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Global Health Governance: Analyzing China, India, and Japan as Global Health Aid Donors

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Abstract

Development assistance is a significant mechanism by which major countries exercise influence in the global health arena. Of the major Asian powers, Japan has long provided significant funding, while China and India have primarily been recipients but are beginning to increase their funding roles. This article examines the amounts, channels, modes, disease allocations and the geographic focuses of their foreign health aid, and delineates the institutional structures that govern the formulation and implementation of foreign health aid policy in each of these countries, to explore what influence China, India, and Japan have and may develop in the global health arena. The article looks in particular at two focal lenses, sovereignty and institutional diversity, to understand what if anything is different from existing approaches to global health governance and what might be expected from these three key Asian nations vis-à-vis global health.

Policy Implications

- Japan's global health leadership transcends its bilateral initiatives. The critical question that emerges now is whether Japan can sustain its will and capacity without clear policy direction from the current government amid domestic turmoil. What is to be done by Japan, and who will do it?
- China and India have not engaged extensively with the global processes as donors. Yet, as recipients they have been open to a wide range of types of actors and relatively relaxed about sovereignty concerns, possibly providing a basis for a similar direction in development assistance for health (DAH) as their programs mature.
- The domestic institutions responsible for external development assistance for health in both China and India would need to be substantially reformed and strengthened for these countries to have the capacity to play leading roles in global health governance in the future.
- China and India increasingly have the capacity to invest greater resources in their own public health systems, which would redress some of the existing imbalances in allocations of global health finance.
- Such domestic investment in domestic health care delivery would enhance India and China's capacity to assume leadership roles and contribute towards innovations within global health and global health governance and augment their status as responsible and responsive global health stakeholders.

Introduction

The burgeoning global health governance literature has as yet paid little attention to the current and potential roles of Asia's leading powers. One way to better understand what if anything might be expected from India, China and Japan is to follow their money, via their foreign assistance dedicated to health. Japan is a long established major donor in the health arena, and China and India are expanding their international roles. Each enters the fray with its own agendas, priorities, values, and commitments that shape its international development and health assistance packages. In this article, we examine the health assistance programs of the three countries using two focal lenses – sovereignty and institutional diversity.

These focal lenses are drawn from the larger study on global health governance on which this special section is based. As Tan et al. (2012) argue, the changing nature of state sovereignty and the growing number and diversity of actors relevant to global health governance are altering the global political landscape, and with it the incipient global health governance architecture. Thus, this article explores what their health aid programs may reveal about their evolving attitudes toward sovereignty as a principle, and about the institutions that have evolved in these countries that will contribute to GHG including, in particular, how these governments are prepared to engage with the plethora of relevant types of actors. We look to see whether there are distinctive national or regional ideas, values, experiences and conceptions underlying their approach to development assistance for health.

To achieve these outcomes, the article is structured as follows. We provide brief snapshots of the domestic health contexts of each of the countries. The empirical section elaborates on the financing estimates of overall external global development assistance for health (DAH), with estimates of the relevant shares for China, India, and Japan. The next section expounds on the institutional arrangements for external health aid governance in the three countries, delineating the institutions responsible for the formulation and implementation of external development and health aid policy. We then analyse the three countries and their experiences through the lenses of sovereignty and institutional diversity.

China, India and Japan's domestic health contexts

Examining the state of each nation's domestic health systems enables us to place their foreign health financing patterns in perspective and provides us a more complete picture surrounding their foreign health aid practices. Three important metrics are considered – percentage of government spending in health care, nature of the national health delivery systems and major health challenges within each country.

Government spending on domestic health care varies across the three countries. WHO statistics reveal that China spent 4.3 per cent, India 4.2 per cent and Japan 8.3 per cent of GDP on health in 2008 (WHO, 2011). Japan's single payment system of government set prices insures against spiraling cost increases. As a result, Japan recently ranked 22nd in the OECD in the percentage of health care expenditures to GDP (Ikegami, 2009). Until recently, government health spending in India and China had been declining. Health care was viewed more as an onerous burden than a productive investment (Bardhan, 2008, p. 934). Moreover, rising fiscal burdens on the state in the 1980s and 1990s forced Beijing and Delhi to pare their health systems. After three decades of declining health care spending, however, India and China have increased total government spending on health by roughly 1–2 per cent of GDP (Mahal and Yip, 2008, p. 926).

Second, the organizational structuring of the health care system also varies. Private health care dominates in India, with little governmental regulation or oversight. Recent estimates indicate that close to 85 per cent of primary health visits are in the private realm, even in the poorest areas (Hammer, 2007). In China,

the public system reigns, despite reductions in subsidies to public health facilities (Bardhan, 2008, p. 934). Beijing has also permitted a parallel private delivery system to grow allowing hospitals to recoup costs that are not redeemable by state subsidies. This public-private divide has engendered a split system where the infrastructure and provision of the care is public but the practices of health care facilities and professionals are essentially profit seeking models, resulting in gross inequities in access to health care (Mahal and Yip, 2007, p. 938). The Japanese system is modeled on the Bismarckian standard – social insurance system that is jointly financed by employers, employees, and the government with services being delivered by a private health care system (Reid, 2009). The Ministry of Health, Labour and Welfare negotiates and sets prices with the insurance providers, who then provide different plans to their consumers. All Japanese citizens are bound by law to be insured (Reid, 2009).

