BUILDING A REGIONAL HEALTH AGENDA: A RIGHTS-BASED APPROACH TO HEALTH IN SOUTH AMERICA? THE CASE OF UNASUR AND ACCESS TO HEALTH CARE AND MEDICINES[1]

María Belén Herrero and Jorgelina Loza

Working Paper 15-8

ABSTRACT

Attention to health policies in Southern regional organizations 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 to what extent 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 in practice mobilising national and regional actors in support of such policies. Our analysis of documentary and interview sources of evidence 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 to implement reforms, set targets and define goals nationally. Third, in the global arena, UNASUR enhances the visibility and 'voices' of the member states. The normative framework provides means for the diffusion of ideas that also allows some distancing from the legacy of the neoliberal framework that has otherwise characterised contemporary histories of regional integration in South America.

Keywords: Union of South American Nations; health; social equity; regional integration; Bolivia; Paraguay.

1. INTRODUCTION

The Union of South American Nations (UNASUR) is a new entity that aims to give the region the political ties to consolidate inter-state cooperation and strengthen the international identity of South America. It comes as part of the new cycle of politicization in regional politics (Dabene, 2012) or as Riggirozzi and Tussie (2012) posit, as part of a struggle for 'post-hegemonic' regionalism in the region (see also Yeates, 2014a). The Constitutive Treaty of UNASUR establishes a broad acceptance of progressive social policy founded on social equity and human rights as an important catalyst for new modes of international cooperation on a regional scale. What is more, of all the functional councils, the Health Council was one of the first (along with Defence Council) to be created and remains the most active.

The rise of left-leaning administrations, in a number of countries in South America, allowed an opportunity structure for pioneering health diplomacy and social inclusion through health. As argued by Yeates (2014a, b), Riggirozzi and Yeates (2015) and Riggirozzi (2014a) the attention to health policies shows a 'social turn' in the life of Southern regional organizations and their mission to meet political demands for social equity. Health is a prime example of an ongoing quiet revolution in the regional political economy of cooperation and diplomacy. As we will see later, Brazil played a key role, and some actors (such as the Minister of Health in Bolivia for example) with vast trajectory in social medicine and the *sanitarismo* made this diplomacy on health more possible.

What makes UNASUR particularly interesting is its vision of regionalism that builds from, and capitalizes on, pre-existing trade-led agreements, specifically MERCOSUR and the Andean Community, but strengthens new areas of regional cooperation, beyond trade-centred objectives. UNASUR thus provides an interesting case to analyze changes in the form and content of regional *social* governance (Herrero and Tussie, 2015; Yeates, 2014a).

Inadequate access to medical care and drugs are a persistent problem in vulnerable populations and it is recognized at the root of the social determinants of health/disease and of social

inequalities (Irwin and 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 policy-makers; supports health surveillance; and leads regional strategies for medicine production and commercialisation (see also Riggirozzi and Yeates, 2015; Yeates and Riggirozzi, 2015).

The aims of this paper are twofold. First, it aims to establish to what extent 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 in practice mobilising national and regional actors in support of such policies. Accordingly, the paper covers the political mechanisms that characterize UNASUR in the health sector. We analyze the mobilisation of diverse actors that initiate and sustain those processes and the role of UNASUR in relation to national actors, governments, business and NGOs. We also analyze the synergies between national and regional levels as they can offer opportunities and resources for actors involved in promoting rights-based health policies based on social justice.

The paper is based on mixed methodology fieldwork involving an analysis of primary and secondary data, and the collection of qualitative and quantitative data. Primary and secondary data collection and analysis available in relation to Bolivia, Paraguay and the UNASUR region was carried out. As for the primary data, we conducted interviews with policy actors in Bolivia and Paraguay and at the regional level during the course of 2014-15. The country studies (Paraguay and Bolivia) were carried out to capture how regional policy development connects with national domains and with what effects on policy, actor engagement and practice. The research was guided by the snowball method. We conducted 25 interviews in Paraguay, 12 in Bolivia and eight at the regional level. Our respondents were from different areas: health ministries, foreign ministries, planning secretaries, human resources areas, offices of international relations, epidemiological surveillance, national universities, NGOs, civil society to

investigate: their views on UNASUR commitments, policies and practices with poverty reduction; their own engagement with UNASUR in their respective areas; their opinions about advantages and shortcomings of UNASUR; their assessment of regional policy development and decision-making; and their perspectives on the opportunities for strengthening regional health policy and leveraging policy development processes - and the barriers to doing so.

Data from interviews was supplemented with secondary data analysis of official documents from national and regional agencies (provided by these actors). The interviews were analysed using qualitative analysis techniques by cross-national analysis within the region with the aim to locate and identify how regional policy making in the health poverty nexus intersects with and is refracted through distinctive features of the national political, social or economic situation, and with what consequences and effects for poverty reduction.

We examine the regional process as evolving through UNASUR in relation to access to health care and medicines for two principal reasons. Firstly, poor health and poverty are mutually-reinforcing and socially-structured by gender, age, class, ethnicity and location. Inadequate access to health care and medicines is at the root of the social determinants of health/disease and require a multidimensional approach. In this sense, access is an issue in peri-urban informal settlements and, significantly, in rural areas, many of which are often border areas where there is scope for innovation in cross-border regional policy coordination in support of universal access to healthcare. Secondly, health is emerging as a distinctive focus and attention hub of social policies in decision making for regional integration, at the same time that regional integration is acquiring a central role to attempts of enhancing quality of life in the region through the lens of health and the social policy (Riggirozzi and Yeates, 2015).

Regarding our study country cases, we focus on Bolivia and Paraguay, both democracies, for three reasons. First, they are similar in terms of overall disease burden and have a 'double burden of disease'; non communicable diseases that exert the most important influence on years of life lost in those countries, and the persistence of infectious and communicable diseases that affect, principally, the most vulnerable groups (specially women, children, the elderly population, indigenous people, and people living in border areas). Second, during the

last decade, both these countries are conducting major reforms with the improvement of living conditions through social policies, as well as in their health systems, aimed at improving access (Table 1). Third, both countries activated national reforms at the same time that they were promoting participation in regional blocs, in particular in UNASUR. Many health policies they launched correspond with what UNASUR began to uphold (for example, Bolivia providing universal care[2], and Paraguay harmonizing primary care). Thus, both countries launched reforms subsequent to the neoliberal policies of the 1990s that disproportionately affected impoverished population and excluded large swathes of the population from health services. Interviewees contend that regional cooperation was essential to underpin reforms especially since 2008 with the heightened political influence of UNASUR. For example, they mentioned the important support to President Evo Morales when he was weakened and almost ousted during a secession attempt (UNASUR, 2008a)[3].

The practice of member states at UNASUR Health[4] 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 flags 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, the Inter-American Development Bank, 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 from a rights-based approach that is more political and structural (AL04, AL06, AL07, AL08). This translates into unpacking the social determinants of health, the promotion of public health

---

[2] Beyond the consensus in the region on the need to reform the health system, there are two major trends regarding content. The universal health coverage reform proposes market competition as in the rest of the economy. In other words, health becomes the expression of neoliberalism as it introduces commodification offering insurance options with multiple fund managers / service buyers and providers of services and channeling large fiscal subsidies to sustain it. Most adherents emphasize almost exclusively universal health insurance. The most prominent examples are the reforms in Latin America, Chile, Colombia, and Peru. The other stream (universal health systems) suggests the establishment of a single system or public health service. It draws on the state where public health services ensure equal access, appropriate and free services required for the entire population with the same need (Whitehead and Dahlgren, 2006). This approach thus proposes de-commodification and supports the redistributive role of the state through social services. The most outstanding Latin American examples are Cuba and Brazil and this conception underlies reforms in Venezuela, Bolivia, and Ecuador among others (Lancet, 2012; Laurell, 2012).

[3] In 2008 there was an attempted coup in Bolivia to overthrow President Evo Morales. Unasur was key to curbing the secessionist attempts of the departments of Santa Cruz, Tarija, Beni, Pando and Chuquisaca, who tried to stage a coup against President Morales, supported by the US Embassy (USA) in Bolivia. The body, headed at the time by the president of Chile, Michelle Bachelet, offered unconditional support to the constitutional government of Evo Morales, based on the recent popular support for the indigenous leader, achieved in the popular referendum in July 2008. The leaders based their decision on the political principles of the Treaty, in denying recognition to any attempt at constitutional breakdown or fracture in the unity of the Bolivian State. (TelesurTV, 2015; Telam, 2015).

[4] For legibility, from now on: UNASUR

schools and the improvement of national health systems. Interviewees were very clear to point out, as this informant of the Health Ministry of Paraguay did, that *"its role is not to define policies but encourage countries to adopt policies" (PY02).*[5]

There are different levels at which UNASUR regional policies operate and which in turn have implications in the way these norms and policies move in the region and are tabled at the global level. A related issue underpinning this is if the contribution of the regional level of governance contributes to the reduction of national asymmetries and whether it opens new opportunities for global health diplomacy.

At the centre of our enquiry is the question if UNASUR has a committed focus on social determinants and the right to health in their health policy regarding access to health care and medicines, as indicated by policy agendas, policy development processes, and resourcing, and if this focus can contribute to the improvement of quality of life and the reduction of health inequities. The central hypothesis underpinning this question is that there are unexplored synergies between the role of UNASUR and the reduction of inequities (http://www.open.ac.uk/socialsciences/prari/index.php). The paper aims to contribute to an improved understanding of how regional policies influence the national agenda and whether, in turn, regional policies have the capability to institutionalise a rights-based approach to health in national policies. This study also helps understand how UNASUR as a political bloc is helping to build a revitalised health diplomacy founded on an understanding of health as a human right.

---

[5] Translations from Spanish to English are our own.

