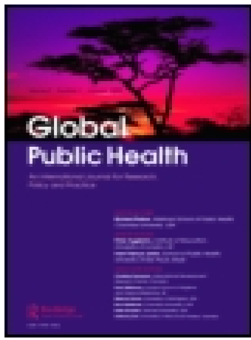

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Building a regional health agenda: A rights-based approach to health in South America

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ABSTRACT
Attention to health policies in Southern regional organisations reveals a new 'social turn' in the regional political economy of international cooperation. The aims of this paper are twofold. First, it aims to establish the extent to which the Union of South American Nations (UNASUR) has adopted and sustained policy interventions committed to addressing social inequities and asymmetries in relation to health, as indicated by regional policy agendas, policy development processes and resourcing. Second, it seeks to understand how UNASUR is mobilising national and regional actors in support of such policies. Our analysis of documentary sources and interviews leads us to draw the following conclusions. First, we argue that the UNASUR regional framework has a committed social equity/rights focus in relation to access to health care and medicines, with a clear focus on reducing asymmetries between countries. Second, although UNASUR does not enforce national commitments on health and medicines, it nonetheless plays a role in expanding domestic policy horizons and policy capacities. In this respect, we find that UNASUR interventions lead to initiatives and actions aimed at implementing reforms, setting targets and defining goals nationally. Third, in global arena, UNASUR enhances the visibility and 'voices' of the member states.

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Introduction

The Constitutive Treaty of the Union of South American Nations (UNASUR) establishes a broad acceptance of social policy as an important catalyst for new modes of cooperation and states the need to institute a new regional body. Moreover, of all the functional councils, the Health Council was one of the first to be created (along with Defence Council) and remains the most active despite differences at other levels. UNASUR is a new entity that aims to give to the region the political ties to consolidate efforts between countries in political, economic and social issues and strengthen the international identity of South America. Its creation comes as part of the new cycle of re-politicisation in regional politics (Dabene, 2012) or as Riggirozzi and Tussie (2012) posit, as part of a struggle for post-hegemonic regionalism.

The coming to power of left-leaning administrations in most South American countries since the beginning of 2000 allowed the creation of an opportunity structure for pioneering health diplomacy and social inclusion through health. As argued by Riggirozzi (2014, p. 434), the attention to health policies shows a 'social turn' in the life of Southern regional organisations and their mission to

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cooperate in order to meet high-profile social demands. Health is a prime example of an ongoing quiet revolution in the regional political economy of cooperation and diplomacy.

What makes UNASUR particularly interesting is its vision of regionalism that builds from, and capitalises on pre-existing trade-led agreements, specifically the Mercado Común del Sur (MERCOSUR) and the Andean Community, but strengthens new areas of regional cooperation, beyond trade-centred objectives. The emergence of UNASUR is an interesting case to analyse changes in the form and content of regional governance (Herrero & Tussie, 2015).

Inadequate access to medical care and drugs are a persistent problem in vulnerable populations, and it has been recognised as the root of social determinants of health/disease and of social inequalities (Irwin & Scali, 2010). UNASUR in particular leads regional theme-specific networks and country-based working groups to implement health projects; enables initiatives referring patients between member states; leads and disseminates research and communication technologies for practitioners and policymakers; supports health surveillance; and leads regional strategies for medicine production and commercialisation (see also Riggirozzi & Yeates, 2015; Yeates & Riggirozzi, 2015).

In order to accomplish this analysis, a study based on a qualitative approach was conducted, including primary and secondary data. The primary data were collected through in-depth interviews from two country cases (Bolivia and Paraguay), with regional actors related to the institutional frame of UNASUR and public health in general. Fieldwork was carried out during 2014 and 2015, including more than 35 interviews with health ministers, former officials in charge of health public policies and representatives of regional and national organisations. In this document, the identity of the interviewees will remain anonymous.

This paper aims to establish to what extent UNASUR has adopted and sustained policy interventions committed to addressing social inequities and asymmetries in relation to health, as indicated by regional policy agendas, policy development processes, and resourcing. It also seeks to understand how UNASUR is mobilising national and regional actors in support of such policies. To this end, the paper presents and reviews evidence about UNASUR commitment in reducing social inequalities through its health policies (specifically those relating access to health care and medicines), as indicated by policy agendas, indicators, metrics, and resources. In so doing, this paper contributes to achieve a broader understanding of regional health diplomacy and the process of *unasurisation* of health policies (Herrero & Tussie, 2015), as long as the process of building a new health framework for the region.