In all three countries, non-communicable diseases such as diabetes, cancer and heart disease form the bulk of the disease burden. Non communicable diseases rose from 41.7 per cent in 1973 to 74.1 per cent of all Chinese deaths in 2005 (Normile, 2010, p. 422), and caused 60 per cent of Indian deaths in 2005 (Mahal et al., 2010). From 2005–15, China and India are projected to spend 0.9 and 1.5 per cent of their respective GDPs to curb heart disease, strokes and diabetes (WHO, 2010). China and India also continue to face daunting challenges regarding infectious diseases. In India, such diseases represent some 30 per cent of the disease burden (John et al., 2011, p. 254). UNAIDS contends that India has the third largest number of individuals with HIV/AIDS after South Africa and Nigeria (UNAIDS, 2010). Tuberculosis is resurging across the country, with 2 million new cases surfacing in 2009 and a disturbing presence of multi resistant strains of the pathogen (John et al., 2011, p. 255). John et al. (2011, p. 263) grimly note that, 'India is a textbook case for anyone wishing to study infectious diseases'. China faces equally significant challenges on the infectious disease front resulting from the rise of SARS, avian flu and the resurgence of tuberculosis and HIV/AIDS (Wang et al., 2008, p. 1598).

Japan's primary health challenges stem from non-communicable diseases. Cancer caused 31 per cent of all deaths in 2007, and heart disease 14 per cent (Government of Japan, 2010). Despite having the longest life expectancy in the world, and methodical improvements in health infrastructure, health systems, and standards that have substantially reduced their occurrence in Japan, infectious diseases do remain a significant threat, and preparedness for future pandemics remains a priority (Cyranoski, 2005, p. 237). In all three countries, ageing populations will pose significant challenges for health care delivery in the future, especially in Japan, where mental health problems afflicted 35 per cent of all Japanese citizens above the age of 65 in 2008 (Government of Japan, 2010).

Global development assistance for health (DAH)

The last two decades have been revolutionary for global health – new actors, new priorities, and a litany of new financial commitments from a multitude of sources. With emerging powers like China and India entering the fray as global health donors, mapping and documenting the flows, channels, modes, and volumes of global development assistance for health (DAH) has become more complex and more important. Despite the absence of a comprehensive tracking index for global health assistance, estimates collated from bilateral pledges, multilateral aid flows, private philanthropic contributions and civil society estimates yield a fairly robust picture of global DAH and Asia's contributions to them.

Over the past two decades, health issues rose on the global agenda, a trend reflected in the quantities of foreign aid dedicated to health. DAH grew from US$5.6 billion in 1990 to US$10.51 billion in 2001 and US$21.79 billion in 2007, the latest year for which disaggregated data are available (Institute for Health Metrics and Evaluation, 2010). Dodd and Hill estimate that global health aid consumed 10 per cent of overall ODA in 2005, rising from a little under 3.5 per cent in 1985 (Dodd and Hill, 2007, p. 3).

Governments provided the lion's share of the global DAH commitments, giving US$15 billion in 2007. US commitments reached US$9 billion in 2007; Britain followed, pledging an estimated US$2 billion. Contributions from emerging nations (excluding China) approximated roughly US$520 million in 2006 (McCoy et al., 2009, p. 409). Contributions from private philanthropic foundations reached roughly US$4 billion in 2007; the Bill and Melinda Gates Foundation alone accounting for roughly half that total (Ravishankar et al., 2007, p. 2119).

Across the three countries, substantial portions of global health financing come from governmental sources. Despite being constrained by ever deepening fiscal burdens, Japan has maintained a high level of global health commitments. A rough estimate of Japan's DAH was US$700 million in 2007; Tokyo continues to be one of the largest government contributors to the UN and the Global Fund for AIDS, Tuberculosis and Malaria (Pilcavage, forthcoming). Japan is also a major contributor to the World Bank International Development Association (Llano, et al., 2011, p. 1259).

It is more difficult to obtain credible estimates of China's overseas aid, given domestic political sensitivities in both Beijing and among its aid recipients about publicizing aid flows, inadequate inter-ministerial information sharing and limited aid expertise in Beijing and the absence of a clear development aid system and lexicon within the Chinese government (Davies, 2010, p. 49). However, Wang et al. (2012) have estimated that commitments were on the order of US$300 million for 2007–08.

India, like China, lacks concrete datasets detailing its global DAH contributions. However, one estimate by Devi Sridhar (2008) pegs India's foreign health aid at US$226 million in 2007–08 (McCoy, 2009, p. 409). From these rough estimates, it appears that China, India and Japan allocated approximately US$1.3 billion for DAH in 2007 through their governmental arms, which then, roughly constitutes 6 per cent of the US$21 billion of global DAH in 2007.

