows for a more cross-sectoral interaction between governments. In the WHA, countries are encouraged to draw their representatives from the area of health (WHO n.d. f, Article 11). APEC, by contrast, holds regular dialogue on various non health-specific topics (see APEC Secretariat: n.d.a). APEC has made good use of this advantage to involve ID issues in a range of non health-specific forums, including the Committee on Trade and Investment (APEC 2003d: 3) and the Tourism Working Group (APEC 2003e: 2–3). The 2005 HTF Meeting on Avian Influenza Preparedness and Response was attended by members' representatives from a range of government bureaucracies including agriculture, health, emergency preparedness and foreign affairs (APEC 2005c).

ii. Second, the WHO has no institutionalised communication channel with the private sector (Reid and Pearce 2003: 10; Horton 2002: 1605). APEC, however, does have such a dialogue channel in ABAC (see above at Section 2). APEC has made good use of its private sector linkages as ID issues have featured in ABAC discussions (APEC Secretariat: 2003). Also, pharmaceutical companies have attended LSIF Meetings (APEC 2004c).

iii. Third, interstate interaction in APEC operates at more levels than it does at in the WHO. The WHO does not hold a Leaders' Summit (WHO n.d. f). Furthermore, unlike the WHO, APEC also holds 'low-level' dialogue between members' regulatory boards,

customs authorities and inspection officials through the LSIF (APEC 2004d; APEC 2004c) and the HTF (APEC 2005c).

APEC's capacity to entertain a more comprehensive dialogue between its members allows it to add value to WHO activities in four ways:

i. First, APEC members can partake in ID interstate policy discussion across a wider range of sectors than in the WHO, and include the private sector in this process.

ii. Secondly, it allows APEC members to agree to additional cooperative measures and procedures over and above those recommended by the WHO. Indeed, APEC has been able to set such procedures in relation to non-health specific areas of the ID threat—an area where the WHO has been less active. The APEC SARS Action Plan, for instance, engaged the trade and tourism dimensions of the SARS outbreak in addition to the strictly health-related ones (APEC 2005o: 3–4). Likewise in APEC's AI Strategy, members pledged to strengthen interaction with the business community to address agricultural industry practices that are conducive to zoonosis, as well as to exchange information of management of travellers (APEC 2005: 3)—neither of these measures were mentioned in the WHO's recommendations for national AI planning (WHO 2005: 10–42; WHO: 2005c).

   In this way, APEC can act as a laboratory for new international initiatives, which, if successful within APEC, could then be proposed to the WHO for incorporation into WHA conventions and resolutions. APEC has played such a role in supporting the WTO (Petri 1999: 16) when, in 1996, APEC reached a non-binding agreement on a set of liberalisation measures in the IT sector. This was then passed onto the WTO where it secured the support of a critical mass of non-APEC members and was converted into binding law (*ibid*: 9). As discussed above, the diversity of APEC's membership puts APEC in an especially good position to do this: in uniting both developed and developing countries (Oxley 2005) APEC is quite an accurate microcosm of the WHA.

iii. Third, it allows for the establishment of personalised networks in a wider range of fields and also at deeper levels. Indeed, the HTF has noted that the networks formed at the lower levels, such as those between customs officials, are especially valuable, because it is often these networks that form the front lines of cooperative anti-ID efforts (APEC 2004: 9; APEC 2004a: 7–8).

iv. Fourth, the WHO does not have a Leaders' Meeting, and so cannot generate profile for ID issues in the way that APEC does.

The *regularity* advantage APEC allows for more regular member interaction than does the WHO. The WHA generally only meets once a year (WHO n.d. f, Article 13),[11] as do the RCMs.[12] APEC forums, by contrast, meet more regularly. Alongside the annual Leaders and Ministerial summits, SOM holds a meeting three times a year (see APEC Secretariat: n.d), and the HTF, like many other working groups, has held 2–3 meetings every year since its creation (See generally, APEC Secretariat: n.d.b).