2. WHY HEALTH AND HEALTH RIGHTS IN THE NEW AGENDA OF REGIONAL INTEGRATION IN SOUTH AMERICA?

> "We must understand that the right to health is not just a philosophical principle" (Samper, ISAGS, 2014).[6]

Global health policies became part of the neoliberal transition that swept international organizations in the 1980s and 1990s and a central site for the implementation of neoliberal reforms and structural adjustment. Market orientation led to a selective focus understood as a series of simple and often low-quality benefits targeted to the poor: it had a serious impact on the health sector and particularly in primary care (Giovanella et al, 2015). At the same time, access to more complex health care increasingly became associated as the ability to pay. 'Vertical' programmes targeting populations or specific problems with the creation of targeted health insurance were strengthened, which deepened the segmentation of health systems; poverty rates and income inequality increased region-wide (Soares, 2001; Riggirozzi, 2014b, 2015). Table 1 summarises some principal health inequalities in the two country case studies.

---

[6] Translated from the original: "Debemos entender que la salud como derecho no se trata de un simple postulado filosófico."

Table 1. Summary of main health indicators in the region and Paraguay and Bolivia

Indicators	Bolivia	Paraguay	LATAM
Demogaphics			
Population [Thousands]	10.671	6.802	595.972
Proportion of urban population [%]	**67,6**	**63**	**79,6**
Proportion of population less than 15 years old [%]	34,9	32,4	
Proportion of population 60 years and older [%]	7,4	8,2	
Annual population growth rate [%]	1,6	1,7	
Total fertility rate [child/woman]	3,2	2,9	2,2
Crude birth rate [per 1,000 pop.]	25,7	23,7	17,8
Life expectancy at birth [Years]	**67,3**	**72,3**	**74,8**
Socioeconomics			
Calories availability [Kcal/day per capita]	2.172	2.518	2.937
Literacy rate [%]	91,2	93,9	91,3
Gross National Income (GNI), per capita, current US$ [$ per capita]	**2.040**	**2.970**	**8597**
Highest 20%/Lowest 20% income ratio [Ratio]	**27,8**	**17,3**	**16,7**
Poverty headcount ratio at $ 1.25 a day (PPP) [%]	**15,6**	**7,2**	
Poverty headcount ratio at national poverty line [%]	**51,3**	**32,4**	
Unemployed proportion of the labor force [%]	3,4	5,6	
Proportion of population using improved drinking water sources [%]	88	86	94
Proportion of population using improved sanitation facilities [%]	**27**	**71**	**79**

Indicators	Bolivia	Paraguay	LATAM
Mortality			
Infant mortality rate [per 1,000 lb] (Reported less than 1 year)	**50**	**16,9**	**15,5**
Neonatal mortality rate [por 1.000 lb] (Under 1 year)	**27**	**11**	
Postneonatal mortality rate[por 1.000 ba] (Under 1 year)	**23**	**4,5**	
Under-5 mortality, estimated [per 1,000 lb] EDA (%)	...	3,8	2,8
Under-5 mortality, estimated [per 1,000 lb] ARI (%)	...	5,4	6,9
Under-5 mortality, estimated [per 1,000 lb]	**51**	**22**	**17,3**
Maternal mortality ratio, reported [per 100,000 lb]	**190**	99	80
Estimated general mortality rate [per 1,000 pop.]	...	7,1	6,5
Estimated mortality rate from communicable diseases, adjusted by age [per 100,000 pop.]	...	69,9	59,5
Estimated mortality rate due to tuberculosis [per 100,000 pop.]	...	2,4	
Estimated mortality rate from ischemic heart disease [per 100,000 pop.]	...	75,9	66,1
Estimated mortality rate from cerebrovascular diseases [per 100,000 pop.]	...	**75,9**	47,9
Estimated mortality rate from neoplasms, adj by age [per 100,000 pop.]	...	112,4	103,7
Estimated mortality rate from external causes, adj by age [per 100,000 pop.]	...	75,7	77,4
Estimated mortality rate from transport accidents [per 100,000 pop.]	...	**29,5**	19,7
Estimated mortality rate from diabetes mellitus [per 100,000 pop.]	...	57,3	43,3

Indicators	Bolivia	Paraguay	LATAM
Morbidity and risk factors			
Low birthweight proportion [%]	...	...	**8,6**
Prevalence of nutritional deficiency in children less than 5 years [%]	**27,1**	**24,4**	
DMFT index at age 12 [Teeth] (12 years)	4,6	2,8	
Number of confirmed cases of poliomyelitis [Cases]	0	0	
Number of confirmed cases of measles [Cases]	0	0	
Number of registered cases of diphtheria in children under age 5 [Cases]	0	0	
Number of registered cases of pertussis in children under age 5 [Cases]	0	37	
Number of registered cases of tetanus neonatorum [Cases] (less than 1 year)	0	1	
Number of registered cases of cholera [Cases]	0	0	
Number of registered cases of human rabies [Cases]	1	0	
Number of registered cases of yellow fever [Cases]	2	0	
Malaria (%)	**15**	**3,5**	**14,2**
Tuberculosis incidence [per 100,000 pop.]	**84**	**35,3**	**34,4**
Incidence of sputum smear positive (SS+) tuberculosis [per 100,000 pop.]	**56,5**	**20,4**	**19,3**
AIDS incidence [Per 100,000 population]	2,3	5	10
Number of prevalent leprosy cases [Cases]	40	507	
Prevalence of overweight among adult population [%] (20-74 years)	**59,9**	**69,5**	

Indicators	Bolivia	Paraguay	LATAM
Resources, servicies and coverage			
Proportion of under-1 population immunized against poliomyelitis [%] (less than 1 year)	**82**	**75**	**93**
Proportion of population of 1 year of age immunized against measles [%] (1 year)	**84**	**77**	**94**
Proportion of under-1 population immunized against diphtheria, pertussis, and tetanus [%] (less than 1 year)	**82**	**76**	**93**
Proportion of under-1 population immunized against tuberculosis [%] (less than 1 year)	**90**	**76**	**96**
Prevalence of contraceptive use in women [%]	58,4	79,4	66
Proportion of pregnant women attended by trained personnel during pregnancy [%]	**58,5**	79	**87,3**
Proportion of deliveries attended by trained personnel [%]	72,4	94,9	93,7
Physicians ratio [10,000 hab.]	**4,9**	**13**	**17,3**
Professional nurses ratio [10,000 hab.]	**5,5**	**9**	**13,9**
Dentists ratio [10,000 hab.]	**0,8**	**7**	**3,9**
Hospital beds ratio [per 1,000 pop.]	1,1	1,3	2,1
Annual national health expenditure as a proportion of the GDP [%] (Public)	**2,1**	**4,3**	
Annual national health expenditure as a proportion of the GDP [%] (Priv)	**1,6**	**3,1**	

Source: *Iniciativa Regional de Datos Básicos en Salud. PanAmerican Health Organisation (PAHO). 2013.* http://www1.paho.org/Spanish/SHA/coredata/tabulator/newTabulator.htm

The alarming increase of the impoverished and marginalized sectors (Svampa, 2000), with almost half of the total population in poverty and a high percentage in extreme poverty called for projects capable of tackling poverty and creating mechanisms to reduce social debt and return to the old tradition of welfare states in which social policies and health were key axes.

Health has always been related to citizen rights and institutionalized as part of a democratic right, a tool for inclusion and a milestone in welfare (Tobar, 2012). In this sense health has been linked to the concept of citizenship and political construction of nationalism and nation states (e.g. Argentina), while health and democracy have been integral to the process of re-democratization (e.g. Brazil) (Mariani, 2007). Health has played a key role in the democratic ethos of the region. There is a strong background of *sanitarism* and social medicine which developed an approach linked to social epidemiology, collective health and social determinants of health (Whitehead et al, 2001; Solar and Irwin, 2010).

In this context, Coitiño (2014) mentions that a week after the signing of the UNASUR Treaty in Brasilia, the Southern Command of the United States announced the reestablishment 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. The concern led to the establishment of the South American Defense Council. But the creation of the Defense Council could be seen as an offensive move. Banking on the expertise in health and the considerable intellectual resources 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 prioritized, one of *hard* power motivated by the need to enhance coordination and military cooperation in the region; and one of *soft* power as a space for integration in health and challenges of global health (Coitiño, 2014).

These points are key to understanding why an essentially political body as UNASUR takes health as a centrepiece of its approach to building a new regionalism, becoming, in the context of social policies, a tool towards self- reliant development, 'a regional cause' against external influence and the approach of international organizations and donors. The rise of left leaning administrations in a number of countries in South America in the mid to late 2000s allowed a unique opportunity to pioneer health diplomacy and the inclusion of social policies through health. Unlike MERCOSUR and the Andean Community that addressed health in the context of trade liberalization, UNASUR addressed health from a social policy approach and in a different political and economic environment. As a respondent from the Health Ministry of Paraguay

referred *"Mercosur is a regional economic market and UNASUR is a political union" (PY15)*

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 from regional relationships and with global diplomacy (Buss, 2011). The General Secretary of UNASUR, Ernesto Samper, highlighted that health has a central role in the purpose of social inclusion as an articulator of the new social agenda:

> Health is a right. In recent years we have achieved fundamental advances in the region and the reduction of poverty rates and regional health objectives, the rate of infant mortality and access to basic health services. However, the deep inequality in income distribution prevents access to the health of some large sectors of the population. (Samper E. in ISAGS, 2014).

This point is important considering that a key and distinctive feature of most countries of the region is the explicit discourse around the right to health, and health as a right. Moreover, being explicitly mentioned in the UNASUR treaty (UNASUR, 2008b; UNASUR, 2008c), many countries have translated this commitment into practice by incorporating 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 et al, 2015).

In the Union of South American Nations' Constitutive Treaty the main objective is

> to build, in a participatory and consensual manner, an integration and union among its peoples in the cultural, social, economic and political fields, prioritizing political dialogue, social policies, education, energy, infrastructure, financing and the environment, among others, with a view to eliminating socioeconomic inequality, in order to achieve social inclusion and participation of civil society, to strengthen democracy and reduce

asymmetries within the framework of strengthening the sovereignty and independence of the States. (UNASUR, 2008b: 1)

Two of its specific objectives are 'inclusive and equitable social and human development in order to eradicate poverty' and 'overcome inequalities in the region; and universal access to social security and health services' (UNASUR, 2008b:1). The UNASUR Health Council became a site where regional cooperation with a distinctive 'social' agenda came to be instituted (see also Yeates and Riggirozzi, 2015; Riggirozzi, 2015; Amaya, Rollet and Kingah, 2015).