Why health and health rights in the new agenda of regional integration in South America?

Coitiño (2014) mentions that a week after the signing of the UNASUR Treaty in Brasilia, the Southern Command of the United States announced the re-establishment of the Fourth Fleet, responsible for naval operations in South America. This raised concerns among governments of the region, especially in relation to another attempt to destabilise left-leaning governments, leading to the establishment of the South American Defense Council. But the creation of the Defense Council could be seen as an offensive move, so, banking on the expertise in health and the considerable intellectual resources accumulated in the establishment of a Health Council was mooted. The aim was to have a *hard* Council hand in hand with a *soft* one. Coitiño argues that to move UNASUR two instruments were prioritised, one of *hard* power motivated by the need to enhance coordination and military cooperation in the region; and one of *soft* power in order to create a space for integration in health and deal with global health challenges (Coitiño, 2014).

These points are key to understand why an essentially political body such as UNASUR choose to include health in its construction of a new regionalism, making it a tool for self-reliant development, 'a regional cause' against the external influence and approach of international organisations or donor partners. The coming to power of left-leaning administrations in a number of countries in South America created a unique opportunity to pioneer health diplomacy and the inclusion in those

countries of social policies through health. Unlike MERCOSUR and the Andean Community, that treated health in the context of trade liberalisation, UNASUR addressed health with a social policy approach and in a different political and economic environment. As a respondent from the Health Ministry of Paraguay referred, 'Mercosur is an economic regional market and UNASUR is a political union' (PY15, personal interview, October 2014).[1]

The practice of member states at UNASUR Health[2] makes health one of the most dynamic areas of regional cooperation within UNASUR at the present time. This is important considering that one of the banners of UNASUR is the right to health, and one of its main goals is to promote universal health systems. While prevailing international cooperation (such as the Pan American Health Organization (PAHO), the Inter-American Development Bank (IDB), the Global Fund, the Bill and Melinda Gates Foundation) aims to address certain specific diseases through so-called vertical interventions and programmes, supported by specific funding, UNASUR seeks to address health with a rights-based approach that is more political and structural. This translates into unpacking the social determinants of health, the promotion of public health schools and the improvement of national health systems.

From this perspective, international health agencies and various governments have sought to include in their public policies these factors as a strategy that considers health beyond a mere biological concept, converting it into a multidimensional concept (Breilh, 2008; Breilh, 2009; García-Ramírez & Vélez-Álvarez, 2013; Herrero, 2015; Irwin & Scali, 2010). The authors refer to social determinants of health to understand the link between epidemiology and social conditions, based in the theoretical search of the relation between social factors and demographic patterns of diseases distribution (Barata, 2000, 2005). Even though the consideration of social and cultural factors existed before the appearance of the concept of social determinants (Barata, 2005), the novelty of this framework was the recognition of the link between unfavourable life conditions and inequalities and the distribution of diseases prevalence (Barata, 2005; Krieger, 1994; Urquía, 2006).

With this framework, the South American Health Council of UNASUR incorporated the issue of social determinants of health and created the Technical Group on Health Promotion and Action on the Social Determinants of Health, whose mission is 'to strengthen health promotion and action on social determinants in order to reduce inequities in each of the member countries, by generating information, intersectorial coordination, and community participation in the formulation, implementation, and monitoring of health public policies' (2010). In its 'Five Year Plan', UNASUR adopts a social determinants approach and a transversal perspective in its policies, promoting the development of partnerships and networks with various sectors of society (UNASUR, 2010). It also propose to increase the number of countries in the region that reorient their health systems towards a focus on social determinants and to incorporate

In the words of Buss, in this context, health was central not only as a health problem of transnational relations, but also and primarily as a social right that should be approached by regional relationships and with global diplomacy (Buss, 2011). The General Secretary of UNASUR, Ernesto Samper, mentioned that health has a central role in the purpose of social inclusion as an articulator of the new social agenda (Samper E. in South American Institute of Health Governance [ISAGS], 2014). UNASUR refers explicitly in its principles, values and objectives of the social determinants of health and inequities, and therefore upholds a structural notion of poverty reduction, through addressing the social determinants of health with approaches and interventions that follow a more horizontal and holistic notion of health. After being explicitly mentioned in the UNASUR treaty (UNASUR, 2008a, 2008b), this commitment has been translated into practice by many countries that have incorporated rights, principles and standards in constitutions and legislation together with health policies and programmes, treating health as an asset of citizenship rather than a market commodity, and promoting an equitable path to universal access. These human-rights-based approaches are characterised by a focus on the underlying social determinants of health and an emphasis on the principles of universality, meaningful participation, transparency, equality and interculturality (Yamin & Frisancho, 2015).

