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HEALTH AND REGIONAL INTEGRATION:

HEALTH GOVERNANCE CHALLENGES IN MERCOSUR[1]

Andrea C. Bianculli and Andrea Ribeiro Hoffmann[2]

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[2] Andrea C. Bianculli is Research Fellow at the Institut Barcelona d'Estudis Internacionals (IBEI), Andrea Ribeiro Hoffmann is Professor of International Relations at the Pontifical Catholic University of Rio de Janeiro and Visiting Professor at the Freie Universität Berlin. Corresponding author: Andrea Ribeiro Hoffmann, email: a_ribeiro_hoffmann@puc-rio.br)

Abstract

This paper analyses the process of institutionalization of regional cooperation in health in the Common Market of the South (Mercosur). In so doing, it looks into the policy and regulatory frameworks promoted, and comparatively assesses Mercosur member-states' national systems of health. Our argument is that the bloc lacks a clear definition of the model to be pursued to promote regulation and the provision of health services, being this further hindered by the strong differences across domestic health systems. In all, the possibility of achieving consensus on common norms and standards at the regional tier of governance is not very promising. Moreover, the health agenda in Mercosur seems to be losing its raison d'être given the activism of the more recently created UNASUR in this area.

Keywords: Regionalism; Social Policy, Health Policy, Mercosur, UNASUR, Governance, Regional and Domestic Regulations

1. Introduction

This paper explores to what extent Mercosur has provided regulation and policies in the area of health. Whereas regional cooperation in health has some tradition in Latin America,[3] it is a relatively new development in Mercosur. Created in 1991 by Argentina, Brazil, Paraguay and Uruguay, Mercosur was aimed at promoting economic cooperation, primarily via trade liberalization. This initial focus on the regulation of free trade changed over time as Mercosur enhanced its political and social dimension, especially since the mid-2000 with the so-called 'left turn' in its member-states and the election of Presidents Lula da Silva in Brazil, Nestor Kirchner in Argentina and Tabaré Vázquez in Uruguay. Mercosur was thus transformed from a (liberal) trade bloc into a multisectorial organization within a new paradigm of development in which social policies such as health policies became a key dimension. The social agenda was further consolidated with the creation of the Mercosur Social Institute (ISM) in 2007 (Briceño-Ruiz 2010).

In order to explore the governance of health in Mercosur, its possibilities and challenges ahead, this paper firstly traces the process of institutionalization of regional cooperation in this area, including the policy and regulatory frameworks and activities being promoted (section 2). It then briefly summarizes the domestic health system of its member-states (section 3) and then proceeds to assess Mercosur's achievements and main health governance challenges (section 4), wherein the relative strengths of Mercosur are situated in relation to UNASUR. The final part (section 5) concludes with some thoughts on the future paths of regional health cooperation in the South America.

2. The institutionalization of regional health cooperation in Mercosur

The Treaty of Asuncion (signed in March 1991, in force in November 1991) does not refer to health. Still, the provisional structure laid down included a commission on health products in the Working Group on Technical Norms (SGT 3) (GMC Resolution 51/1992) to discuss the

[3] The Pan-American Health Organization (PAHO) was stablished in 1902 and is the world's oldest international public health agency. As a specialized agency of the Inter-American system, it provides "technical cooperation and mobilizes partnerships to improve health and quality of life in the countries of the Americas". It also serves as the Regional Office for the Americas of the World Health Organization (WHO); see http://www.paho.org/hq/index.php?option=com_content&view=article&id=91&Itemid=220&lang=en, date accessed 14 August 2015.

Other initiatives involving some of the current Mercosur member-states include the Andean Health Organization/ Hipólito Unanue Agreement within the Andean Pact – now Andean Community. The Caribbean Community was also one of the regional blocs that first implemented initiatives in the health field (Carrillo Roa and Santana 2012; SELA 2010).

harmonization of sanitary norms to abolish technical obstacles and allow the free movement of food and health products (Acosta et al 2007; Sánchez 2007). More specifically, the SGT 3 dealt with pharmaceuticals and blood products, blood, cosmetics and disinfectants (Guimaraes Queiroz and Giovanella 2011:184).