Financing by channel of health assistance

An extraordinary array of actors shape and fund health across borders. Within the panoply we find not only national governments and their bilateral aid agencies (USAID, US Department of Defence, Peace Corps, DFID, CIDA, JICA, GIZ etc.), which provided the largest chunk (35 per cent) in 2007, but also:

- intergovernmental organizations (WHO, UNDP, UNICEF, World Bank, etc.) with another quarter of the total (US$5 billion)
- regional Development Banks (ADB, AfDB, and IADB) (roughly US$365 million)
- non-governmental organizations (Oxfam, CARE International, World Vision International, Family Health International, IPPF, etc.), which have become key funding channels accounting for some US$4 billion (McCoy et al, 2009, p. 409)
- private philanthropic foundations (Rockefeller, Gates Foundation)
- public-private entities (Global Fund, GAVI), which administered an estimated US$1.8 billion accounting for 9 per cent of global DAH in 2007
- other regional (ASEAN, EU), inter sectoral (IHP) and plurilateral (IBSA) entities.

Of the US$8 billion global DAH allocated through bilateral channels in 2007, the three Asian countries contributed US$0.85 billion, just over a tenth. Multilaterally, the Asian countries combined to provide US$0.45 billion or 4 per cent of the US$13 billion channeled through various UN agencies, World Bank, and regional development banks in 2007.

Of the three, Japan has by far the most substantial track record as a donor. Its official health aid of US$700 million is split between bilateral and multilateral channels. Tokyo allotted approximately

US$186 million to the Global Fund, US$71 million to the WHO and US$150 million to the UN's health apparatus. Bilaterally, Japan disbursed US$300 million (Pilcavage, 2012, forthcoming). In addition, the Japan Committee for Unicef raised US$124 million of private funds for UNICEF. Japan has been a crucial actor in the fight against polio, partnering with the WHO since 1975, providing US$22 million to WHO and UNICEF in the 1990s for the successful campaign to eradicate the disease in the East Asia/Western Pacific region (OECD, 1999), providing polio vaccines, cold chain system and surveillance, technical cooperation and research on poliovirus, and hosting 30 WHO Collaboration Centres and the National Institute for Infectious Diseases (which focuses on polio). In addition, Japan has been supporting the WHO Centre for Health Development in Kobe, Japan since its inception in 1995.

China allocated approximately US$300 million in bilateral assistance, US$2 million to the Global Fund, US$18 million to the WHO and US$15 million to the UN's health apparatus in 2007 (Wang et al., forthcoming). In addition to the US$226 million being administered by ministerial agencies in 2007, India gave the WHO US$3.7 million, US$5.2 million to UNICEF, and US$0.2 million to the Global Fund (Wang et al., 2012, forthcoming).

Financing by mode of health assistance

Ravishankar et al. (2009) further disaggregate global health financing into three types of health related assistance: in kind commodities in the form of drugs and medical supplies, in kind support through research, services management and technical assistance; and financial loans and grants. Sixty per cent of global DAH is allocated in the form of financial loans and grants amounting to US$13 billion in 2007, with the two forms of in kind transfers constituting the other US$8 billion or 40 per cent (Ravishankar et al., 2009, p. 2115). The WHO's biennial budget of 2006–07 amounted to US$3.6 billion, with US$1.57 billion being disbursed in the form of in kind technical support and assistance (Institute of Health Metrics and Evaluation, 2010). Another important point to note is the increasing overlap between broader overseas development aid and aid tied specifically to health. Non health ODA (e.g. in infrastructural form) can indirectly affect health outcomes and hence forms an important element of the health aid trajectories of the three countries being analyzed.

Substantial portions of Chinese and Indian bilateral aid are in the form of in kind services. China's Health Aid to Foreign Countries is primarily led through the deployment of Chinese medical teams (CMTs), construction of health facilities and hospitals, and the development of human resources in the health care sectors of recipient countries (Wang et al., forthcoming). Similarly, India's preferred mode of assistance is technical assistance on overseas health projects. Programmatic data from the Indian Ministry of External Affairs indicate a heavy concentration of foreign health aid directed through the construction of hospitals and clinics, deputation of medical and paramedical experts, and the development of water, sanitation, agricultural processing projects, etc. (Government of India, 2009).

Although Japan continues to uphold a robust bilateral grant aid apparatus that imparts technical assistance abroad, it has assumed a more global role. As Pilcavage notes, Tokyo's stewardship has proved seminal in the advancement of several vital global health causes – G8 Summits in Okinawa (2000) and Toyako (2008), HIV/AIDS, maternal, newborn and child health, Global Fund for AIDS, Malaria and Tuberculosis, etc. Japan has been engaged in regional cooperation, especially in terms of economic cooperation and trade since it began providing ODA, but Japan has been exerting efforts at establishing special regional health initiatives and funds, such as the Japan-ASEAN Integration Fund to fight pandemic influenza. The ASEAN-Japan Plan of Action includes cooperation between ASEAN nations and Japan to address global issues such as combating infectious diseases and promoting human security (Pilcavage, 2012, forthcoming). Japan also engages in tripartite cooperation under the USAID-Japan Partnership for Global Health with developing countries, Japan also has the option of significant regional

influence via its leading role at the Asian Development Bank, where it was one of the two largest shareholders and a leading contributor to various special funds. All ADB presidents to date have been Japanese nationals. However, ADB funding for health has been quite limited, around 2 per cent in FY 2008 and less than one per cent in FY 2009 (ADB 2008, 2009).