3. UNASUR HEALTH: FEATURES

In our study, most of the respondents agreed that UNASUR by the nature of its constitution itself took up health as a political issue from the start, and therefore health was also incorporated at the level of norm promotion. As one informant that have worked at Ministry of Health in Bolivia declared *"It is not the same to go alone to the General Assembly of the World Health Organization as to go together as member of a political bloc" (BO06)*. Most respondents believe that the added value of UNASUR is to reduce asymmetries between countries and to enable stronger bargaining power. What is more, some respondents highlighted that while traditional regional bodies follow a focused strategy to address disease by disease (i.e HIV, malaria and tuberculosis), UNASUR defines health as a right and therefore has a structural notion of poverty reduction. The social determinants of health frame of health politics (rather than disease by disease approach). With the universalization of health systems as an horizon, its policies are linked to access to health.

Thus, UNASUR also strives for a voice in global health, gaining political prominence through two parallel movements but highly relevant in terms of health diplomacy. On the one hand, to include the issue of health in other agendas such as the Rio + 20. On the other, for Health in All Policies and reforms in the Assembly of the World Health Organization UNASUR upholds universal coverage and access to medicines (Coitiño, 2014). Gaining voice in global diplomacy is a central driving force that also allows identity building. For example, UNASUR was able to

negotiate as a bloc in the 67th World Health Assembly over the report submitted by the Health Development Advisory Panel on Research. The report mentioned the scope of diseases that could be investigated and sought to focus efforts on Type III[7] diseases that primarily affect poor countries. But thanks to the performance of the bloc and especially of Argentina, Bolivia and Colombia in discussions, UNASUR ensured that the Plenary also considered the Type II and I diseases (ISAGS, 2014b).

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 South American Institute for Health Governance (ISAGS) that accounts for the various models of comprehensive health care adopted over time and was submitted to the World Health Assembly (WHA). The initiative aims to provide governments with information to identify strategic policies for local or regional action, facilitating decision-making.

> UNASUR as a coordinating body for regional public policies put on the negotiating table not only the interests and concerns of the region, but also the way in which countries see things, influencing how to design certain policies and actions in the field of global health. UNASUR has much to contribute. (ISAGS, 2015:1)

Such consolidation of a unified front and a shared mandate taken to the WHO is another remarkable milestone for the interviewees from Bolivia and Paraguay. As a respondent from the Ministry of Health, Bolivia, argues, for Bolivia this mandate allows an influence and effectiveness that cannot be achieved singlehandedly.

> [The greatest potential of UNASUR is] Its mandate for WHO. It is representative at WHO. There is force on social issues. As UNASUR we have greater chances of fighting for what you want. (BO04)

---

[7] Type I diseases affect both rich countries and poor countries, and especially pertains to the large vulnerable population in each country (eg hepatitis B, diabetes and cardiovascular disease). Type II diseases affecting both rich countries and poor countries, but in the latter is a considerable proportion of cases. Examples of such diseases are HIV / AIDS and tuberculosis. Type III diseases are those that are overwhelmingly or exclusively developing countries, such as "sleeping sickness" (WHO, 2012).

Such effectiveness of representation is considered one of UNASUR's main advantages. Although our interviewees highlight the opportunity of taking a common position to a global sphere like the WHO, some of them pay attention to the risks of creating new regional blocs that may overlap with the efforts of previous regional experiences and can lead to competition. As a member of the International Relations Area of Ministry of Health from Bolivia mentioned

> But the downside is that sometimes it can seem very tedious. I mean there are so many organizations, UNASUR, ALBA, CAN; many representations, you offer an opinion, and it lie there. Very tedious in that sense (BO02)

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). Values, 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 institutionalise problem solving capacities (i.e. dengue network, network of public health schools; cancer network). Finally, UNASUR has had great influence from other very important players in the field of health in the region as ALAMES and of organizations like *Médicos del Mundo*. The importance of this is that it brings together the key figures in the region many of whom are part of the *Salud Colectiva* movement. In addition many of them have participated (and currently continue to do so) in decision-making spaces. From these vantage points they have influenced the bases and principles of UNASUR and in positioning health as a central track for cooperation

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 to move toward the universalization of health care in Bolivia, Colombia and Peru (Giovanella et al, 2015). It is also involved in the diffusion of

information on combating HIV/AIDS, influenza H1N1[8] and dengue fever and non-communicable diseases[9] across the region, and has developed mapping techniques to coordinate shared policies for the production of some key medicines (Buss and Tobar, 2009; Gollan, 2015). Here, the role of ISAGS is crucial. Respondents repeatedly highlighted the role of ISAGS, for example these two respondents from the Minister of Health from Paraguay.

> And for me it ISAGS creation was an important strategic factor. The political decision to create the South American Institute of Government in Health, as an instance of governance and development expertise to support countries to strengthen their systems, I think there is still much ... (PY01)

> He is working with funding ISAGS obviously, to do a mapping of regional production of supplies and prices, to map, as to what that refers to generic drugs. These initiatives more than who have a very strong commercial component, they are policy initiatives that ultimately have at least pursued greater access or that people have more and better access to lower their costs, reduce that effect. (PY02)

ISAGS brings together an innovative network of health ministers of member countries, academics, health specialists, and technicians with the aim of supporting and strengthening national and sub-regional capacity in the formulation, implementation, and evaluation of policies and long-term plans. ISAGS leads a network of similar country-based institutions dedicated to the production of knowledge and preparation of key professionals for the management of national health systems[10]. The establishment of ISAGS is a pioneering step

---

[8] Some examples of this are: Declaration from the Health Council of UNASUR "UNASUR Salud frente a la amenaza mundial de la influenza", Ginebra, 20 May 2009 (UNASUR, 2009a); Joint Statement from the Health Council of UNASUR where the supremacy of health issues was highlighted over commercial interests, Communication, Asunción del Paraguay, 23 July 2009. They stressed the importance of having special funds and human resources (UNASUR (2009b).

[9] UNASUR (2009c) An agreement was reached on an initiative from Argentina to address dengue. At the same meeting Brazil, Ecuador and Suriname asked to include the topic of epidemiological surveillance of non-communicable diseases.

[10] The South American Institute of Government in Health (ISAGS) is an intergovernmental public institution associated to the Health Council. Its aim is to contribute to the development of governance and leadership in health. It was created by the Heads of State on a proposal from the Health Council at a meeting in Cuenca, Ecuador, in April 2010. The Institute´s own actions are planned on the grounds of its Triennial Work Plan 2012-2015. This Triennial Plan, which was ratified by the Council, is focused on three areas: social determination of health, political economy of health and universal systems. Since 2013, ISAGS submits its Annual Operating Plan (AOP) to the Council for approval. The Plan encompasses the activities that will be implemented throughout the year. The organization must perform five main functions (www.isags-unasur.org). Regarding the organizational structure ISAGS is composed by the Directive Council, the Consultative Council and the Executive Direction. The Directive Council is one of ISAGS' permanent bodies and guides the Institute´s activities in accordance with the priorities of the South American Health Council. It is formed by the Ministers of Health of member countries. The Consultative Council is formed by the coordinators of the Technical

mostly dedicated to tackle 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 with a five year plan since its start (2010- 2015). The plan operationalizes agreed goals, which reflect the priorities defined by the Ministries of Health and by the technical groups and networks that comprise the Council.

Each technical group has an allocated budget which is invested in specific projects, for example, in the price data bank for medicines. The data bank is a strategy centred on coordinating an active resistance to the price setting power of pharmaceutical companies and along with the strategy of mapping the regional productive capabilities. It receives financial support to the value of US$ 300,000. In this sense, UNASUR is seen, as some of our interviewees emphasised, as a means of strengthening the bargaining position of states with companies. Although bargaining is not taken up jointly, information is shared and price discrimination and 'skimming' can be prevented. Information sharing decreases asymmetries vis-a-vis firms and between countries.

Policy uptake

The most important difficulties stressed by our interviewees in relation to policy uptake reside at the national level. These gaps in national uptake are related to the conception of UNASUR itself. It has worked on the basis of consensus and strived for a process of minimalist and gradual policy convergence/coordination in terms of holding a common perspective on

---

Groups and Structuring Networks, as well as by specialists in critical health-related fields of knowledge. The organ is responsible for the formulation of recommendations regarding the planning, management, execution and the evaluation of the programs developed by ISAGS (ISAGS, 2015 http://www.isags-unasur.org/)

particular issues, such as medicines pricing, exploring convergent capacities and capabilities for production of medicines and services.

When working together in UNASUR, for example, patents and access to medicine have demanded a more nuanced assessment of how regional arrangements can maximize and enhance the reach and outcomes of public policy, emphasizing that economic interest in the global health industry and intellectual property treaties should not become an obstacle to protect public health.

Projects on access to health and the upholding of health as a basic right are based in the acceptance of the variety of situations in member a country. Our interviewees highlight this combination of the benefits of a general principle that acknowledges different contexts and national health systems (PY19). From these differences emerge the main items for cooperation: a five-year plan that can enable a regional information system. For example, a respondent from the Ministry of Health in Paraguay, also a member part in a civil association

> A five-year plan aimed just to have a list of diseases of compulsory notification
> within UNASUR linked to similar processes of detection, related to competition of
> public health laboratories, and similar standards, case definition, so that data are
> comparable. That tied to the construction of the information system, you can
> compare data even to some level of the nomenclature of statistical unit that in
> each country is different. (PY19)

The five-year plan together with the information system, are vectors to disseminate a regional perspective that each country will apply at the national level. There is no monitoring and evaluation of policy uptake so interviewees could not judge how it evolved. They insisted that the five-year plans appear as the way to build concrete working guidelines that will improve the possibility of policy uptake in national contexts with similarities in their health systems.