This allows APEC to add value to the WHO process in the following ways:

i. First, it renders APEC a more effective socialiser of states, in that it allows for a more iterated interaction process (Ravenhill 2000: 161). Members have more opportunity to influence each other in APEC than in the WHA.

ii. Secondly, it facilitates the building of personalised networks, in that members' officials have more opportunity to get to know each other.

8 APEC and ASEAN: a risk of duplication?

The Association of South-East Nations (ASEAN) is a very important organisation of international cooperation. Comprised of 10 member states from South East Asia,[13] ASEAN plays a crucial role in the broader Asia–Pacific region. Significantly, ASEAN facilitated cooperation among its members in response to the 2003 SARS outbreak (Curley and Thomas 2004: 28), and ID-issues have since featured prominently on ASEAN's agenda (see, for instance, ASEAN 2005; ASEAN Secretariat 2006). While the focus of this paper is the relationship between APEC and the WHO, given ASEAN's importance to the Asia Pacific region, it is difficult to discuss APEC's counter-ID efforts without mentioning how these might interact with those of ASEAN. This section will make some brief comments on this point: first, it will examine whether there is a risk of duplication between APEC and ASEAN counter-ID efforts; second, this section will briefly outline the points of comparative advantage that APEC has *vis-à-vis* ASEAN, and how APEC can harness these to complement ASEAN's work to effectively contribute to global counter-ID cooperation.

A risk of duplication? Before considering whether there is a risk of duplication between APEC and ASEAN counter-ID efforts, it is interesting to note how little concern has been dedicated to this point. For academic commentators and policy practitioners alike, this point seems to have been rarely raised as an issue. Indeed, one is hard-pressed to find any academic literature exploring the general risk of duplication between APEC and ASEAN, let alone

exploring this risk in the context of ID cooperation. Similarly, APEC's members have repeatedly voiced concern within APEC that its efforts should not duplicate the work of the WHO (APEC 2001), no such concern has been raised with regard to ASEAN. Indeed, while representatives of the WHO have participated in HTF meetings, the ASEAN secretariat has not (see (APEC 2005c); there is no indication in the archives that it was invited to do so. ASEAN, likewise, has not voiced any awareness of the fact that its work should complement and not duplicate that of APEC.

There are two potential explanations for the lack of concern regarding APEC's interaction with ASEAN: either APEC members and academic commentators are guilty of a massive oversight, or they are so confident that the two organisations will not duplicate each other's work that they do not feel the need discuss this issue in any detail.

The latter of these two explanations is far more plausible than the former. Indeed, the levels of interaction and integration between the two organisations are so great that, even in the absence of a positive statement on the issue from either APEC or ASEAN, we can presume that both organisations are well aware of the risk that they might duplicate each other's work. By extension, we can presume that both organisations are actively working to minimise this risk. This is the case for the following reasons:

i. First, all bar three of ASEANs ten member nations are also members of APEC—thus comprising one third of APEC's membership (see APEC Secretariat 2007; APEC Secretariat n.d. d). This allows for close and regular dialogue between the two organisations, which ensures a high level of coordination between them. Indeed, within APEC, ASEAN effectively functions as a sub-group for coordinating ASEAN positions vis-à-vis APEC's developed members or its members from the Americas.

ii. Second, the institutional character APEC and ASEAN further facilitates the coordination of these efforts: both APEC and ASEAN are member-driven organisations: while ASEAN has a larger central secretariat than APEC (Gyngell and Cook 2005: 7), neither organisation has a large, overarching supranational secretariat in the way that organs such as the UN and the WHO do. The secretariats of APEC and ASEAN play a relatively small role in their functioning. This explains why, despite the HTF's mandate to engage in dialogue with other international organisations, the ASEAN Secretariat has never been present at its meetings: APEC and ASEAN being member-driven as they are, the presence of ASEAN *members* at the HTF meetings has been enough to ensure coordination between the two organisations. This point is reinforced by the fact that on technical questions, such as those concerning ID management, it is usually the same officials representing member economies in APEC meetings and ASEAN meetings. This ensures that ASEAN Nations' representatives

in these forums are well aware of the work of both organisations, and further facilitates coordination between them.

iii. Third, there is a substantial overlap between the regions on which ASEAN and APEC focus. The organisations share a close focus on East Asia, and so there is significant interest for them in ensuring the complementarity of their efforts.