Financing by diseases

DAH tends to target specific diseases rather than broader strengthening of health systems, and Asia's contributions follow the global trends. Disbursements allocated for HIV-AIDS ratcheted up from US$200 million in 1990 to US$5 billion in 2007, a quarter of total DAH. Owing to several landmark global commitments, funding for maternal and neonatal health rose to an estimated US$3 billion in 2007. DAH for tuberculosis and malaria follow with estimates of US$1.5 billion in 2007 for each. Non communicable diseases, including cancer, diabetes, and heart disease constitute a small proportion of global health assistance amounting to US$125 million in 2007. Unspecified and other illnesses account for the other half of the global DAH.

Examining funding by diseases reveal China and India's split identities as both donors and (net) recipients (Japan is a net donor). Tokyo contributed US$186 million to the Global Fund's efforts in tackling AIDS, tuberculosis and malaria in 2007, and pledged an additional 1 billion from 2005–09 through its Health and Development Initiative[1] (Japan International Cooperation Agency 2005). China and India contributed a total of US$4 million in the same year. The two nations have received approved grants from the Global Fund totaling approximately US$2 billion, having already drawn roughly US$1.2 billion (Global Fund, 2011). On the maternal and neonatal health front, Asia plays a peripheral role. China, India and Japan gave US$250 million to UNICEF, in effect, contributing 8 per cent of the global DAH allocated for maternal health (Wang et al., forthcoming). Japan, however, has advanced GAVI's campaign in several other ways. Japanese investors, in alliance with GAVI and the International Finance Facility for Immunisation (IFFIm) have raised over US$1 billion for immunization and vaccination purposes through the issuance of vaccine bonds (GAVI, 2011a). Institutionally, JICA has also served as a base of operations for GAVI to deliver vaccination and immunization services in areas where optimal health delivery systems are wanting (Japan International Cooperation Agency, 2011). Tokyo has also recently pledged US$9 million for 2011 in GAVI's latest funding drive (GAVI, 2011b).

Financing by regional focus

The largest share of official development assistance for health globally goes to sub-Saharan Africa, which received close to US$5 billion or 25 per cent of the total global allocations in 2007. Some US$3 billion, or 14 per cent, was directed towards Asia (merging the East Asia-Pacific and South Asia). Latin America absorbed another US$2 billion.

Japan's health assistance dovetails with the global focus on sub-Saharan Africa. Japanese grants and technical assistance initiatives for health related projects in Africa have been incrementally rising since 1990, aligning with the shifting global health consensus on eradicating infectious diseases across the continent. And, Japan has been hosting the Tokyo International Conference on African Development (TICAD), every five years since 1993. Economic growth in Japan's priority region – Asia – reduced the need for assistance there and enabled Japan to shift its ODA to Africa, in line with Japan's ODA charter, which focuses on humanitarian needs. However, some claim this trend in funding may have been driven by a strategic move for Japan to secure a seat on the UN Security Council and a possible endorsement from the African Bloc (Lehman, 2005; Pilcavage, 2012).

China has developed a robust relationship with the African continent in the last three decades through its overseas development assistance, including health. China has assisted in the construction of 133 infrastructure projects, 38 hospitals, and dispatched over 16,000 medical personnel to Africa over the past fifty years to over 53 African countries (Davies, 2010, p. 56). According to Brautigam (2011, p. 4), China's motives for its engagement in Africa have varied across the decades, reflecting the currents of the international political system and China's role at those junctures (Brautigam, 2011, p. 4). In the 1960s, aid flowed to help African countries escape the ravages of colonialism. As ideological concerns waned from the 1970s, aid policy gradually became subsumed under commercial relations underscoring bilateral economic cooperation (Davies, 2010, p. 38). This focus intensified since the 1990s under the context of the Forum on China Africa Cooperation (FOCAC), which prizes the concept of developing and sustaining mutually beneficial partnerships forged through South-South cooperation (Davies, 2010, p. 54). At the 2009 FOCAC summit in Egypt, China pledged to 'provide medical equipment and anti-malaria materials worth RMB500 million (US$73.2 million) to the 30 hospitals and 30 malaria prevention and treatment centers built by China and train 3,000 doctors and nurses for Africa' (Brautigam, 2011, p. 6).

Unlike Japan and China, whose aid generally dovetails with the global trend of targeting Africa, India directs most of its health related assistance to the South Asian region (Government of India, 2007). Delhi explicitly hopes these efforts will yield peace and advance amity within South Asia (Government of India, 2010), and it may also reflect a desire to extend its commercial and strategic influence within the region (Price, 2011, p. 9). But India has concurrently maintained a marginal influence across the African continent since 1964 through two flagship training programs – Indian Technical and Cooperation Programme (ITEC) and Special Commonwealth Assistance for Africa Programme (SCAAP) (Government of India, ITEC, 2011). After having been forged under the context of decolonization and the incipient Non-Aligned Movement (NAM) in the 1960s, relations between Africa and India have matured to focus on mutual geoeconomic interests (Katti et al., 2009, p. 3). Recent Indian Ministry of External Affairs budget outlays (2010–11) to Africa reveal a spurt in the transfer of funds to facilitate technological development in sectors such as education, health care, tourism, across the continent (Government of India, 2010). Recent agreements formalized under the India-Brazil-South Africa (IBSA) Tripartite Framework present another South-South forum for India to share its experiences, comparative advantages, and finances in the area of overseas health assistance (India Brazil South Africa Dialogue Forum, 2011).