Despite the lack of monitoring, an example of policy uptake stands out in Paraguay. Following the regional push and the umbrella of legitimacy, the country is bent on an information system known as Vigias. The experience of the Red Andina de Vigilancia Epidemiológica (RAVE) and the

stepping stones provided by Mercosur provided building blocks and significant inputs. The project of an information system was validated at ISAGS and counted with a significant financial support from Brazil (PY19).

But the process by which such policies or programmes are defined is not that clear despite our repeated questions: our interviewees mentioned the stages of a definition in UNASUR but vaguely. The policy transfer process as well as the policy making process is apparently based on the strength of UNSAUR ideas on accessibility, universality and especially on the idea of identity and the construction of a broadly based shared path. As we see in our field work, the main although not only contribution of UNASUR at country level has been the construction of the sense of belonging to a region that holds similar characteristics but mainly, faces the same difficulties in providing access to health and medicines.

Although our interviewees did not see the national health institutes as active some authors (Rosenberg et al, 2015) argue that they can play a strategic role in generating knowledge and evidence to facilitate decision-making through monitoring and research on the social determinants of health and health inequities. What is more, they consider that institutes should play a significant strategic role in identifying and analyzing correlations between patterns of production and consumption, social divisions that exist in the territory, conditions of development, and the health of their populations (Rosenberg et al, 2015). Considering social inequalities, institutes can address these inequities by complementing their traditional activities with this new strategic role. That view was not engrained among our interviewees, who insisted that UNASUR's value added is centered at the global level, an ambition that is out of reach for small landlocked countries, Paraguay and Bolivia, our country cases. Interviewees also mentioned that the process itself allowed health not to go to the backburner as had happened in trade negotiations or adjustment loans when health ministers had been denied access to meetings and received the results only after international agreements had been locked.

4. RECLAIMING THE REGION: BETWEEN NATIONAL POLICIES AND HEALTH DIPLOMACY

Our documentary analysis shows, and many of the interviews agree, that despite a low degree of institutionalisation in UNASUR there is a formal process for policy and decision making. 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.

In this context the overall process enables installing a theme and creating the space to debate alternatives. The norm creation process does not press 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.

> There are five technical groups. One works on universal access to drugs, which is a critical issue. A second one is monitoring and responding to public health issues. A third works on the development of human resources; four is the theme of promotion and social determinants, five, universal health system (PY01)

These groups are technical instances that enable implementation of a specific programme of action, or even for the design of a political initiative. As a respondent from ISAGS mentioned:

> The groups seek to coordinate countries so that in global conferences there is only one voice. The two technical groups that have been particularly high profile were the group on medicines and social determinants. Universal systems are now gaining ground. Here lies the core of the identity of the bloc. (AL02)

As we described in the preceding section, and as a respondent from Ecuador that participated in the elaboration of the Quinquenal Plan said, decisions taken at the regional level are not translated into laws or commitments at the national level (AL03). 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. This is reflected in what the respondent from Paraguay says:

> UNASUR depends largely on tighter coordination of the agendas of the groups and that these agendas in turn, are harmonized with regional and global agendas. The work is known internally, and recognized externally. Today the big step is the articulation of agendas and generating cooperation for tighter implementation. That it would definitely affect the reduction of poverty. (PY02)

However, this does not reflect a lack of influence of UNASUR at the national level. One of our interviewees argues "*UNASUR is an enabling factor that creates incentives for the formulation of strategies and policies*" (AL03). 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.

> UNASUR has a political profile. All the documentation, consensus, the agreements are not internalized into legislation as in Mercosur, but agreements enable socialization and each agency implements according to its possibilities. (PY02)

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 *it 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. As one of our respondent from Bolivia mentioned:

> Each country is sovereign and decides independently how it will implement. There is no binding commitment. There is a guideline […] that is adopted as a national policy. Therefore the mere fact that the presidents approve a policy turns it into a structural framework for action. (AL04)

Another interviewee sustained *"UNASUR does not want to be a technical space, there already are others. It wants to be a political space, for discussion and analysis"* (AL03). With this lens we need to analyse the national adoption of regional decisions in the following paragraphs.

Regional policies do not evolve in a top down direction but there is an assembly 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 ISAGS we need to keep in mind how the global health agenda moves from one institution to another (AL06). For example, some WTO rules are binding and others are declarations to which countries can hook their policies, such as the one on TRIPs and health; in the WHO declarations and even resolutions are not binding (except for the regulatory framework of snuff for example). In health even when a country accedes, it is not obliged to meet these regulations, because they are not binding (AL06). This coincides with what a member of the civil society from Bolivia mentioned:

> They are declarative, then, as I say, we participate, they take resolutions that make a statement; and due to good moral commitment we have or we should, do it, because we belong to the bloc. (BO09)

To further state this point, UNASUR has no national or regional binding instruments, but rather statements and initiatives in the field of health (Yeates and Riggirozzi, 2015). These can then become guides to action in the field of diplomacy. As another informant from the civil society said, at regional level, they guide the work of diplomats and international relations health offices (AL07).

As mentioned by other respondents there are different types of norms. First there are statements, for example, policy statements made by ministers that can then become a concrete initiative. Such is the case of the political declaration of health ministers on the need to provide supplies and medicines due to the influenza pandemic, and taking as a fundamental principle the right to health. In this statement they ratified the concept of public health over economic and commercial interests (UNASUR, 2009d). 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

(UNASUR, 2010b). There is also a statement with regard to the specific economic situation in relation to dengue. After the outbreak Argentina tabled a motion for agreement between ministers to reinforce the commitment to combat dengue (UNASUR, 2009c).

In this sense these initiatives are regional declarations that arise with agreement from 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 this case, the 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 to install the theme 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 (disabilities or drugs initiatives as analyze below)[11]. These initiatives again switch 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 started among all the countries is the strengthening of health systems. A plan was set up with the schools of public health on development of human resources was elaborated, periodical meetings of the schools were held and training of trainers were promoted (AL07). 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.

According to one respondent from a NGO, these regional agendas are consulted, even if not always subsequently implemented at the national level (AL07).

> It is a patchy process, because some actions are implemented and others not (...). That is why a major disadvantage is the lack of a secretariat with more powers of enforcement power, more direct, more dynamic (AL07).

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 identified as such, countries begin to perceive that the UNASUR may be a good place to raise proposals and priorities from their national counterparts to gain support in those priorities. This not only strengthens the regional policies and national policies, but also helps to build confidence and thereby advance cooperation and integration (AL07). As a member of ISAGS said, *"A prime example is the universal systems initiative and access to drugs. That's because these areas are very receptive, everything goes through here" (AL02).* We will see this process of regional policy specifically in the area of drugs and access to health services.

To close this section, let us state that the main contribution of UNASUR is the construction of an identity on social issues and the mutual reinforcement of cooperation over neglected issues or issues that had suffered the brunt of neoliberal reforms. Without downplaying concrete efforts as ISAGS, the data bank on prices of medicine and the initiatives over information systems, our interviewees highlight (both from Bolivia and Paraguay) the importance of the consolidation of a new regional diplomacy, based on an important information exchange and the knowledge transfer process related to learning and sharing practices.

> The theme of these international fora*, the issue* of being able to collect that experience and the issue *of* technical assistance; because really that's the reason *, for* which we attend*, to* see and maybe to be oriented not only convey your experience. Meetings help you technically on these issues*.* In the end we are not strangers. For example, we share many similarities with Ecuador people*,* culture*,* and now even in our Constitution. We both include well being *in* the Constitution and the new policies. *Sharing* helps a lot, but it helps even more when we can apply internally*, and give them* continuity. *(BO06)*

Now, the political nature is UNASUR's strongest feature, we exchange experience and knowledge *which then favors* integration and the creation of a regional public good *for the* countries *(PY01)*

On those kinds of advantages, we found a strong consensus aligned with the critical view of the relation between the regional and national levels. The respondent from Paraguay made an interesting observation:

The possibility of exchange of successful experiences and for the countries that are the bottom rung of the ladder in asymmetry is to accelerate processes without making the same mistakes, when processes are transposable. It is also positive as induction mechanisms for countries like Paraguay, which responds to a conservative dynamic, to review their processes. And to follow regional guidelines. Because in the end, to enter in bloc positions you have to go into debate. That promotes UNASUR.

Interviewer: Do you think UNASUR induces commitments from countries?

Of course. Because it forces you to go to regional meetings with national positions, decisions are then generally consensus. And if there is a country that makes no concessions and rejects all positions on the table, it is stigmatized. So there is peer pressure for decision-making. (PY19)

In other words, the preparation for meetings is in itself a valuable catalyzer and an induction mechanism. In addition, the pressure of UNASUR over countries appears to some interviewees as an inevitable consequence of the current political context where countries are open to mutual influences and reciprocal diffusion of policy lessons.

5. UNIVERSAL ACCESS: FACING A DEBT, A NEW SOVEREIGNTY.

UNASUR's flag in global health is the promotion of policies related with the right to health and universal access (Herrero and Tussie, 2015). Addressing public policies that facilitate access to medicines and 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 has the distinction of 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 also possible to identify in the field of medicines the three levels in which this issue operates and in 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 internalization of some of them, which contribute to building health diplomacy. Even though, in this topic as in all others, it is important to note, as we mentioned before, that the documents of UNASUR are normative frameworks but not binding texts.

At the regional level one of the principles of UNASUR is to attempt the reduction of asymmetries between countries by enhancing productive capacity of the region in the field of access (UNASUR, 2008a). Countries consider 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. Hence key to this goal is the pursuit of the 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). Thirty percent of total health spending in countries from South America is on medicines (EBC, 2015).