Three years later, The Protocol of Ouro Preto (signed in December 1994, in force in December 1995) established Mercosur's permanent institutions and decision-making procedures, based on an intergovernmental structure. The main organs created were the Common Market Council (CMC), the Common Market Group (CMG), the Trade Commission (TC), the Joint Parliamentary Commission (JPC), the Economic and Social Advisory Forum (ESAF) and the Administrative Secretariat (AS). To develop the bloc's multiple tasks, a large number of Technical Committees, Working Groups and Ad Hoc Groups were also devised to deal with specific policy areas, as in the case of industry, competition, environment, agriculture and customs. In addition, specialized sectoral meetings at the ministerial level propose policy initiatives in specific areas.[4]

Health policy was one of the topics for which a Meeting of Health Ministers of Mercosur (RMS) was established already in 1995 (CMC Decision 03/1995). Made up of the national health ministers, this meeting also involves the participation of the associated member-states as observers and of the PAHO as technical-advisory body.[5] The RMS is the hierarchically superior instance at the political level and responsible for the definition of the bloc's policy and strategies in the area of health. It is thus related to the CMC. The RMS offers an institutional space for the discussion of macro policies, regulations and strategies in the area of health for Mercosur and defines negotiating guidelines based on projects and common work-plans through the different joint (intergovernmental) commissions in several areas. Most of the regulations issued deal with public health surveillance, control and standardisation of sanitary products.

In a similar vein, though from a technical approach to health policy, in 1996, the CMG approved the creation of the Working Group on Health (SGT 11) (CMG Resolution 151/1996),[6]

[4] For details about Mercosur institutional structure, see Olmos (2012).

[5] Associated member states have free trade agreements with Mercosur and participate as observers in all organs; despite the lack of a formal right to vote, they do have a considerable influence in the process of consensus making. Mercosur associated member-states include Bolivia (1996), Chile (1996), Peru (2005), Colombia (2004) and Ecuador (2004). Venezuela became full member in 2013, whereas Bolivia concluded a treaty of accession to become a member-state in 2012, which was renewed with a new protocol accession in July 2015 to be now ratified by the national congresses of Brazil and Paraguay.

[6] The direct antecedent was the Sub Commission 11 until 1995, which then turned into the Subgroup 10, opening thus a space for the creation of SGT 11.

which brings together leaders, specialists and technical experts from the national ministries and other related public bodies. Its main objective is the harmonization of legislation and guidelines in policy areas already defined, to promote technical cooperation and joint actions among member states in health care services, goods, commodities and products, epidemiologic and sanitary surveillance and controls (Acosta et al 2007). Thus, the SGT 11 aims to support and protect health, while allowing for the dismantling of existing obstacles to regional trade and comprehensive and quality health care (Guimaraes Queiroz and Giovanella 2011).

The SGT 11 covers three main areas: health products, health surveillance and health care services. Each of these policy areas are dealt with in specialized commissions, structured into sub-commissions and ad hoc groups, to pursue specific policy objectives. Furthermore, these three main health commissions are guided by particular negotiating mandates, underscoring the need to articulate national systems through cooperation, common initiatives and professional development. Building upon common interests and the policy areas prioritized by member countries, these mandates frame the working of the SGT 11 and establish its relations with other decision-making bodies of Mercosur, together with proceedings to organize, systematize and circulate information.

As Mercosur moved beyond trade liberalization, the negotiating mandates of the SGT 11 changed accordingly, thus broadening and deepening its regulatory scope. Whereas its first mandate, dating back to 1998, was intended to harmonize quality parameters in terms of goods, services and productive factors in the area of health, later mandates, as in 2007, promote the harmonization of legislation and guidelines to achieve technical cooperation and coordinate joint activities between member states (Guimaraes Queiroz and Giovanella 2011:185).