iv. Fourth, coordination between ASEAN and APEC is further facilitated by the close interaction between members of both organisations outside the APEC context, both through bilateral channels and through other regional groups. For instance, Australia and Indonesia have held a strong dialogue on ID-issues (Curson and McRandle 2005: 27). ASEAN also holds annual talks with Australia, Canada, Chian, Japan, the Republic of Korea, New Zealand, the Russian Federation, and the United States (ASEAN Secretariat: 2007a)—all of these countries being members of APEC. Likewise, groups such as the East Asia Summit (an annual forum which brings together the 10 ASEAN states plus Australia, China, Japan, India, New Zealand and the Republic of Korea, see Australian Department of Foreign Affairs and Trade n.d.) and ASEAN +3 (a forum uniting ASEAN's 10 members with the People's Republic of China, the Republic of Korea and Japan) give members from ASEAN and APEC an additional opportunity to ensure coordination between the two organisations. Indeed, ID issues have featured on both the agenda of ASEAN +3 (ASEAN+3 Joint Statement 2003) and of the East Asia Summit (East Asia Summit Declaration 2005).

Points of comparative advantage While it is extremely unlikely that APEC will duplicate ASEAN's work in the field of ID, there are two specific ways in which APEC can actually *add* value to ASEAN efforts. Both of these stem from the organisations' membership differences.

i. First, Chinese Taipei and Hong Kong China are separately represented in APEC but not in ASEAN (see APEC Secretariat 2007; APEC Secretariat n.d. d). Again, this allows for these economies to engage effectively in regional ID cooperation and goes some way in overcoming the *fragmentation* of international ID management.

ii. Second, while United States, Canada, Australia, Japan, China, Russia are represented in APEC, they are not part of ASEAN (see APEC Secretariat 2007; APEC Secretariat: n.d. d). It has already been noted that all of these countries hold annual talks with ASEAN, either on an individual basis or through forums such as the EAS and ASEAN+3. Thus, even without APEC, ASEAN is able to engage the resources and brainpower of these members.

Nonetheless, APEC provides yet another opportunity for these economies to contribute to capacity building and policy development in the region, thus adding value to the ASEAN process.

9 Conclusion

APEC can thus contribute to more effective global ID management in the following ways:

i. Through its capacity to socialise governments, APEC can help overcome *irrationality.*

ii. APEC can act as a forum for information sharing, which can improve national ID planing and *transparency.* However, APEC has a limited capacity to reveal information that members might find embarrassing.

iii. APEC can facilitate consensus between its members as to standard ID-related procedures and benchmarks. This can accelerate national ID planning and improve coordination in international counter-ID efforts. However, APEC should not be expected to forge meaningful consensus on the politically sensitive aspects of ID management.

iv. APEC Leaders' meetings can attract international attention to the ID threat. This can help countries to overcome *irrationality* and to bring greater levels of attention and resources to their national ID planning and capacity development efforts.

v. APEC can enhance connectivity through its capacity to build personalised networks.

These efforts add value to and do not duplicate those of the WHO for the following reasons:

i. APEC's different membership allows for a different, non-duplicative network for international cooperation. It allows APEC to counteract *fragmentation* by bringing together economies from three regional organisations.

ii. APEC offers members a different mode of interaction: APEC is a state-driven discussion forum; the WHO is a supra-state driven legal decision making body. This allows APEC to act as an additional, non-duplicative avenue for information sharing, as members learn from each other and not from a central secretariat. It also allows APEC to facilitate interstate diplomatic pressures in a way that the WHO cannot. Lastly, it is APEC's interstate nature