> Certain themes come from several years ago, addressing very constant and serious,
> in UNASUR, such as the issue of access to medicines. Now these policies will make a
> bank of prices, for example, because laboratories would charge a price to Bolivia,

and they charge a separate price to Brazil, much lower in Brazil than in Bolivia, which is outrageous. I think all this is, it is being seen in the health agenda. Actually yes there is a level of awareness that ministers go, it is cooperation that is taking place. I have no doubt that everything would be much worse if there were no UNASUR. (AL01)

Minute 1/2009 of the Health Council established 4 objectives for the technical group on universal access to medicines (UNASUR 2009e). These are: to map capabilities to produce medicines and other health supplies; to exchange experiences in order to address in an integrated way the barriers that limit access to essential medicines; to develop a proposal for universal access to medicines, considering the productive capacities of the region; to exchange information on the quality of medicines, as well as according to public health needs (UNASUR, 2009e). Part of the work on internalization and consolidation of this has received the support of the Development Bank of Latin America (CAF) (UNASUR, 2009f).

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 data bank on drug prices and the map of capabilities for public production of essential drugs are part of the "Fondo de Iniciativas Comunes" of UNASUR and will have a U$S300.000 fund. 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. The bank's aim is to establish reference prices so that countries can tell the differences in prices across countries and use these as evidence to bargain with suppliers. The final goal will be to reduce health costs and to 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 what 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 short these policies seek

to ensure universal access to medicines. To the challenge of developing productive capacity, UNASUR has added the political challenge of designing regional strategies towards better access to medicines through joint negotiations with pharmaceutical companies. The purpose is to ensure fair prices for drugs, diagnostic kits, vaccines and medical equipment and the improvement of human and industrial capacity. What is more the Defence Council of UNASUR, adopted the concept of Health Sovereignty to promote public production of drugs in the countries of UNASUR. The Defense Council has emphasized the importance of the South American Drug Production Program in the field of Defense (Rovere, 2015).

Production capacity has advanced constantly in Brazil with a strong investment in research, development and public production. Argentina, in turn coordinates 39 public production drug centres. Uruguay has also recently installed a public production laboratory. What is more, in Ecuador between 2013 and 2014 the Institute of Intellectual Property (IEPI) granted compulsory licenses to nine drugs. This decision could achieve savings of between 23% and 99% in their acquisition, which allows access to medicines for citizens (Ministerio Salud Pública Ecuador, 2014). Bolivia has made important decisions about establishing policies to ensure access to medicines (Rovere, 2015). In January 2006, at the beginning of the presidency of Evo Morales, Bolivia moved to promote health sovereignty. In 2014 Evo Morales announced that Bolivia and Cuba would produce medicines, in order to import fewer medicines and reduce expenditure (RT, 2014; Rovere, 2015). In Paraguay, these initiatives were very important in order to improve national health policies on drugs, related with norms of quality and acceptable standards. As a respondent from the Direction of National Strategic Human Resources in Health of the Ministry of Health said

> This is a huge change in the regulations on drugs. Everything that was done in the region forced Paraguay to meet the quality standards. So many companies entered this good practice. Before our drug companies did not conform to this, yet when we started working through UNASUR they had to adjust to these quality standards. And that is a big change. (PY09)

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. 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 (Riggirozzi, 2014a; Herrero and Tussie, 2015). For example, during the pandemic of Influenza H1N1, members of UNASUR declared through the Resolution 02/2009, the importance of promoting the use of joint strategies with PAHO for the purchase of medicines and supplies of public health interest to ensure quality and equity conditions with the principles of lower prices for all countries (UNASUR, 2009g).

During the 63rd World Health Assembly in 2010 and in the context of stronger South-South cooperation in health, a proposal from the 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 World Health Assembly in May 2012. Proposed by UNASUR and led by Ecuador and Argentina, 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 (Riggirozzi, 2014a; Coitiño, 2014).

Four years later, at the 67th World Health Assembly in May 2014 UNASUR member states took a common position 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, 2014c).

Finally it has started a joint negotiation as an alternative through the PAHO Strategic Fund. A UNASUR meeting had previously considered the expansion of the Strategic Fund. This consists of the establishment of an ad hoc committee for the joint negotiation of drug prices, especially those of high cost. The acquisition will be made through the PAHO procurement mechanisms by which the organization is available to its Member States, in conjunction with the national systems of each country. During the meeting, the ministers decided that the mechanism will become operational in the first round tentatively scheduled to manage the purchase of three drugs to treat Hepatitis C and one for HIV (Ministerio de Salud Argentina, 2015, NODALTEC, 2015).

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 regionalization 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 new public production of drugs and policies for generics. Finally, the third stage of 'norm internalization', takes place if funds are allocated for production or national legislation is adopted. We see diffusion without the backing of binding agreements.

6. REDUCING ASYMMETRIES: THE CASE OF ACCESS TO HEALTH CARE.

In South America universal social protection in health is an ambition in the horizon. The main features that stand out in health systems in Latin America are coverage segmentation, fragmentation and privatization in the financing and provision of health services. There remains considerable segmentation of social protection in health in the presence of various subsystems that affect different sectors of the population by labour activity, social position and ability to pay. These subsystems are: social insurance covering the population in the formal labour market (20% to 40% of the population); a public health system with partial coverage of the population

of lower income from direct public provision; iii) selective coverage by public insurance package targeted at specific groups implemented from 1990; and iv) private health insurance; besides spending pocket copayments (Giovanella et al, 2015).

In this context the exclusion of large sectors from health care persists. In some countries there is still a significant proportion of the population excluded from healthcare services that early in 2000 involved 60% of the population (PAHO, 2012). Approximately 45% of Bolivia's population had no access to health services, and 72% had no social security or medical insurance, in Paraguay, 38,6% of the population had no access to health services and 81,1% had no social security coverage or private health insurance (PAHO, 2012). Addressing public policies that facilitate access to health care services is another key to ensuring the right to health. In this path, access services and an integral health are other two main elements of the effective implementation of health as a right.

In this way, South America began to promote the idea that health should be conceived as a right and individuals should have access not only to medicines but to quality care. This idea implies the need to redefine the regional health component in terms of accessibility, universal coverage and equity. So here we see some reforms being undertaken in the region with the aim of reversing the health outcomes resulting from neoliberal policies. Regional policies can stimulate the development of strategies at the local and national levels, recognizing primary health care as the cornerstone for the realization of universal health systems. In this context, as some respondents mentioned, particularly from country case studies, primary care can be a factor influencing the transformation of health systems nationally. As member form the Ministry of Health of Paraguay highlighted:

> Another thing that helped us a lot, for example, now our health policy to achieve equitable care across the country is based precisely on an initiative that is regional. The country had to adapt and to switch to primary care. Then we had a big effort to raise awareness and get going. It started with 500 units. Now 6% of the health budget is focused on primary care. And that is an achievement of the

region, starting in the region and eventually implemented in the country. (PY09)

What about the role of UNASUR in this path? Respondents from the regional level consider that UNASUR can play a crucial role insofar as regional integration helps reduce asymmetries between countries, move towards building a comprehensive system of health care and adopt 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, on October 2009 the technical group on universal systems (UNASUR 2009h) was established and made a number of recommendations: to promote the recognition of health as a human right, resulting from the influence of social determinants, environmental, cultural, biological-genetic and health systems and to promote the constitution of integrated health services networks based on primary care to facilitate the creation of universal health systems.

In this regard there is now a proposal to study and evaluate the creation of mechanisms for financing cooperation between UNASUR countries in order to strengthen integrated delivery networks based on primary care; recommend countries to increase funding for renewed primary care and to increase citizen participation in health services in order to promote empowerment of civil society (UNASUR, 2009h). In addition the initiative proposes to advance the search for a common methodology for basic diagnosis and monitoring of national health systems, to identify gaps to achieve universal coverage. The Technical Group also promotes complementarity between national services to exchange information and enhance mutual learning.

Subsequently a Meeting of Ministers held in November 2009 agreed on the construction of the network bringing together health system institutions under Resolution 07/2010 (UNASUR, 2010). Another objective following the trajectory of health in the region, is to obtain a more comprehensive and integral model of human resources training to incorporate the concept of social determinants of health and disease and to facilitate intersectoral action. For this the Ministers promote the attainment of universal public systems and, the framework of social

determinants of health, both in the context of health as a right (Giovenella et al, 2015). Here, the role of ISAGS is crucial given that it leads a network of country-based institutions dedicated to the production of knowledge and preparation of key professionals for the management of national health systems. The presence of ISAGS as an agent of norm and policy diffusion is central to this diplomacy.

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. A former official of the ministry of health of Paraguay, highlighted that:

> I think it's an interesting achievement to have placed the social determinants of health and the building of universal health systems in the Five Year Plan. I think that gives a horizon, a framework for a government that wants to orient its policy in that regard and align regional policies. This is possible. (PY08)

The presence of ISAGS as a focal point for expanding policy capacities solidifies South American thinking but more to the point of embeddedness, ISAGS may create organic thinking that enhances the political position of the actors in health and can institute alternative practices to those promoted by the market.

So, as we can see, it is possible to identify also three levels in which this issue - access to health services -operate (national, regional and global levels). We can identify specifically how some problems have arisen from the national level, to be perceived as a need for both countries and the region as a whole. In the process of designing and implementing actions to strengthen access to health systems and looking towards holistic health at the Fourth Meeting of the South American Health Council, Colombia tabled a statement on the issue of equity in health and chronic non communicable diseases. Another is the case of Ecuador when it wanted to promote issues of maternal and neonatal mortality, and at that same meeting, asked to consider a resolution to be tabled at the 64th World Health Assembly. Paraguay proposed sharing material

on healthy eating for consideration in the regional agenda (UNASUR, 2011). It is interesting that these latter two initiatives were adopted ad referendum, pending national consultation with authorities. These initiatives show the circuit from national to regional level to be elevated to the global sphere and to return with the format of resolutions and declarations at the national level. At this level finally, they can be translated into national policies.