Many factors explain the emergence of UNASUR, like the rise of left governments in the region, the urgency to face the consequences of neoliberal's politics, the need of a Defense Council, the importance of social policies as a catalyst for new modes of cooperation and the need to institute a new regional body. Its origin is closely related to the need for South American countries to build common positions in global forums, which has made UNASUR begin to stand by their actions in global health governance as an agent of claims based on rights (Coitiño, 2014). In our study, most of the respondents agree that UNASUR took up health as a political issue from the start, as contemplated in its very constitution, and therefore, health was also incorporated at the level of norm promotion. Most respondents believe that the added value of UNASUR is to reduce asymmetries between countries and to enable stronger bargaining power.

Values and policy paradigms may also diffuse into national policy debates and framing of policy solutions encouraging social learning and enhancing normative influence. The influence of epistemic communities is considerable, reinforced through the establishment of thematic networks that potentially can institutionalise problem-solving capacities (i.e. dengue network, network of public health schools, cancer network). Finally, UNASUR has had great influence on other very important players in the field of health in the region as, for example, the Asociación Latinoamericana de Medicina Social (ALAMES). The importance of this is that it brings together the key figures in the region in the health sector, many of which are part of the *Salud Colectiva* movement. In addition, many of them have participated (and continue to do so) in decision-making spaces. From these vantage points, they have influenced the bases and principles of UNASUR and positioned health as a central track for cooperation. Interviewees were very clear in pointing out that, as did this informant of the Health Ministry of Paraguay, 'its role is not to define policies but to encourage countries to adopt policies' (PY02, personal interview, October 2014).

Reclaiming the region: Between national policies and health diplomacy

Our documentary analysis shows that there is a low degree of institutionalism in UNASUR, something confirmed by many of our interviews. As said before, the Health Council relies on a Coordinating Committee, the ministers' network and the technical groups for the five big working areas as they present initiatives to Heads of State. The overall process enables bringing an issue to the fore and creating the space to debate alternatives. The norm creation process does not put pressure on countries; it gives visibility to proposals to deal with asymmetries. Heads of State sign agreements that help health ministers to move the agenda at country level and increase their own bargaining power within national bureaucracies.

Essentially UNASUR triggers a necessary dialogue between actors that empower each other and share experiences; it creates new spaces for policy coordination and collective action. The commitment is to take the guidelines created in UNASUR and to embed *them down* to the national space. There is a knowledge-sharing process that goes from countries with previous experiences in that working area to countries with emerging developments.

Another interviewee sustained that 'UNASUR does not want to be a technical space, there are others already. It wants to be a political space, for discussion and analysis' (AL03, personal interview, November 2014). Drawing on this suggestion, we notice that regional policies do not evolve in a top-down direction but there is an assemblage of different levels. The regional level is a hinge where policies converge and from which policies diffuse. Consequently, there is no unilateral transfer policy (top-down), or a single way of adoption. As mentioned by one respondent from Instituto Suramericano de Gobierno en Salud (ISAGS), we need to keep in mind how the global health agenda moves from one institution to another (AL06, personal interview, July 2015). For example, some World Trade Organization (WTO) rules are binding and others are declarations to which countries can hook their policies, such as the one on Trade-Related Aspects of Intellectual Property Rights (TRIPs) and health; in the World Health Organization (WHO) declarations and even resolutions are not binding (except for the regulatory framework of snuff for example).

Our interviewees agree that the ideal scenario would be that countries were bound to implement the decisions approved at the regional level but that is not in the nature of the institution that merely strives for consensus and ways to reach the global level. Decisions taken at the regional level are not necessarily translated into laws or commitments at the national level.