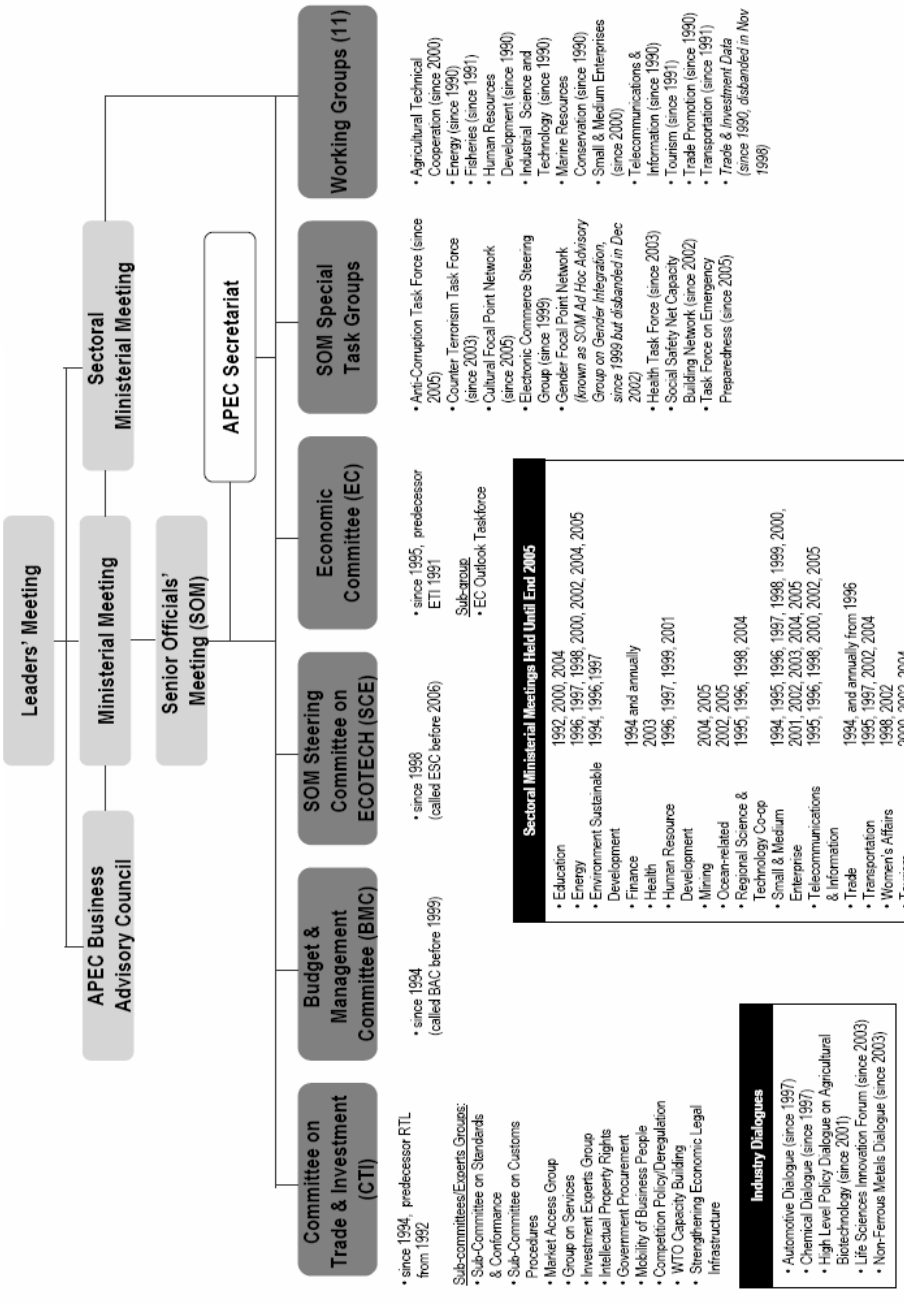
that allows it to assist regional and bilateral capacity building initiatives by acting as an arena where such initiatives can be 'test run'.

iii. APEC offers a more comprehensive interstate dialogue. It allows APEC members to discuss, and build consensus on, a wider range of ID issues. It also allows APEC to build personalised networks at low levels of ID-related bureaucracies. The Leaders Meeting attracts international attention to ID issues in ways that the WHO cannot.

iv. As APEC holds meetings more regularly than the WHO, it is a better builder of personalised networks.

Clearly, APEC is in a position to significantly help the WHO's ID efforts.