> The issues gain visibility, recognition and so on all enabling consideration at the national level. We know that we do not have a supranational structure but it plays a very important leverage role. (PY02)

> The primary health paradigm is an achievement of the region, starting in the region which eventually must be implemented in the country (PY09)

In this sense the two case studies (Bolivia and Paraguay) have carried out reforms in their health systems aimed at improving levels of public access, incorporating moreover the vision of comprehensive health, social determinants of health and citizen participation. Both are driving health policies focused on the most vulnerable populations (women, children, elderly, disabled and indigenous communities) and initiated processes to reform health systems. From 2008 on both Paraguay and Bolivia implemented major changes in access and health care. Health ceased to be a neglected issue to become a priority. However, serious gaps remain especially in terms of access to high cost drugs and access barriers to health care services.

In the case of Paraguay, the implementation of primary care had traditionally prioritized vertical programmes. In 2009, the government presented "Paraguay for All: A Proposed Public Policy for Social Development, 2010–2020" (Government of Paraguay, 2010a), an initiative that articulates 11 emblematic programmes that have four key foci: quality of life, social inclusion, economic growth without exclusion, and results–based management. As a result, there is an ongoing process to ensure the right to health. Health is conceived as a right supported by the principles of universality, equity, integrity, multiculturalism and social participation. This determines a new conception of primary health care that was materialized in the initiative of the Ministry of Public Health and Social Welfare with the creation of a Directorate for primary care. Its tasks include

supporting the implementation of a network of health services and the family health units of the national health system. Since 2008 copayments were cancelled and "Public Policies for Quality of Life and Health with Equity", was implemented (Giovanella et al, 2015). In December 2009 the Ministry of Public Health and Social Welfare adopted Resolution 1.074 establishing that all services provided by state health care centres be free of charge (Government of Paraguay Paraguay, 2010b). That same year, the country exceeded its goal of creating 500 family health units, which provide services to 30% of the population, giving priority to the communities that are most vulnerable and have been historically overlooked. Today access to public sector health care services is free and universal. However, as we will see, one of the biggest challenges facing the health system is to extend health service coverage.

Bolivia is also carrying out important reforms to promote free and universal access to public health services; primary health care; health promotion; intersectoral action on social determinants; and the adoption of an intercultural approach. What is more, Bolivia incorporated in its Constitution access to health as a universal social right and established the state as guarantor. Taking up the model of Alma-Ata, primary health care is conceived as *Salud Familiar y Comunitaria Intercultural* and free public services is the most important goal (Giovanella et al, 2015). It is looking forward to progress under the constitutional commitment to set up a unified health system that promotes healthy life- styles and offers universal preventive and curative care for the population (Giovanella et al, 2015). A respondent from the Unit in charge of issues of UNASUR Ministry of Foreign Relations of Bolivia said;

> Bolivia's position is very, very clear in this regard. Policy will follow very closely the constitutional, universal right to health. Northern Bolivia already holds universal health as have Brazil and Cuba. (BO03)

The growing prevalence of chronic, non communicable diseases demands a care model that focuses on health promotion and on prevention, with the aim of eliminating risk factors and improving the country's social determinants. Regarding health coverage, the number of primary health care centres has increased since 2008, although other health facilities have not improved

significantly. Currently the Ministry of Health implements programmes that directly provide prioritized services: *Programa Mi Salud* (health teams that offer free care in prioritized areas); *Residencia Médica de Salud Familiar Comunitaria Intercultural* (graduate medical training programme to act in the most vulnerable areas and identify social determinants of health); *Bono Juana Azurduy* (cash transfers to the population); *Programa Multisectorial Desnutrición Cero*; *Programa Moto Méndez* (identification of equipment and care for people with disabilities) (Government of Bolivia, 2010a; Giovanella et al, 2015). Finally we observed that within the priorities for epidemiological surveillance, the authorities are gathering the main indicators for the national information system for the review of key data on determinants. However, the health system continues to be characterized by fragmentation, segmentation, lack of articulation, inequity, and lack of social solidarity. It is the intent of the proposed unified system to guarantee the right to health and universal and free access to its services by all residents (Government of Bolivia, 2010b). Moreover, it is crucial to note that Bolivia is one of the few countries to have incorporated traditional medicine and multiculturalism as key components of the new model of care and management.

One point mentioned in the interviews that we need to highlight is the importance UNASUR gives to the concept of social determinants of health. The concern for health inequalities has been the engine driving action on the social determinants considering that social factors are the root of most health disparities. Moreover, most respondents stress that UNASUR has given greater importance and priority to social policies and reduction of asymmetries with a strong emphasis on social justice. From both countries and different sectors said that;

> Another thing that helped us a lot, for example, to promote equitable care across the country is based precisely on an initiative that is regional. (PY09)

> We are starting to work in surveillance, monitoring of health inequities. We are incorporating social determinants, environmental, and suddenly we are also looking at social and economic factors, etc., which may have an impact on some diseases. (PY10)

Primary health care has promoted that families attend the health center. That is changing. (BO08)

Latin American countries are also abandoning the idea that health is about disease and we are moving to address social determinants, social participation, is still a level of guidance. (BO02)

We were able to observe that policies concerning health insurance and coverage continue to follow exclusively national trends. While UNASUR upholds health as a right and universalisation of health systems, on the ground implementation is patchy. It depends on each country. Some countries still follow the paradigm of universal coverage, while others are trying to implement the universal system. A respondent from the regional level explain this clearly:

What happens is that international agencies and cooperation such as the Global Fund, direct their programmes to X or Z pathologies or problems and then end up driving the policy of each country. That is why difference remains at country level. We try to understand what are the factors that lead to an epidemic or a condition or event that then needs forced intervention. (AL04)

What the process shows is that the agenda of international health in the region is becoming more multi-centric, and having a space from which to reflect and build new knowledge for action and even to generate policies, many of which are very different to 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). That is seen as more traditional thinking focusing on 'the poor' rather than on a more comprehensive, inclusive and equitable construction.

The binomial health-poverty often ends up in compensatory policies and the field of health becomes an instrument to fight poverty, with insurance for the poor, baskets of medicines for the poor and everything for the poor, with poor resources at times (AL08).

Despite the fact that it is explicit in one of the main objectives of the Constitutive Treaty, the participation of the civil society is still a challenge. As we gathered from the interviews, social movements and civil society organizations are poorly involved and hardly consulted. The interviews conducted with civil society organizations 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[12], for which a first step would be the mapping of organizations willing to work at the regional and national levels. Bolivia is very advanced on this process at the country level with its policy the "Diplomacy of Peoples". Our field work shows evidence of this increasing traction but also that it is still far from civil society demands. As one respondent from civil society points out:

The truth is that UNASUR may be doing many things, but people do not find out. Then it seems it's a very secretive core of government officials where participation of civil society is very limited or reduced. But in this case, I mean the participation of civil society, decision-makers, as not only to make decisions but also to take into account the concerns of civil society and build bridges, that there is more transparency in the processes, more openness, more public accountability, more social responsibility.

Interviewer: And you believe it is possible to include civil society in this process of regional integration?

---

[12] The Minutes of the First Forum of Citizen Participation in the Regional Integration – UNASUR (2014) (Cochabamba, Bolivia, 13 and 15 August 2014) said regarding Integration: "Support and encourage the formation and constitution of the South American UNASUR Citizenship. We express the importance of strengthening the South American citizenship, as an axis of integration and construction from the social fabric, through the progressive recognition of the rights of nationals of a Member State resident in any of the other states of UNASUR. Promote activities that promote real impact of citizen participation in decisions concerning public policies of common interest in the region. Developing and strengthening solidarity and cooperation among the people promoting the holding of meetings and regular exchanges between organizations and social movements of UNASUR. Promote mechanisms for the effective representation of citizens to the advice of UNASUR existing or to be created." (Available at: http://movimientos.org/es/content/acta-del-primer-foro-de-participaci%C3%B3n-ciudadana-en-la-integraci%C3%B3n-regional-%E2%80%93-unasur. Accessed 16 November 2015)

It's possible, but we must also recognize and criticize those who exercise the decision, having to recognize that there are no serious efforts. There is some coordination among members of civil society, say in Bolivia there are many associations of patients, AIDS patients, patients with tuberculosis, malaria, diabetes" (BO05)

While civil society is so far kept at bay, it is important to mention that the leadership and standing of state actors (with a greater role in external relations) has increased in relation to the previous phases and models of regionalism which were more business oriented. Many authors point out that UNASUR still remains as a presidential initiative, with a strong influence of the executive powers in the discussions and decisions. Our field work confirms this interpretation. A Member Ministry of Foreign Affairs said:

Governments are at the helm. Some governments do consult with organizations, perhaps other governments do not; but we have guidelines approved by our authorities (BO08)

All this points to 'hyper-presidentialism' and inter-ministerial logic as the characterising features of the decision making process.[13] 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, mobilize local experts and actors in pursuit of health governance (Riggirozzi, 2014a; Riggirozzi, 2015; Yeates and 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, mobilize local experts and actors in pursuit of rights-based health

---

[13] This point was made at a PRARI-organised Policy Roundtable *Políticas Regionales en Salud: La incursión de UNASUR en la Diplomacia en Salud (Regional Health Policy: the incursion of UNASUR in Health Diplomacy)*, 8th July 2015, UNU-CRIS/ISAGS/UASB, hosted by the Simon Bolivar Andean University, Quito, Ecuador. See http://www.open.ac.uk/socialsciences/prari/events/]

governance (Riggirozzi, 2015; Riggirozzi and Yeates, 2015; Yeates and Riggirozzi, 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 ideas 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. The effort is to provide a framework to be heard, to give voice not only to the region but to neglected voices of countries that did not have before (see Yeates, 2014 on the amplification role of regional organisations). This feature is highly valued in both of our countries. As a respondent from the Health Minister of Paraguay declared:

> It is not the same to go on your own to the General Assembly of the World Health

7. CONCLUSIONS

Our study has allowed the identification, comparison and evaluation of the development of regional health policy and its potential impact on regional and national contexts. Firstly, it has allowed us to study the regional policy process, in terms of the emergence, diffusion and localization of norms and to what extent the policy process is related to the principle of health as a right. UNASUR has built a new institutionalism exemplified with the Five Year Plan, but mainly with 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 from which policies diffuse nationally. This speaks to 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. Once these initiatives emerge, some of them are taken to the global sphere with the aim of promoting specific issues in the international health agenda. Behind the high level political statements, regional working groups acquire a life of their own and take charge of introducing themes on the agenda. Issues that attract a consensus at this lower level can move 'up' the agenda to be addressed by ministers and heads of state who will raise specific issues in their political statements.