However, this does not reflect a lack of influence of UNASUR at the national level. One of our interviewees argues that 'UNASUR is an enabling factor that creates incentives for the formulation of strategies and policies' (AL03, personal interview, November 2014). Our interviewees agree that the national-level impact depends on the country's circumstances to take up the normative framework agreed. This means that national officials receive some empowerment to open up spaces within their government and to strive to improve the installed capacities of the national health system.

As mentioned by other respondents, we could observe that there are different types of norms. First there are statements, for example, policy statements made by ministers that can then become a concrete initiative (AL06, personal interview, July 2015). Such is the case of the political declaration of health ministers on the need to provide supplies and medicines due to the pandemic influenza, and accepting as a fundamental principle the right to health. In this statement, they ratified the concept of public health over economic and commercial interests (UNASUR, 2009a). A statement was also issued after the earthquake in Haiti, in order to request additional IDB funds and to create a fund of UNASUR as well (2010). There is also a statement with regard to the specific economic situation in relation to dengue. After its outbreak, Argentina tabled a motion for agreement between ministers to reinforce the commitment to combat dengue (UNASUR, 2009b). These initiatives are regional declarations that arise from the agreement reached among all countries, whether stemming from a regional shared need, a bilateral need between countries or from a single country.

An example of the latter has been the problem of shortage of drugs in Colombia. In Colombia, in 2012, there were shortages of drugs for the treatment of cancer and that country requested collaboration and participation of nations such as Brazil and Argentina, through the presentation of the problem to UNASUR (Ministerio de Salud y Protección Social de Colombia, 2012). In this case, a single country led to the setting up of Forum UNASUR, an initiative that could be expanded to the rest of the region, as other countries were experiencing similar shortages. A statement from ministers aimed at bringing the issue to the fore to be discussed regionally. That is, although as mentioned above statements are not mandatory they lead to initiatives or actions, set targets and define goals. Once these actions or initiatives emerge, some of them are taken to the global sphere with the aim of promoting them in the international health agenda, for example through the WHO Assembly (drugs initiatives as analysed below).[3] These initiatives switch again to the regional level and then, in terms of political mandates, to the Member States, for example by establishing mandates to ensure supply of inputs, medicines and training of human resources, or encouraging work on social determinants, or on the improvement of primary health care and to establish funding for them. An example of an issue that was agreed upon among almost all the countries of the region is the strengthening of health systems. A plan was set up with the schools of public health on development of human resources, periodical meetings of the schools were held and training of trainers were promoted (AL07, personal interview, July 2015). While UNASUR Health currently does not have mechanisms for control, countries can conduct activities to monitor actions and to report on the achievement of goals and objectives.

Thus, UNASUR also strives for obtaining a voice in global health, gaining political prominence through two parallel movements highly relevant in terms of health diplomacy. To do so, UNASUR has been driven by global scenarios in which there has been an increase in health issues on the agenda (Rio + 20, ICPD + 20, World Conference on SDH, etc.). These scenarios are permeated by two different global movements, one linked to the opening and globalisation of the health market and the other one linked to rights (related to Alma-Ata, forums such as Health in All Policies, the Framework Convention Snuff Control). Beyond these two movements that pervade the stage, there is also a change with the emergence of debates on the agenda of health and development in the WTO, World Intellectual Property Organization (WIPO), among others (Coitiño, 2014).

Gaining voice in global diplomacy, UNASUR is a central driving force that also allows a regional identity building. For example, it was able to negotiate as a block in the 67th World Health Assembly (WHA) over the report submitted by the Health Development Advisory Panel on Research (ISAGS, 2014). In this case, UNASUR member states took a common position on 10 issues regarding the following themes: vaccines, disabilities, monitoring of the Millennium Development Goals, Post-2015 Agenda, repercussion of the exposure to mercury, health contribution to social and economic development, access to essential medicines, strengthening of the regulation systems and follow up of the Recife Political Declaration on human resources and of the report presented by the Consultative Expert Working Group on Research and Development (ISAGS, 2014).

Thus, the participation of the South American Health Council in international fora is central to the mission of building a shared agenda. An example of this has been the mapping of experiences of primary care in the Americas carried out by the ISAGS that accounts for the various models of comprehensive health care adopted over time that was submitted to the WHA. The initiative aims to provide governments with information to identify strategic policies for local or regional action, facilitating decision-making.