Appendix A Asia–Pacific Economic Cooperation



Source: APEC Secretariat (n.d. 3), 'Structure – Asia Pacific Economic Cooperation' (webpage), http://www.APEC.org/APEC/about_APEC/structure.html (last accessed 25th April 2006.

Appendix B APEC Document Sources

General APEC documents

2006, 'US Approaches to Preventing and Controlling Emerging Infectious Diseases', document submitted by the USA to the APEC Health Task Force Symposium on Emerging Infectious Diseases, held 4–5 April in Beijing, China, doc. ref. 2006/HTF/SYM/005.

2006a, 'Cross Sectoral Coordination in Response to EIDs', document submitted by New Zealand to the APEC Health Task Force Symposium on Emerging Infectious Diseases, held 4–5 April in Beijing, China, doc. ref. 2006/HTF/SYM/014.

2006b, 'Progress of Emerging Infectious Disease Prevention and Control', document submitted by Korea to the APEC Health Task Force Symposium on Emerging Infectious Diseases, held 4–5 April in Beijing, China, doc. ref. 2006/HTF/SYM/009.

2006c, 'Preparedness for Human Pandemic in Middle-Income Economies', document submitted by Thailand to the APEC Health Task Force Symposium on Emerging Infectious Diseases, held 4–5 April in Beijing, China, doc. ref. 2006/HTF/SYM/019.

2006d, 'Establishment and Management of Stockpiling of Antiviral Drugs in Malaysia', document submitted by Malaysia to the APEC Health Task Force Symposium on Emerging Infectious Diseases, held 4–5 April in Beijing, China, doc. ref. 2006/HTF/SYM/018.

2006e, 'Risk Communication in the Prevention of Avian Influenza', document submitted by the Hong Kong China to the APEC Health Task Force Symposium on Emerging Infectious Diseases, held 4–5 April in Beijing, China, doc. ref. 2006/HTF/SYM/012.

2006f, '2005 APEC e-Health Initiative Project Progress Report', presentation by Korea at the Health Task Force Meeting, Ha Noi, Viet Nam, 27–28 February, doc. ref. 2006/SOM1/HTF/024.

2006g, 'Report of the APEC Workshop on: 'HIV/AIDS and Migrant/Mobile Workers', paper submitted by Canada to the Health Task Force Meeting, Ha Noi, Viet Nam, 27–28 February, doc. ref. 2006/SOM1/HTF/006.

2006h, 'APEC Project update: Enhanced APEC Health Communications: Collaborative Preparedness in Asia Pacific', submitted by the USA to the APEC Health Task Meeting held in Ha Noi, Viet Nam, 27–28 February, doc. ref. 2006/SOM1/HTF/022.

2006i, 'Progress Report: Public Health Emergency Preparedness Course', paper submitted by the USA at the Health Task Force Meeting, Ha Noi, Viet Nam, 27–28 February, doc. ref. 2006/SOM1/HTF/009.

2006j, 'Health Task Force Chair's Report to SOMI 2006', paper submitted by the Chair of the Health Task Force to Senior Officials' Meeting I, Ha Noi, Viet Nam, 1–2 March, doc. ref. 2006/SOMI/025.

2006k, 'Modern Communications for Preparedness', submitted by USA to the APEC Health Task Force Symposium on Emerging Infectious Diseases, held 4–5 April in Beijing, China, doc. ref. 2006/HTF/SYM/007.

2006l, 'Global Challenges of EIDs to Human Health' document submitted by the WHO to the APEC Health Task Force Symposium on Emerging Infectious Diseases, held on 4–5 April in Beijing, China, doc. ref. 2006/HTF/SYM/002.

2006m, 'Socio-Economic Impacts of Emerging Infectious Diseases: The Case of Avian Influenza' document submitted by the Asian Development Bank to the APEC Health Task Force Symposium doc. ref. Ref. 2006/HTF/SYM/003.

2006n, 'Global Challenges in Prevention and Control of Avian Influenza and Pandemic Preparedness', document submitted by the UN to the APEC Health Task Force Symposium on Emerging Infectious Diseases, held 4–5 April in Beijing, China, doc. ref. 2006/HTF/SYM/015.