Secondly, the study of two countries along with the UNASUR framework allows us to capture

the different ways in which the development of regional policy is refracted through specific national contexts, the percolation into agendas and processes as well as the commitment of different actors. While UNASUR does not generate binding regulations, it leads to actions or resolutions that can legitimize and encourage national policies that standing on their own may be weak. The regional process in itself has legitimized 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. At this point it should be noted that the main actors are health ministers and agencies. Such direct diplomacy in the hands of health actors, in contrast to other regional organizations, raises the issue of health itself to the fore without the intermediation of foreign or trade ministries. Such autonomy from actors with more neoliberal inclinations or more prone to lobbying from market actors has enabled a change in the domestic balance of forces that had resulted from the hold of trade and foreign ministries over the 1990s ushered in by trade agreements and multilateral lending. 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, all stepping stones to make good the notion of 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 to the regional 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. In fact, UNASUR eschews one-way top- down policy transfer. What we mean with the concept of assemblage is that the policy process shows neither centralization nor hierarchy, policy lessons are shared amongst countries in a continued and mutually nurturing process.

Thirdly the study has allowed us to analyze the relationship between the national and the global level as a result of the countries´ participation in the regional bloc. The synergies between levels

means the regional level boosts the national level of governance, it charts courses of action, it potentially enables change in the balance of forces within countries while at the same time the sharing and pooling of capacities opens roads to influence global health diplomacy. As for the national to the global level findings in both countries our investigations 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.

As we have seen throughout the paper, the UNASUR framework has a committed social equity/rights focus (and quite specifically regarding access to health care and medicines), as indicated by policy agendas, policy development processes, and resourcing. This commitment is seen not only in the initiatives carried to the global level but also in the actions carried out and in 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.

In terms of poverty reduction, the influence of UNASUR is indirect. As respondents insisted UNASUR contributes to foster a health agenda in countries with a focus on rights and inclusion. It contributes to create a consensus, frame discourses and to show ways in which governments can protect and promote rights. Direct implementation depends on each country.

As I said, is the construction of these policies, say, sector or sectors, of different sectors of UNASUR, raising or at least that's the impression I have is like in order to reduce the asymmetries between countries regarding some issues that make the issue of poverty, right ?, the percentage or participation of, say, assignments, GDP for certain sectors that deal with social protection, health, education theme, the issue of in-house services; but it's like that is the role of the UNASUR install the theme, discuss the issue and ensure that the asymmetries are disappearing as up not down, right? As you have an ideal line as to address these issues in the countries, right? Not exactly, not as to generate a standard that eventually one has to meet and a mechanism of, say, pressure, if you want to call it, or the issue of visibility, visibility as a mechanism to enable countries to adopt and make the

necessary arrangements at the national level (PY02)

I think that poverty reduction will depend very much on the country. If you can do is input from successful experiences, or share suddenly or develop policies already know they can be beneficial and try to implement them in the countries. (PY10)

Nonetheless we find evidence of direct influence. For example, as stated above respondents in Paraguay, UNASUR has influenced policies to strengthen primary care and health surveillance. Bolivia for its part emphasizes the importance of the bloc in access to medicines, and how joint negotiations and the data bank will help to improve access. UNASUR legitimized health programmes at country level.

All told, UNASUR is described by our interviewees as an alliance based on a sharpened ideological approach with a very optimistic view of South American regionalism. The possibility of creating regional policies is rooted in political agreement. For policies to be implemented, it is clear that the governments that promoted them need to be consolidated and this is far from given. The lax normative framework provides a fora for diffusion of ideas that allows distancing from the legacy of the neoliberal framework, but not enough to avoid its reproduction.

UNASUR can be understood as a mutual diffusion process between countries and a lesson drawing network, as the regional meetings allow the country members to exchange information, best practices and garner support regarding technical issues. It is also a harmonization network, as it serves for the development of shared regulatory standards or agreements on positions taken to the international level. But transgovernmental networks also have a third feature: they act as an implementation/legitimation network, which helps States to comply with standards for which they have insufficient capacities. We can describe UNASUR Health on the basis of these three features, mutual diffusion, harmonization and legitimation, and very particularly in the small landlocked country studies. Both our cases show the value of UNASUR in facilitating knowledge sharing and policy lessons as well as strengthening connections between neighbouring countries with relatively greater capacity and with which

they share borders. We end by highlighting the perspective of one interviewee working at the regional level, who reflects the kind of regional initiative UNASUR aims and is thought to be:

> The issues of concern are regional problems, not a summation of national issues (...) piled up. The thrust is to break away from that mentality. I think the idea is that, that is not the task of single country. […] I believe that the added value is to be able to see this regional problem and not to think singlehandedly. Thinking as a bloc enables shaping specific policies, for example, a drugs policy for which joint actions make a world of difference. (AL03)

References

Amaya, A.B., Rollet, V. and Kingah, S. (2015) 'What's in a word? The framing of health at the regional level: ASEAN, EU, SADC and UNASUR', *Global Social Policy*, 15(3): 229-260.

Buss, P. and Tobar, S. (2009) 'Diplomacia en Salud en América del Sur: El Caso de UNASUR SALUD', *Revista Argentina de Economía y Ciencias Sociales*, 18(18): 5-11.

Buss, P. (2011) 'Brazil structuring cooperation for health' *The Lancet* 377(9779): 1722–1723.

Coitiño A. (2014) 'Análisis del fenómeno de los procesos regionales de integración en salud como actores emergentes de la diplomacia de la salud global: el caso UNASUR' *Programas de Líderes de Salud Internacional* OPS/OMS (PLSI), PanAmerican Health Organisation: Washington DC, pp. 1-32 (unpublished mimeo).

Dabene, O. (2012) 'Consistency and resilience through cycles of repoliticization', pp. 41-64, in P. Riggirozzi and D. Tussie (eds.) *The Rise of Post-Hegemonic Regionalism.* London: Springer.

EBC Agência Brasil (2015) UNASUR creará banco de precios para ampliar acceso a medicamentos. Available at: http://agenciabrasil.ebc.com.br/es/internacional/noticia/2015-05/unasur-creara-banco-de-precios-para-ampliar-acceso-medicamentos (accessed 29 July, 2015).

Giovanella, L. (ed.) (2015) *Atención primaria de salud en Suramérica.* Rio de Janeiro: ISAGS-UNASUR. Available at: http://www.isags-unasur.org/uploads/biblioteca/2/bb%5B319%5Dling%5B2%5Danx%5B1112%5D.pdf [accessed 30 November 2015]

Gollan, D. (2015) *El medicamento y la especulación financiera*. 25 August 2015. Available at: http://www.pagina12.com.ar/diario/sociedad/3-280093-2015-08-25.html [accessed 30 November 2015]

Government of Bolivia (2010a) *Informe nacional sobre los progresos realizados en la aplicación de UNGASS,* Ministerio de Salud y Deportes. Available at: http://www.ops.org.bo/textocompleto/its32361.pdf [accessed 30 November 2015]

Government of Bolivia (2010b) *Asamblea Legislativa Plurinacional. Proyecto de Ley del Sistema Único de Salud del 21 de septiembre de 2010,* Ministerio de Salud y Deportes. Available at: http://www.ops.org.bo/textocompleto/nsistema32260.pdf [accessed 30 November 2015]

Government of Paraguay (2010a) *Paraguay para todos y todas: propuesta de política pública para el desarrollo social 2010–2020, M*inistry of Health and Social Welfare, President of the Republic of Paraguay. Available at: http://www.preventionweb.net/files/21498_15565propuestadepoliticapublicapara.pdf [accessed 30 November 2015]

Government Paraguay (2010b) *Informe de gestión anual enero–diciembre 2010*, Ministry of Health and Social Welfare, President of the Republic of Paraguay. Available at: http://www.paho.org/par/index.php?option=com_docman&task=doc_view&gid=331&Itemid=253 [accessed 30 November 2015]

Herrero, M.B. and Tussie, D. (2015) 'UNASUR Health: A quiet revolution in health diplomacy in South America', *Global Social Policy,* 15(3):261-277.

Irwin, A. and Scali, E. (2010) 'Action on the Social Determinants of Health: learning from previous experiences', *Social Determinants of Health Discussion Paper 1.* Geneva: World Health Organization, Available at: http://apps.who.int/iris/bitstream/10665/44488/1/9789241500876_eng.pdf [accessed 30 November 2015]

ISAGS (South American Institute of Health Governance) (2014a) 'Ernesto Samper: UNASUR le apuesta a la salud como eje de la inclusión social en la región', Newsletter 9 October, 2014. . South American Institute of Government in Health. Rio de Janeiro, Brazil. Available at: http://www.isags-unasur.org/it_entrevista.php?lg=2&ev=413 [accessed 30 November 2015]

ISAGS (South American Institute of Health Governance) (2014b) "Posiciones comunes de UNASUR hacen avanzar la agenda de Salud Global." Newsletter June 2014. ISAGS: Rio de Janeiro, Brazil. Available at: http://www.isags-unasur.org/uploads/eventos/ev%5B282%5Dling%5B2%5Danx%5B257%5D.pdf [accessed 30 November 2015]

ISAGS (South American Institute of Health Governance) (2014c) "UNASUR Common Positions Make Global Health Agenda Move Forward". Report June 2014. ISAGS: Rio de Janeiro, Brazil. Available at : http://www.isags-unasur.org/uploads/eventos/ev[282]ling[3]anx[256].pdf [accessed 29 July 2015]

ISAGS (South American Institute of Health Governance) (2015) Newsletter May 2015. ISAGS: Rio de Janeiro, Brazil. Available at: http://issuu.com/isagsunasur4/docs/informe_maio_2015_esp_web_novo_2 [accessed 30 November 2015]

Lancet Editorial Comment (2012) 'Universal health coverage: the third global health transition?', *The Lancet*, 380 September 8.