Such consolidation of a unified front and a shared mandate taken to the WHO is another remarkable milestone in the opinion of interviewees from Bolivia and Paraguay. As a respondent from the Ministry of Health of Bolivia argues, this mandate allows an influence and effectiveness that cannot be achieved single-handedly by his country (BO04, personal interview, December 2014).

In sum, firstly a national problem is taken to the regional level to be identified by all member countries of the bloc, for example through the Technical Group, and addressed regionally. Then, once this issue is recognised as such, countries begin to perceive that UNASUR may be a good place to raise proposals and priorities and to gain support from their national counterparts for those priorities. This not only strengthens the regional policies and national policies, but also helps to build confidence between countries and thereby advance cooperation and integration (AL07, personal interview, July 2015).

In conclusion, we can state that the main contribution of UNASUR is the construction of a shared identity on social issues and the mutual reinforcement of cooperation over neglected issues or issues that had suffered the brunt of neoliberal reforms.

Universal access: Facing a debt, a new sovereignty

UNASUR's banner in global health is the promotion of policies related with the right to health and universal access (Herrero & Tussie, 2015). Promulgating public policies that facilitate access to medicines and regulate the pricing of drugs and their impact on public health systems is key to ensuring the right to health. The intervention of UNASUR in the topic of access to medicines distinguishes itself for being well-worked out from its regional base and it is one of the interventions that confirm the role of UNASUR in norm development on the global stage. As we mentioned before, it is possible also in the field of medicines to identify the three levels in which this issue operates and through which norms are promoted (the national level, the regional level and the global level). We can see in the issue of access to medicines the cycle of norms and policies that are occurring in the region, ranging from the emergence of these norms to the internalisation of some of them, which contribute to build health diplomacy. Even though, in this topic as in all others, it is important to note that the documents of UNASUR are normative frameworks but not binding texts.

At the regional level, one of the principles of UNASUR considers reducing asymmetries between countries by enhancing the productive capacity of the region in the field of access to medicines (UNASUR, 2008a). Countries consider that it is important not only to develop a regional mandate on access to medicines and elaborate joint recommendations to strengthen the coordination of productive capacities in the region, but also to reduce barriers to access that arise from the existence of intellectual property rights and those relating to the lack of incentives for innovation and development as 30% of total health spending in countries from South America is on medicines (EBC, 2015).

Hence key to this goal is the pursuit of an agreement on a pricing policy together with a system of surveillance and control, as well as the promotion of production and the use of generic drugs (Rovere, 2015).

Minute 1/2009 of the Health Council established four objectives for the technical group on universal access to medicines (UNASUR, 2009c). These are map capabilities to produce medicines and other health supplies; exchange experiences in order to address in an integrated way the barriers that limit access to essential medicines; develop a proposal for universal access to medicines, considering the productive capacities of the region; exchange information on the quality of medicines, according to public health needs (UNASUR, 2009c). Part of the work on internalisation and consolidation of this has received the support of the Development Bank of Latin America (CAF) (UNASUR, 2009d).

In October 2014, the General Secretariat and ISAGS signed an agreement to generate a bank on drug prices and a map of capabilities to produce them in the region. The importance of these projects is that they can face one of the main problems that affect health systems and the social determinants of health (considering that besides being a right, access to medicines is not the only determinant of health, but one of the most important for the prevention, cure and maintaining of quality of life). The bank's aim is to establish reference prices so that countries can tell the difference in prices across countries and use this as evidence to bargain with suppliers. The final goal will be to reduce health costs and control companies using arbitrary or transfer pricing. The database of drug prices that was developed by ISAGS is the first in a series of joint strategies for the countries of the region to increase access to medicines (EBC, 2015). The bank's price references help each country know how much is paid by others (Gollan, 2015). The map of drug production capacity will define regional policies to replace imports of drugs with local production, make joint purchases, licensing and regulation. Moreover, the change in the epidemiological profile in the region implies the need to expand access to generic medicines for chronic diseases that affect a large percentage of the population. In sum, the Bank of drug prices is a project perceived as a management tool that will improve decision-making and provoke the development of regional drug purchasing strategies by means of providing accurate information regarding drug prices.

> These country and regional processes work in tandem with global initiatives. At the global level one of the first positions tabled by UNASUR at the WHO concerned the impact of intellectual property rights on access to medicines and the monopolist position of pharmaceutical companies on price setting and access to generics. As with other issues, the proposal of a regional policy on drugs is perceived as the construction of a political position and a regional strengthening agent.