Institutional management of DAH in China, India and Japan

As part of our focus on the global health paradigm, we are also interested in understanding the domestic institutions that shape national participation in global institutions.

In all three countries, ministries of foreign or external affairs play a significant role in the determination of overseas development aid policy. The Japanese Ministry of Foreign Affairs (MOFA) coordinates the formulation of international development policy and ODA through an interagency process – the Overseas Economic Cooperation Council, chaired by the Prime Minister. Inputs are drawn from a wide array of ministries and agencies, including ministries of finance, and ministry of economy, trade, and industry. Over the past two decades, MOFA has also engaged NGOs in the policy process through an interorganizational forum. On health aid policy, the MOFA and Ministry of Finance (MOF) function as the overseers with the Ministry of Health, Labour and Welfare (MOHLW) relied upon to supply technical counsel on global health issues. In addition, the government has drawn upon the expertise of academia and the think tank community, such as the Working Group on Challenges in Global Health and Japan's Contributions (informally known as the Takemi Working Group). Within MOFA, the Global Issues Cooperation Division delves into the projects that focus squarely on health and bilateral assistance (Pilcavage, 2012).

Within the Chinese government, five institutions are considered crucial for foreign health aid – the Ministry of Foreign Affairs (MFA), Ministry of Commerce (MOFCOM), MOF, Ministry of Health and the Export-Import Bank of China. The MFA is responsible for determining the quantity of aid to be allocated for a recipient country and it 'drafts the annual plan for aid together with the Department of Aid in the Ministry of Commerce.' It also ensures that China's political interests are not subordinated to commercial considerations (Brautigam, 2009, p. 110). MOFCOM is a 'designated central processing unit' (guiko guanli danwei) and functions as the administrative manager of China's foreign aid (Huang, 2011, p. 24). MOF determines the fiscal allocations for bilateral and multilateral aid initiatives. On multilateral aid pledges, a second department within the Ministry of Commerce (MOC), the Department of International Trade and Economic Affairs (DITEA), manages the process (Wang et al., forthcoming). The Ministry of Health (MOH) manages the deployment of Chinese Medical Teams (CMTs) abroad. Furthermore, China's State Council has recently established a coordinating mechanism, the Global Health Diplomatic Coordination Office to facilitate inter-ministerial cooperation on global health issues, including health aid (Chan et al., 2010, p. 5).

In India, international development policy and the health aid agenda fall predominantly under the Ministry of External Affairs (MEA). The Ministry of External Affairs is principally responsible for bilateral assistance (Price, 2011, vii). The MOF chips in to fulfill the attendant financial tasks involved and receives advice from the MEA on the eventual shape of bilateral assistance packages (Stuenkel, 2010, p. 39). MEA's two technical arms – Indian Technical and Economic Cooperation Programme (ITEC) and Special Commonwealth Assistance Programme for Africa (SCAAP) administer technical assistance for foreign development professionals seconded from their home countries (Government of India, MEA, 2011).

Managing and implementing foreign health aid policy

Once the policies are devised, the institutions, mechanisms and processes instituted to manage and deliver health aid diverge in the three countries. Japan has established a relatively diffused, dynamic, receptive and multi stakeholder governance structure. At the forefront is the Japanese International Cooperation Agency (JICA), an independent administrative institution that harnesses numerous governmental and quasi-governmental agencies to provide technical assistance and implement programs. (Pilcavage, 2012). Since the 1980s, many NGOs including Japan Overseas Christian Medical Cooperative Services (JOCS), Japan International Volunteer Centre, and national affiliates of international NGOs such as CARE and World Vision International have also collaborated in delivering health aid across the world (Pilcavage 2012). Nonetheless, less than 1 per cent of Japan's DAH is distributed to NGOs while over 40 per cent is channeled bilaterally (Llano, et al, 2011, p.1258).

China hosts an institutional labyrinth of organizations managing overseas health assistance. In total, 22 relevant ministries participate in the process of aid management and delivery (Wang et al., forthcoming). One arm of MOFA, the Economic Counsellor's Office (ECO) operationalizes aid in recipient countries. Financial and budgetary estimates and allocations are undertaken by the MOF, which disburses funds to either the MOC or MOH (Wang et al. forthcoming). Other ministries and agencies such as Health, Science and Technology, Education implement aid activities in their respective fields. Specific aid projects in recipient countries are supervised by respective Chinese embassies, executed by the Ministry of Commerce and monitored by the Bureau of International Economic Cooperation, the Department of Aid to Foreign Countries and the Ministry of Commerce (Wang et al. forthcoming). Civil society participation is limited but expanding in China (Florini et al., 2012). As Wang et al. (forthcoming) note, prospects for greater civil society participation are good given their recent post-disaster relief works in several natural disasters (e.g., donations by the One Foundation in relief aid to Haiti and Italian earthquakes, etc.).

India's institutional arrangements are less well understood. Since an overwhelming portion of health and overall development aid from India is channeled bilaterally, the Ministry of External Affairs (MEA) leads in managing and transferring development aid, including health assistance (Stuenkel, 2010, 38). Civil society's role appears to be confined to aid delivery. Gomez (2009, p. 10) discerns a robust hive of NGO activity, especially in the prevention of HIV/AIDS, in partnerships with many global entities like the WHO, World Bank, Gates and Clinton Foundations, etc. The Ministry of Health and Family Welfare appears to play virtually no role in overseas health assistance (Government of India, MOHFW 2009).