Laurell, A.C. (2012) 'Sistemas Universales de Salud: Retos y Desafíos', *ALAMES,* Available at: http://www.alames.org/documentos/sistemasasa.pdf [accessed 30 November 2015]

Mariani, R. (ed.) (2007) *Democracia/Estado/Ciudadanía: Hacia un Estado de y para la Democracia en América Latina*. Lima: Sede Programa de la Naciones Unidas para el Desarrollo - PNUD. http://www.iidh.ed.cr/multic/UserFiles/Biblioteca/IIDHSeguridad/12_2010/be846c2a-a0e6-44d0-9fae-5d9d637df9ff.pdf [accessed 30 November 2015]

Ministerio de Salud Argentina (Ministry of Health, Government of Argentina) (2015) *Ministros de Salud del Mercosur y de la UNASUR aprobaron creación de comité para negociación de precios de medicamentos*. http://www.msal.gob.ar/prensa/index.php?option=com_content&view=article&id=2841:ministros-de-salud-del-mercosur-y-de-la-unasur-aprobaron-creacion-de-comite-para-negociacion-de-precios-de-medicamentos&catid=6:destacados-slide2841 [accessed 30 November 2015]

Ministerio de Salud Pública, Ecuador (2014) *Ecuador concedió nueve licencias obligatorias para medicamentos.* Available at: http://www.salud.gob.ec/ecuador-concedio-nueve-licencias-obligatorias-para-medicamentos-estrategicos/ [accessed 29 July 2015].

NODALTEC (Noticias de América Latina y el Caribe) (2015) *UNASUR propone crear fondo regional para comprar medicamentos contra la hepatitis C.* Available at: http://www.nodaltec.am/2015/04/unasur-propone-crear-fondo-regional-para-comprar-medicamentos-contra-la-hepatitis-c/ [accessed 31 July 2015]

WHO (World Health Organisation) (2012) *"Investigación y desarrollo para atender las necesidades sanitarias de los países en desarrollo: fortalecimiento de la financiación y coordinación mundiales: informe del Grupo consultivo de expertos en investigación y desarrollo: financiación y coordinación."* Geneva: World Health Organisation http://www.who.int/phi/CEWG_Report_ES.pdf [accessed 30 November 2015]

PAHO. Panamerican Health Organization. (2012) "Health in the Americas: 2012". *Regional Outlook and Country Profiles*. Washington, DC: PAHO.

PAHO (PanAmerican Health Organisation) (2013) *Iniciativa Regional de Datos Básicos en Salud*. Washington DC: PAHO. http://www1.paho.org/Spanish/SHA/coredata/tabulator/newTabulator.htm [accessed 30 November 2015]

Riggirozzi, P. and Yeates, N. (2015) 'Locating regional health Policy: institutions, politics and practices', *Global Social Policy*, 15(3): 212-228.

Riggirozzi, P. (2015) *Comparing SADC and UNASUR Regional Health Governance and Policy,* PRARI Working Paper 15-2, Milton Keynes: The Open University [Available at: http://www.open.ac.uk/socialsciences/prari/communications-outputs/].

Riggirozzi, P. (2014a) 'Regionalism through social policy: Collective action and health diplomacy in South America', *Economy and Society*, 43(3): 432–454.

Riggirozzi, P. (2014b) 'Regionalism, Activism, and Rights: New opportunities for health

diplomacy in South America,' *Review of International Studies* 41(2): 407-428.

Riggirozzi, P. and Tussie, D, (eds.) (2012) *The Rise of Post-Hegemonic Regionalism: The Case of Latin America.* Dordrecht: Springer.

Rosenberg, F., Tobar, S., Buss, P. (2015) 'El papel de los institutos nacionales de salud de UNASUR en la generación de evidencia sobre la determinación social de la salud,' *Revista Panamericana de Salud Pública*; 38(2):152–6.

Rovere, M. (2015) 'La producción pública de medicamentos en la Unasur; una mirada desde la salud internacional' *Voces en el Fénix* Available at: http://www.vocesenelfenix.com/content/la-producci%C3%B3n-p%C3%BAblica-de-medicamentos-en-la-unasur-una-mirada-desde-la-salud-internacional [Accessed 20 July 2015]

RT (2014) Bolivia y Cuba fabricarán medicamentos para no depender de «monopolios privados». Available at: http://actualidad.rt.com/actualidad/view/127659-bolivia-cuba-fabricar-medicamentos-monopolios [Accessed 31 July 2015].

Soares, L.T.R. (2001) *Ajuste neoliberal e desajuste social na América Latina.* Petrópolis: Editora Vozes.

Solar, O. and Irwin, A.(2010) 'A conceptual framework for action on the social determinants of health', *Social determinants of health Discussion paper 2: policy and practice.* Geneva: World Health Organization. http://www.who.int/sdhconference/resources/ConceptualframeworkforactiononSDH_eng.pdf [Accessed 30 November 2015]

Svampa, M. (2000) *Desde abajo. Las trasformaciones de las Identidades Sociales*. Buenos Aires: Biblos.

Telam, R. (2015) 'Evo destacó el apoyo de la UNASUR cuando enfrentó un intento de golpe de Estado y agradeció el respaldo de Cristina y Néstor', Available at: http://www.telam.com.ar/notas/201507/112884-evo-morales-bolivia-visita-argentina-cristina-fernandez-de-kirchner-nestor-kirchner-unasur-intento-golpe-de-estado.html [Accessed: 13

November 2015[

TelesurTV (2015) 'UNASUR en la resolución de conflictos,' Available at: http://www.telesurtv.net/news/Unasur-en-la-resolucion-de-conflictos-20150306-0003.html [Accessed: 13 November 2015]

Tobar, F. (2012) 'Breve historia de la prestación del servicio de salud en la Argentina' *Medicina Sanitaria.* Available at: http://www.ms.gba.gov.ar/sitios/regionsanitaria6/files/2012/05/MedicinaSanitaria12.pdf [accessed 30 November 2015]

UNASUR (2008a) *Acta 16 December*, Consejo de Salud Suramericano y Comité Coordinador, UNASUR.

UNASUR (2008b) *South American Union of Nations Constitutive Treaty* http://studentorgs.law.smu.edu/getattachment/International-Law-ReviewAssociation/Resources/LBRA-Archive/15-2/SMB213.pdf.aspx [Accessed 30 November 2015]

UNASUR (2008c) *Decisión para el establecimiento del Consejo de Salud Suramericano de la UNASUR*, UNASUR.

UNASUR (2009a) *Acta May 20*, Consejo de Salud Suramericano y Comité Coordinador, UNASUR.

UNASUR (2009b) *Acta de july 23*, Consejo de Salud Suramericano y Comité Coordinador, UNASUR.

UNASUR (2009c) *Acta N 01/09* – April 20, Consejo de Salud Suramericano y Comité Coordinador, UNASUR.

UNASUR (2009d) *Acta 8 de agosto*, Consejo de Salud Suramericano y Comité Coordinador, UNASUR.

UNASUR (2009e) *Reunión del comité Coordinador del Consejo de Salud Suramericano*. Anexo III: Lineamientos Plan de Trabajo 2009-2010. Comité Coordinador, Acta N 1/09 - 20/04/2009

UNASUR (2009f) *Resolución 01/2009*, Consejo de Salud Suramericano y Comité Coordinador, UNASUR, Ecuador, 24 November 2009.

UNASUR (2009g) *Acta 8 de agosto*. Declaración de la Reunión Extraordinaria del Consejo de Salud Suramericano. Consejo de Salud Suramericano y Comité Coordinador, UNASUR, Quito, Ecuador.

UNASUR (2009h) *Acta 23 de octubre*. Acta de Reunión de Constitución del Grupo Técnico: Sistemas de Salud Universales. Consejo de Salud Suramericano y Comité Coordinador, UNASUR.Santiago de Chile, Chile, 2009.

UNASUR (2010) *Resolución 07/2010*, 30 de abril de 2010. Consejo de Salud Suramericano y Comité Coordinador, UNASUR. Guayaquil, Ecuador.

UNASUR (2010b) *9 de febrero de 2010*. Solidaridad de UNASUR con Haití. Decisión de Quito. Consejo de Salud Suramericano y Comité Coordinador, UNASUR. Quito, Ecuador.

UNASUR (2011) *ACTA 1/11* Consejo de Salud Suramericano y Comité Coordinador, UNASUR, Quito, Ecuador.

UNASUR (2014) *Minutes* of the First Forum of Citizen Participation in the Regional Integration – UNASUR. Cochabamba, Bolivia, 13 and 15 August 2014.

Whitehead, M. and Dahlgren, G. (2006) *Levelling up (part 1): a discussion paper on concepts and principles for tackling social inequities in health*. Copenhagen; WHO European Office. Available at: http://www.who.int/social_determinants/resources/leveling_up_part1.pdf [Accessed 30 November 2015]

Yamin, A.E. and Frisancho, A. (2014) 'Human Rights-based Approaches to Health in Latin America', *The Lancet* 385(9975):26-29.

Nicola Yeates (2014a) 'Global contexts and challenges of building a regional governance of social policy: implications for South America', pp. 141-159, in E. Vivares (ed.) *Exploring the New South American Regionalism (NSAR)*. Farnham: Ashgate.

Yeates, N. (2014b) *Global Poverty Reduction: What can regional organisations do?*, PRARI Policy Brief No 3, The Open University, Milton Keynes. Available at http://www.open.ac.uk/socialsciences/prari/

Yeates, N. and Riggirozzi, P. (2015) 'Global social regionalism: Regional Organisations as drivers of social policy change', paper to International Sociological Association RC19 Annual Conference, University of Bath 26-28th August 2015.