In another manifestation of collective action, UNASUR countries have committed not to buy medicines above the prices settled by PAHO's fund, attempting to prevent commercial interests taking advantage of panic and uncertainty caused by epidemics (Herrero & Tussie, 2015; Riggirozzi, 2014). During the 63rd WHA in 2010 and in the context of stronger South-South cooperation in health, a proposal from UNASUR was to create a specific working group to examine the role of WHO in the prevention and control of medical products of substandard quality, spurious, falsely labelled, falsified or imitation to ensure availability of quality information; and safe, effective and affordable medicines. This resolution was approved at the 65th WHA in May 2012. Proposed by Ecuador and Argentina through UNASUR, this resolution asked for an intergovernmental group to replace the International Medical Products Anti-Counterfeiting Taskforce (IMPACT) – an agency led by Big Pharma and the International Criminal Police Organisation (Interpol) – to act on, and prevent, counterfeiting of medical products as another point in the promotion of policies to ensure equitable access to medicines (Coitiño, 2014; Riggirozzi, 2014).

As we can see up to here, there is an interesting process in the region related with access to medicines. Although UNASUR decisions are not binding, it is possible to identify a cycle in norms, ranging from the emergence of norms, where a leading state with active national policies on drugs persuades other states to back the regionalisation of the norm, such as negotiating acquisitions of new drugs or the establishment of shared mapping capabilities, or implementing a data bank for

regional drug prices. Once the process is set in motion, norm cascade follows, with countries following up and setting up a new public production of drugs and policies for generics. Finally, the third stage of 'norm internalisation' takes place if funds for production are allocated or national legislation is adopted. We see diffusion without the backing of binding agreements.

In connection with the possibility of building a regional paradigm in access to health in the countries of South America, our interviewees highlighted the ability of UNASUR to build positions before trade agreements, describing the underlying objective of the initiative on drugs. For example, an interviewee made a distinction between MERCOSUR and UNASUR regarding patents. He mentioned that in MERCOSUR, as a more commercial bloc, members would discuss patents on a more instrumental-technical level; while in UNASUR members will directly talk against patents, and made more political considerations (PY03, personal interview, October 2014). At this point, some interviewees mentioned that the focus of MERCOSUR is commercial benefits and agreements. While UNASUR, with the vision of equitable access to health products, can generate investment looking for mutual benefits derived from common prices. Thus, the main difficulty in implementing a policy of free movement of goods – in this case, drugs and patents – is the concrete barriers and protectionist policies of national industries. This complicates the possibility of building regional sovereignty over public drug production when countries grant that control to national or transnational private interests. 'We, as a country, had to strengthen the capacity of drug regulation and we requested the support of UNASUR in the region, because it has much more experience and much more force as a bloc in the regulation of medicines' (PY01, personal interview, October 2014).

Despite this, some respondents from Bolivia and Paraguay mentioned that the region still has progress to make regarding access to medicines. They highlighted the existence of private interests in each of those countries benefiting from the production of drugs with excessively high prices for governments on purchases for public health systems.

Regarding access to healthcare services (another main objective in the path towards universal access and the right to health), respondents from the regional level consider that UNASUR can play a crucial role insofar as regional integration helps reduce asymmetries between countries, moves towards building a comprehensive system of health care and adopts policies to promote '*buen vivir*' (a less medically oriented conception of health, more in consonance with the concept of 'well-being').

In this process, it is important to consider that, in October 2009, the technical group on universal systems (UNASUR, 2009e) was established and made a number of recommendations: promote the recognition of health as a human right, resulting from the influence of social determinants, environmental, cultural, biological-genetic and health systems and promote the constitution of integrated health services networks based on primary care to facilitate the creation of universal health systems.

The most significant advances in terms of universality, comprehensiveness and social equity are represented by the unified health systems that Brazil, Venezuela, Bolivia and Ecuador are trying to implement. In this sense, ISAGS/UNASUR contributed not only at the regional, but also at the national level in strengthening governance capacity, particularly creating new regulations and protocols for primary care and hospitals.