Resolutions stemming from the SGT 11 have to go through a long process before they become in force. Once consensus is reached, resolutions have to be transposed to the national level, and only then, they can be implemented in the regional arena.[7] The decision-making process remains strictly intergovernmental. Furthermore, there are still strong differences across national health ministries in terms of their competences, organization, management and funding; all of which, in turn, affects the regional process of harmonization of health

[7] For a detailed analysis of the institutional process within the SGT 11, see Ministério da Saúde (2002).

policies. Difficulties in this area are illustrated by the various degrees of advancement across the different commissions. Out of the 107 resolutions issued by the SGT 11 in 2006, 85 (79%) corresponded to the Commission of Health Products, 16 (15%) to the Commission of Health Surveillance and six (6%) to the Commission of Health Services (Guimaraes Queiroz and Giovanella 2011:186).

When looking at the particular issues in which each Commission has been more active, we find that the Commission on Health Products and Medicaments has moved forward in the area of cosmetics and in the elaboration of regional norms in the area of good practices for the production of medicines and the training of inspectors for their verification. The large number of regulations established by the Commission of Health Surveillance includes issues related to the free movement of products to allow the common market, being this related to previous processes of international harmonization, which in turn could have facilitated consensus at the regional tier of governance (Guimaraes Queiroz and Giovanella 2011). Finally, advancements within the Commission of Health Services have been hindered by the vagueness and imprecision of its own competences (Sánchez 2007:157-159). In all, regional agreements in these last two areas seem to be harder to achieve because of important asymmetries and differences across health systems, policies and regulations of member countries.

From a political standpoint, the RMS proposes measures to coordinate health politics at Mercosur level (CMC Decision N° 3/95). As a regional body of political cooperation, the RMS establishes programs, strategies and guidelines based on the common views of member-states and it promotes agreements among health ministers. However, these agreements do not need to be transposed into domestic legal orders: they constitute joint actions to enhance promotion, prevention, protection and health care.

To deal with this dense agenda, the RMS consists of various intergovernmental commissions, made up of leaders and technical experts from the member-states, bringing to the commission national policy issues to be dealt with at the regional level. Again, the policy issues brought to the RMS have increasingly expanded starting in the 2000s, moving from strategies on communicable diseases and product surveillance to issues more closely related to health promotion and protection. Even if discussions and negotiations do not always end in agreement, the agenda of the RMS has broadened the health policy debate at the regional tier of governance. Some of the health issues the RMS has dealt with includes dengue,

medicine policies, public health and intellectual property, tobacco policy, HIV-AIDs and primary care, among others.

The RMS and the SGT 11 were for a long time the only bodies responsible for health cooperation in Mercosur and have worked rather closely since. However, starting in the 2000s, as social issues – namely social development and inclusion, poverty reduction and the reduction of regional inequalities – were prioritized, emphasis was increasingly placed on the social dimension of regional integration.[8] Building on this prioritization of the so-called social agenda, other bodies were created with an impact on health cooperation, the most important being the ISM.

Following an initiative of the Meeting of Ministers and Authorities of Social Development of Mercosur (CMC/Decision Nº 03/07), the ISM was established in 2007 as a technical and political body in the area of social policy. Its focus is on the elaboration of regional policies and strategic guidelines to reduce social asymmetries among member countries and promote integral human development. Based in Asunción, Paraguay, the ISM is expected to promote the consolidation of the social dimension of Mercosur.

3. The domestic system in Mercosur member-states

The capacity of regional organizations to reach consensus on regional policies and of their member-states to implement and comply with these policies depend to a large extent on their policy preferences and action capacities, and the extent to which they fit with the regional policies (Börzel 2002). We now turn then to the domestic arena. How do Mercosur member-states deal with health policies and regulations? What institutions and structures are responsible for these policies? Mercosur member-states[9] have very diverse approaches to health (see Tables 1 and 2).

[8] With the so-called Buenos Aires Declaration, social issues gained a place on the Mercosur agenda, as shown by the organization of Mercosur summits of social actors and the creation of the Structural Convergence Fund (FOCEM), among others.