Sovereignty and Institutional Diversity: Insights from the DAH patterns of China, India and Japan

The development assistance programs of China, India, and Japan reveal interesting answers to the question of what might be expected from Asia in global health governance in the future, showing distinctive attitudes toward the concept of national sovereignty and rapidly changing attitudes toward the roles of a wide range of actors. Most strikingly, the rhetoric of all three countries displays a sensitivity to the national sovereignty of the recipients of their aid that western donors have only recently begun to emphasize. While all three certainly take their own national interests into account in deciding where and how to allot health assistance, the definition of national interest appears dynamic and contestable.

When they are recipients rather than donors, China and India both seem quite open to the involvement of a wide range of nonstate actors. Since 2002, China has received financial support from the Global Fund to tackle HIV, tuberculosis and malaria, from DFID for the China-UK HIV/AIDS Prevention and Care program; from the National Institutes of Health for research on AIDS; from AusAID on developing community-based intervention programs in collaboration with Chinese Centre for Disease Control; from the World Bank on HIV prevention programs in various provinces; and from the Ford and Clinton Foundations to bolster the capacity of NGOs in mitigating the AIDS epidemic (Gomez, 2009, p. 18). Beijing has begun to push China's private sector to contribute. In a recent summit hosted by the Ministry of Health and the Global Business Coalition on HIV/AIDS, Chinese former vice premier and acting health minister, Wu Yi, pushed the corporate sector to undertake a more forceful role in stemming HIV/AIDS; an unprecedented clarion call for many in the health community (Chan, 2009, p. 7). The SARS episode also affected and influenced China's attitude to sovereignty. As Chan et al. (2010) describe, the crisis proved to be the accelerant to push through a series of public health reforms that had hitherto been politically unpalatable. Embedded under this shift is the increased space ceded to global health actors (WHO, UNAIDS, UNICEF, etc.) and NGOs (GFATM, BMGF, Clinton Foundation, etc.) to help address infectious threats, notably HIV/AIDS.

In India, donors like Global Fund, GAVI DFID, USAID, World Bank, Gates and Clinton Foundations have injected millions of dollars to support NGOs, state governments and the ministries of finance and health in Delhi to combat AIDS. Beijing and Delhi have given essentially free reign to these nonstate actors and their domestic partners within India and China in mitigating infectious diseases (Gomez, 2009).

As a donor, post SARS China invested greater resources in global health diplomacy through the provision of health assistance to areas ravaged by infectious diseases (Chan et al., 2010, p. 4–5). And more broadly, China's recent white paper on foreign aid reflects an emphasis on the wishes of sovereign recipients: 'China provides foreign aid within the reach of its abilities in accordance with its national conditions. Giving full play to its comparative advantages, China does its utmost to tailor its aid to the actual needs of recipient countries' (Xinhua News, 2011). Moreover, China and India both prefer to provide tangible in kind services in the form of technical and infrastructural assistance that bolsters the public health apparatus of the recipient governments such that they can progressively deliver health care to their citizenry, arguably enhancing their sovereign capacities.

India's development aid programs demonstrate a preference towards reciprocity and mutual benefit. Where pertinent, it urges recipient countries to disclose their needs and requirements before pledging assistance. Gareth Price attributes this practice to the endurance of Nehruvian principles of nonintervention and self-sufficiency, which accord emphasis on state led development, itself borne out of India's nationalist struggles. Delhi, however, has also displayed a penchant to focus more on projects that are practical in orientation, largely in the form of training and capacity building programs, whose impact sustains long after project completion (Price, 2011, vii-viii).

Japan's view of the principle of sovereignty appears particularly flexible. It demonstrates a strong concern for the sovereignty of its recipients, providing assistance on a 'request basis' known as the yosei shugi system, which places great value on the recipient countries' sovereignty in a perspective on development policy that varies from Japan's western counterparts (Orr, 1990; Lehman, 2005). There is an assumption in the 'request basis' system that the recipient countries have the ability to decide and protect their own interest, and the type of aid provided by the Japanese reflects a compromise between the parties.

At the same time, as one of the chief material and ideational proponents of the human security paradigm since its inception, Japan has shepherded the emergence of a discourse that challenges traditional notions of national sovereignty and focuses on the individual rather than the country as the unit of concern, and Tokyo has enshrined its tenets within ODA policy (Pilcavage, 2012). It has propagated the human security discourse through high level policy speeches and symposia, mainstreaming the concept in bilateral and multilateral discussions, and funding grassroots human security projects that target victims of natural disasters, conflict areas, refugees and internally displaced people (Government of Japan, 2009). Japan's leadership in several important global health campaigns – the 1994 Global Issues Initiative on Population and AIDS, the 2000 Okinawa G8 Summit that emphasized global health, specifically infectious diseases, the 2008 Toyako G8 Summit that highlighted health system strengthening and the MDGs, the Tokyo International Conferences on African Development (TICAD) that have been held since 1993 – demonstrates a continuing commitment to global health governance. Japan has elicited the participation and insights of various domestic and global health actors in devising health policy, involving such entities as the Takemi Working Group, the Africa Japan Forum and academia. Japan has also championed the importance of strengthening health systems and health Information as a critical factor in health improvement (Government of Japan, 2008).