ISAGS is UNASUR's brainchild and novel creation that contributes to create a common set of beliefs and policy positions that are transferred to other institutional channels (inter-ministerial meetings; WHO). ISAGS has trained policymakers and practitioners by setting up a network of public health schools in Bolivia, Guyana, Peru and Uruguay and has also provided support directly to ministries of health in Guyana and Paraguay on primary care and the preparation of clinical protocols. It has supported reforms aimed at moving towards the universalisation of health care in Bolivia, Colombia and Peru (Giovanella, 2015) and is also involved in the diffusion of information on combating HIV/AIDS, influenza H1N1 and dengue fever and non-communicable diseases across the region, and has developed mapping techniques to coordinate shared policies for the production of some key medicines (Buss & Tobar, 2009; Gollan, 2015).

The establishment of ISAGS is a pioneering step in tackling issues of management and redistribution of resources in the form of human capacity as well as professionally, for enhancing research and development. In this respect, ISAGS seeks to identify existing industrial capacities in the region to coordinate common policies for production of medicines and other goods, advancing the industry and creating competitive advantages in global negotiations. It has set in motion a process where knowledge is used in the development of policies and institutional agreements. The policy transfer process is very intense in this regard. An important feature of the Health Council is that it has worked to structure its broad initiatives within a five-year plan since its start (2010–2015). The plan operationalises agreed goals, which reflect the priorities defined by the Ministries of Health and by the technical groups and networks that comprise the Council (ISAGS, 2015).

The presence of ISAGS as a focal point for expanding policy capacities solidifies South American thinking at the same time it becomes ingrained. ISAGS may help creating organic thinking that enhances the political position of the actors in health and can institute alternative practices to those promoted by the market.

The participation of civil society is still a challenge, despite the fact that its necessity is made explicit in one of the main objectives of the Constitutive Treaty. As we gathered from the interviews, social movements and civil society organisations are poorly involved and hardly consulted. The interviews conducted with civil society organisations in Bolivia and Paraguay showed scarce contact with and limited knowledge of UNASUR or its policies. The traction of civil society is on the increase despite the fact that the UNASUR framework for this purpose has not yet been created. The Bolivian government has been working on the proposal of creating a civil society forum as a way to reinforce the participation of civil society in UNASUR, for which a first step would be the mapping of organisations willing to work at the regional and national levels. Bolivia is very advanced on this process at country level with its policy named 'Diplomacy of Peoples'. Our fieldwork shows evidence of this increasing traction but also that it is still far from civil society demands.

However, UNASUR evidences the construction of epistemic communities too that work in the diffusion of ideas and the dissemination of knowledge, as ISAGS. This points to the role of UNASUR as 'regional broker', meaning that the bloc has the capacity to generate a broader consensus, and mobilise local experts and actors in pursuit of health governance (Riggirozzi, 2014, 2015; Yeates & Riggirozzi, 2015). Social participation as such can be seen as a conduit to enable the continuity of policies, but it remains in its infancy in UNASUR. It is possible to speak of UNASUR as a 'broker' moving between three self-reinforcing levels of governance, national, regional and international exhibiting an ability to generate broad consensus, and mobilise local experts and actors in pursuit of rights-based health governance (Riggirozzi, 2015; Riggirozzi & Yeates, 2015; Yeates & Riggirozzi, 2015).

What the process shows is that the agenda of international health in the region is becoming more multi-centric, creating a space to reflect and build new knowledge for action and even generate policies, many of which are very different from the traditional field of international health. As one interviewee mentioned, the region poses challenges to the approach focused only on diseases, even taking away the concept of poverty (AL08, personal interview, June 2015).

So far, UNASUR remains a politically closed process confined to actors that work to support and learn from each other. It has tried to construct the idea that regional and global relations can also be mutually reinforcing strategic relationships and that it is possible to achieve joint positions in international health issues.

Conclusions

As we have seen throughout the paper, the UNASUR framework has a committed social equity/rights focus (specifically regarding access to health care and medicines), as indicated by policy agendas, policy development processes and resourcing. Since its origin, UNASUR has placed its focus on the right to health and health sovereignty, through a strong sense of collective action

and political integration, including in some regulatory frameworks. Considering that the social determinants of health are the direct causes of poor health and inequalities in the population, the driver of the policies of UNASUR is health, rather than disease. What is more, UNASUR promotes a move towards horizontal cooperation and cross-cutting policies, moving away from the traditional and vertical hegemonic model of donors and recipients.