2006o, 'Fighting Against AIDS' document submitted by UNAIDS to the APEC Health Task Force Symposium on Emerging Infectious Diseases, held 4–5 April in Beijing, China, doc. ref. 2006/HTF/SYM/022.

2005, 'APEC Initiative on Preparing for and Mitigating and Influenza Preparedness', submitted by SOM Chair to the 17th APEC Ministerial Meeting, held in Busan, Korea on 15–16 November, doc. ref. 2005/AMM/002anx13B.

2005a, 'HTF Chair Report – Health Task Force Updates and Potential Deliverables', paper submitted by HTF Chair to the Senior Officials' Meeting III, 13–14 September, Doc. Ref. 2005/SOM3/037.

2005b, 'APEC Meeting on Avian and Influenza Pandemic Preparedness and Response–Chair's Report', submitted by Australia at the Concluding Senior Officials' Meeting, Busan, Korea, 12–13 November 2005, Doc. Ref. 2005/CSOM/031.

2005c, 'Participant List', submitted by the Chair to the APEC Meeting on Avian and Pandemic Influenza Preparedness and Response, held in Brisbane, Australia, 31 October–1 November, Doc. Ref. 2005/HTF/AI/021.

2005d, 'The Eleventh APEC Ministerial Meeting: Summary Report', summary for the SOM II meeting held in Jeju, Republic of Korea, 31 May.

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Notes

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1 Those who give it little mention include Cabarello-Anthony 2005: 475–495, and Kamps and Hoffmann 2003: 81–108; those who are critical include Curley and Thomas 2004: 28.

2 See APEC Leaders Summit Declaration 2004: 3; APEC Leaders' Summit Declaration 2005: 14; APEC Meeting of Ministers Responsible for Trade Declaration 2005: 14; APEC Meeting of Ministers Responsible for Trade Declaration 2005: 11–12.

3 McInnes and Lee 2006: 16; see also Lee and McKibbin 2003: 2–4; see also McKibbin and Sidorenko 2006: 4–12.

4 Cohen, McKay 2004: A11; see also Cohen, Pottinger and Inada: 2004b: 31 and Grudgings 2005; see also Hill & Associates Risk Consulting 2005: 9–15.

5 Gyngell and Cook, 2005: 7; see also Patrick: 2005: 139–163, Singapore Pacific Economic Cooperation Council: 40; see also Elek 2005: 38.

6 See generally APEC Secretariat: n.d. b; see specifically APEC 2005e, APEC 2005f, APEC 2005g, APEC 2005h, APEC 2005i, APEC 2005j, APEC 2005k; see also APEC 2006, APEC 2006a, APEC 2006b, APEC 2006c, APEC 2006d, APEC 2006e.

7 APEC 2005g: 2, APEC 2005h: 3; APEC 2005i: 3; APEC 2005j: 2; APEC 2005k; see also APEC 2006: 2; APEC 2006a: 3; APEC 2006b: 2; APEC 2006c: 2; APEC 2006d: 2.

8 See, for example, APEC 2005m; APEC 2006f; APEC 2001a; APEC 2006g; APEC 2006h)

9 See, for example, APEC 2005a; APEC 2005q; APEC: 2006j; APEC 2005b, cited in APEC 2001b, APEC 2002

10 See APEC Secretariat: n.d. b; documents not to have been submitted by Member Economies were: APEC 2006l; APEC 2006m; APEC 2006n; APEC 2006o—documents submitted by the WHO, by the Asian Development Bank, by the UN and by UNAIDS respectively to the APEC Health Task Force Symposium on Emerging Infectious Diseases, held on 4–5 April in Beijing, China.

11 See also WHO online archive for WHA meetings at http://www.who.int/gb -last accessed 30th April 2006.

12 See for example, World Health Organisation Regional Office for South East Asia n.d.; World Health Organisation Regional Office for the Western Pacific n.d.; World Health Organisation Pan American Health Organisation 2002, Article 12.

13 Viet Nam, Cambodia, Laos, Myanmar, Indonesia, Malaysia, Brunei Darussalam, Thailand, Singapore and the Philippines.

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