The increased commitment of these countries, especially Japan and China, to global health governance in recent decades is also reflected by the efforts and resources they have invested in having some of their nationals elected to the top leadership of international health organizations such as the WHO. In 2009, Japan put forth resolution EB124.R8 at the 124th WHO Executive Board (EB) session and resolution WHA62.12 at the 62nd World Health Assembly (WHA), which were both on primary health care, including health system strengthening. This was the first time Japan initiated a resolution at the EB and WHA, and both resolutions were accepted. Similarly, China led EB126.R6 on birth defects at the 2010 WHA. Curiously, India has been less prominent in this arena.

But there are also elements of more narrowly defined notions of national interest at play. In their foreign health aid programs, all three countries rely heavily on their foreign affairs ministries, which by definition are the most likely to think in terms of sovereign interests when deploying foreign assistance. In China's case, the MOFA and the MOC jointly determine the contours of health assistance. The MEA oversees the process of structuring and delivering health aid in India. In Japan, the MOFA functions as the principal arbiter in formulating aid policy through an interagency process, following which it delegates the responsibility of implementation to JICA and others.

Japan's 2003 revised ODA Charter explicitly defined national interest as one of its ODA goals although in the past gaiatsu (external pressure), especially from the US, has played a part in the quantity of Japan's ODA as well as its policies. Japanese foresight in hosting Tokyo International Conference on African Development (TICAD) since 1993 enabled it to utilize TICAD as an instrument for Japan's assistance and diplomacy to Africa.

Chinese and Indian health assistance in Africa may also reflect national foreign policy aims. Although Beijing does not attach conditionalities to its assistance, China does expect token support on certain principles, particularly the notion of One China (Davies, 2010, p. 57). Similarly, Delhi refrains from conditionalizing aid, but it has deployed it to advance geopolitical imperatives in South Asia and geo economic interests in Africa. Infrastructural financing in Africa by the Indian government assists in facilitating market access for Indian companies across the continent and this financing line has been recently extended to an astounding US$5 billion over the next three years by the Indian government (Maasho, 2011).

An overwhelming part of China and India's DAH takes the form of bilateral aid. Although Japan's experience over the past few years does herald a shift away from bilateral grants and aid, they do continue to employ it as evidenced by their pledged commitments, which hit US$300 million in 2007, which further indicates their comfort with maintaining the status quo despite being buffeted by recent crises (Pilcavage, 2012). It might be argued that the level of a country's contribution to international agencies and the share of this in its total international aid provide a measure of a country's commitments to the provision of the global public good, in a way that bilateral aid does not. On the other hand, the capacity for foreign aid of developing countries such as China and India has generally been limited, and bilateral aid may be a more efficient way to allocate that limited aid to countries and sectors which they know would bring greater benefits for the recipient countries. This would also imply that, with the rise of their economic power vis-à-vis today's developed countries, one could and would expect them to increase their share of aid through multilateral channels. Indeed, Wang et al. (forthcoming) have shown optimism in that direction in the case of China.

Institutional diversity

Japanese officials also seem more willing than their Chinese and Indian counterparts to incorporate a broader range of actors in shaping assistance policies. In their largely bilateral health assistance programs, China and India focus on building the hardware of recipients' health systems, providing badly needed infrastructure but not generally engaging the full range of actors in global health governance.

The same attitudes toward nonstate actors hold true internally as well. Tokyo frequently avails itself of several nonstate actors that include NGOs, think tanks, nonprofit organizations, and academia in determining and deploying Japan's foreign health assistance. Japan's broadened its perspectives beyond its purely national interests to a more global perspective. However, less than 1 per cent of Japanese DAH is allocated to NGOs (Llano et al., 2011, p. 1258). On the other hand, China and India have been disinclined to allow much of a role for nonstate actors in their ODA policy, including foreign health assistance. This is reflected in the technical outlook of their international development and health assistance packages that only require calibration with their governing philosophies and agendas. It also prevents the establishment of a conceptual link with the governing episteme of the global health governance paradigm that stresses the interdependencies of global health.

Understanding what DAH shows us about Chinese, Indian, and Japanese attitudes toward national sovereignty and institutional diversity as factors in global health governance is complicated by the reality that all three are large and diverse countries with complex domestic bureaucracies and interests all vying

to influence the direction of aid policy. As of now, India and China do not possess an independent agency for international development and cooperation. Policy formulation in India is concentrated in external affairs, whereas several agencies are relevant in China – commerce, foreign affairs, and finance. In both cases, institutional barriers make harmonizing national development and public health agendas with the global health paradigm difficult. Japan is a relatively coherent actor in health assistance, having vested responsibility for implementing aid policy with JICA (Pilcavage, 2012).