UNASUR added to the sanitarian and redistributive challenge the political test of designing regional strategies towards better access to medicines through international negotiations in the bloc and improvement of human and industrial capacity in South America. This accounts for the links between regional integration and social development, and new forms of regionalism as a process of collective action in the region and for the region. This commitment is seen not only in the initiatives carried out at the global level, but also in the actions performed and the resolutions implemented at the regional level and national level. The greatest advances were observed in the area of drugs, where path-breaking policies are in motion. UNASUR has built a new institutionalism exemplified not only by the Five Year Plan, but mainly by the creation of ISAGS, which has enhanced policy capacities and policy horizons. The regional level of governance acts as a hinge, which enables coordinated tabling of global initiatives and policy diffusion on the national level. This speaks of a process of mutual diffusion. As mentioned above, political statements are not mandatory, but they lead to initiatives or actions to implement reforms, set targets and define goals.

The regional process in itself has legitimised coordination between health ministries and opened spaces for the construction of a positive agenda. It enhances the political position of government actors and allows the structuring of alternative practices to those promoted by the market. Such direct diplomacy in the hands of health actors, in contrast to other regional organisations, allows to raise the issue of health to the fore without the intermediation of foreign or trade ministries. The change in the balance of forces is reflected very particularly in the attention to primary care and drug pricing policies, joint purchases and joint production, important stepping stones to tackle the social determinants of health. Public health networks and health institutes gain ground as key players in specific issues (such as the network of cancer). But the regional/national channel is a two-way street. Ideas for regional health policies are also disseminated and reconstructed from the national level to the regional level with creation, transmission, interpretation and receipt in a two-way process. The research on vector-transmitted diseases and the proposal of building regional mechanisms to monitor them is a prime example of a national initiative or concern that is rescaled regionally. In other words, there is more assemblage of norms that travel in several directions than one-way, top-down policy transfer. The idea of assemblage implies that the policy process shows neither centralisation nor hierarchy, policy lessons are shared amongst countries in a continued and mutually nurturing process.

Thirdly the study has allowed us to analyse the relationship between the national and the global level as a result of the countries' participation in the regional bloc. Our findings show that UNASUR helps to reduce asymmetries between countries and gives smaller countries a voice and an opportunity to participate in the global health agenda. All respondents agree that the greatest thrust of UNASUR is aimed at the global level of governance.

South America became a space for containment and opposing arguments, as well as a space for negotiation. In this sense, UNASUR Health, at least in the field of medicines and access to health services, looks towards the construction of a new sovereignty of health in the region, thus becoming an element of change in regional diplomacy. The constitution of UNASUR is given in a very particular context in the region, involving the emergence of a new space for deliberation and implementation of policies that were positioned as criticism of neoliberalism and its consequences in the countries of the region. UNASUR arises from the need to strengthen regional bonds and embraces global solidarity, instead of global governance and liberal, market-driven economic policies. Hence, it is essential to analyse the emergence of a body such as UNASUR and its focus on changing the neoliberal approach on health policy and adopting a regulatory framework for this issue.

We believe that there are two dimensions to take into account related to the current winds of change in the region. The first one involves the region outward. This refers to UNASUR as a political and intergovernmental bloc, since it is an actor which is directly subjected to political changes in the region and within the countries. Although the future scenario is uncertain and we do not know yet where it may go, we can suggest that a new era is coming, characterised by inaction and difficulties to operate and reach a consensus. Since the ruling criteria are unanimity, it works best for UNASUR if all countries are aligned. It remains to be seen whether these differences between member countries are greater than their similarities, while deeper changes are taking place in the most heavily weighted countries of the region.

The second line is related to the organism itself and the region inward. UNASUR Health Council was able to build institutions at national and local levels, even with more interference in local decision-making through working groups, thematic networks and ISAGS. This situation creates the possibility of continuing health actions on the ground, as a more decentralised structure of the policymaking process. However, the geopolitical changes that the region is facing require us to ask what will happen to the strides made in regional integration and health as contradictory economic and political schemes are introduced. In light of this divide that the society is facing today, it is of utmost importance to continue researching international health, the role of different actors involved and how they build a global agenda.

Notes

1. The authors reproduce in this paper the codification established by the institutional framework of this research project (PRARI/ESRC) in order to preserve the identity of the interviewees.
2. For legibility, from now on: UNASUR.
3. Many of these actions are available in Records of the sessions of the World Health Assembly (http://www.isags-unasur.org/index.php?lg=2).

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