The dual role of China and India as both recipients (with substantial health problems and domestic poverty) and donors (with robust economic growth, particularly in China) make it even more difficult to determine a sense of direction. As Global Fund statistics reveal, India and China have collectively paid US$26 million to date in assistance to the Fund (The Global Fund, 2011a). However, both nations currently possess approved grant amounts that total US$2 billion, with disbursals that collectively stand at over half a billion US dollars each (The Global Fund, 2011b). The Gates Foundation has pledged US$50 million to China and US$338 million to India to combat HIV/AIDS. World Bank boosted its HIV funding to India by US$250 million in 2007 (Gomez, 2009, p. 10–11). Although such heavy use of available global resources may have made sense for two developing countries with such huge populations, health needs, and still-developing systems of domestic health governance, critics have argued that it distorts the process through which global funds are allocated to tackle pervasive health threats, siphons funding away from other low income countries, especially in Africa, that are decimated by these diseases, and places immense fiscal pressures on entities like the Global Fund, which is struggling to renew investments (Chow, 2010). In addition to pressure to reduce their role as recipients, they face growing pressure to increase their role as donors. GFATM Director Michel Kazatchkine recently appealed to emerging donors to take a more proactive donor role: ‘As these countries come in and play more political leadership roles, they have to enter into the global solidarity effort when it comes to health’ and ‘I really think it is time for the G20 to come into the circle of donors’ (Garrett and Alavian, 2010, p. 6).

Conclusions

Looking through the sovereignty and institutional diversity lenses to examine how the official health assistance programs of Japan, China, and India reveals a complex picture. Not surprisingly, there are immense differences across these three Asian countries and little evidence of a single coherent regional perspective on global health governance.

Japan has engaged much more deeply with global health governance initiatives than have its regional neighbors, contributing far more to multilateral health programs and accepting influential roles for nonstate actors in its assistance programs. On the ideational side, Japan has contributed a human security paradigm that makes individuals, not countries, the focus of concern.

China and India, in contrast, have benefitted substantially from multilateral initiatives to which their material contributions have been limited and their ideational contributions nonexistent. They have been receptive to receiving aid from nonstate actors but framing their own health assistance programs overwhelmingly in bilateral terms, focused around infrastructure and technical assistance, and not well connected to global health initiatives. Designating such ministries as foreign affairs and commerce to take the lead in formulating development policy leads to a scenario that David Fidler refers to as ‘transformation of health for the benefit of foreign policy’ (Owen and Roberts, 2005, p. 1). Both India and China have remained tepid towards involving nonstate actors - major sources of experience and expertise - in the formulation of health oriented assistance.

But these are dynamic processes. As we write, developments in each of the three countries appear poised to shape their future overseas development and health aid agendas. The triple disaster—earthquake,

tsunami and the nuclear maelstrom—that hit Japan in March 2011 has made Japan a receiver of assistance again, and will most likely affect Japan's future budgetary allocations. Already in the red, Japan will be forced to reorganize its priorities to rebuild devastated areas, a scenario that may imperil future Japanese leadership on the global health front. The recent unveiling of China's white paper on foreign aid (Xinhua Newsnet, 2011) officially proclaims China's arrival on the international development stage, with an alternative approach to aid that institutionalizes the importance of mutual benefits and sovereignty, principles that have informed Chinese aid programs for the past three decades (Huang, 2011, p. 20). The recent establishment of a centralized foreign aid agency in Delhi, armed with a hefty financial and operational mandate, could enhance India's management of aid and enable it to better manage its strategic interests via aid within and beyond the region (Patel, 2011).

To date, these three countries have had limited roles in shaping global health governance. Japan has clearly had the most as demonstrated by the large amount of contributions to multilateral organizations and its hosting major forums such as the G8 Summit. In general, the three show greater rhetorical sensitivity to the sovereignty of the recipients of their aid than has be common with western aid, and have been less likely to direct their aid via nonstate or hybrid bodies.

Although one could be tempted to draw comparisons between the approaches of China, India and Japan to those models of ODA adopted by the developed countries, this has to be done in the context of history and the reality that novel approaches are continuously evolving. Post WWII there was perhaps an underlying moral desire on the part of western powers to help countries which were former colonies in the developing world. This would partially explain the altruistic, multilateral and mostly 'top down' approaches of ODA that has developed in the last five to six decades, arguably starting with the Marshall Plan and the establishment of the Bretton Woods institutions such as the IMF and the World Bank. Arguably, Japan as a former colonial power during WWII, has followed to some extent, the western model. In contrast, China and India were preoccupied with post war reconstruction and development and internal turmoil for much of the 20th century and have only recently begun to be involved in ODA in a meaningful manner. Having shared with the struggles of many Asian countries, and perhaps still a little wary of the domination of the western powers, India and China in particular, have approached ODA in a more bilateral and equal footing with underlying national self-interest, rather than the global common good, driving their policies. It also seems that the relatively small amounts of ODA allocated by these two countries, at least as compared to western nations, have been spent with a view on economic and security considerations which directly affect them.

Based on the analysis presented in this paper, it would be reasonable to conclude that the approach adopted by India and China is, indeed, different to those adopted by the developed nations including Japan. The two models are not however, mutually exclusive, and one can imagine a future scenario where they are, in fact, complementary especially as both stronger capacity and institutions develop in China and India. The challenge in the future will be to strike the appropriate balance and to have governance mechanisms and structures in place to achieve this objective. As emerging economies mature in the coming decades, with concomitant increases in ODA, these aid programs are likely to significantly change the nature of global health governance hand-in-hand with more traditional approaches to ODA.

Footnotes

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[1] The HDI is another instrument in the Japanese MOFA's campaign against Infectious Diseases; it was designed as a successor to Okinawa Infectious Diseases Initiative, formed at the G8 Okinawa Summit.

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