[9] Only the four original full member-states are included. For more details about the domestic systems, see Bianculli and Ribeiro Hoffmann (2015).

Table 1: Health in the domestic legal order

Member-state	*Domestic legal order*
Argentina	Weak constitutional treatment of the right to health until 1994, when the constitutional reform recognized the safeguard and protection of health consumer relations (Art. 42), but more important still is the full recognition of the right to health by giving precedence to international agreements over domestic law.
Brazil	Health is a fundamental and universal right in the 1988 Constitution (Art.196).
Paraguay	Health is recognized as a basic right in the Constitution (Art.68-69), and health sector legislation guarantees health promotion and protection to all citizens.
Uruguay	Right to health is recognized in the Constitution (Art. 44), but it is defined as a responsibility of the individual; the state has thus only a subsidiary responsibility in legislating all health- and public-hygiene-related issues and providing prevention and care services free of charge only to the people who cannot afford them. The state also plays a role in the regulation of private service.

Source: Own compilation.

Table 2: The governance of domestic health systems

Member-state	*Domestic health system*
Argentina	The health system relies today on a mixed of public, co-operative and social health care organizations (*'obras sociales'*) and private schemes.
Brazil	The national public system is free to all citizens through the Unified Health System (SUS). Private health services are widespread given the lack of effectiveness of the SUS.
Paraguay	Paraguay's National Health System (NHS) is regulated by Law No. 1032/96, which establishes the provision of health services through the public, private, and mixed subsectors, health insurance programs and universities (Art. 4).
Uruguay	Health protection is historically based on mandatory private insurance, though the public health care system provides for people who cannot afford to pay for private health care. The most popular option has traditionally been a hospital plan called 'mutualista.'

Source: Own compilation.

The strongest contrast is found in their domestic legal orders. While in Brazil health is a fundamental and universal right since the Constitution of 1988, in Uruguay health is the

responsibility of the individual despite recent reforms trying to broaden the scope of state activities in regulation and provision. Scholars point out that the health system in Uruguay is fragmented and made up of an ensemble of institutions, relying on different areas of expertise, objectives and organizational structures, resulting, in turn, in a rather complex system (Borgia 2008). The recent reforms are perceived as having produced beneficial outcomes, including the unification of health coverage, and bringing together different national programs under a broad single benefit plan and the substantive increase in the number of people enrolled under the Integrated National Health System (SNIS) (WB 2012).

Argentina has also changed is approach in the last years. In 1994, with the latest constitutional reform, the state recognized the safeguarding and protection of health through various means. Health protection is mentioned in relation to consumer relations in Article 42. According to Abramovich and Pautassi (2008), this does not entail universal guarantees and thus fails to cover adequately the current idea of the right to health, its content and scope, as defined in international human rights law. In fact, it is by giving precedence to international agreements over domestic law that the right to healthcare and protection is now guaranteed in Argentina.

In Paraguay, the 1992 Constitution established the right to health and the state's responsibility to protect and promote health (Arts. 68 and 69). However, and building on data from the United States Agency for International Development (USAID) and PAHO (2009), 35.1% of the population remain excluded from these rights due to a series of shortcomings in the current institutional and regulatory health mechanisms. The government of former-President Fernando Lugo advocated a primary healthcare strategy as the focal point of the entire national health system (PAHO 2013), but political instability and change of government did not allow its implementation. Paraguay still relies on international cooperation and regional cooperation through Mercosur and UNASUR to guarantee the population's health.

Considerable variation is also observed when looking across the budget allocation patterns and number of physicians per capita, where Brazil has the worst ratio while Uruguay scores much better (see Table 3).

Table 3: Budget allocated to health

Member-state	*Annual national health expenditure as a proportion of the GDP [%] (Public)*	*Annual national health expenditure as a proportion of the GDP [%] (Private)*	*Physicians' ratio [10,000 hab.]*
Argentina	5,9 (2014)	2,6 (2014)	32,1 (2004)
Brazil	4,0 (2014)	5,0 (2014)	15,1 (2010)
Paraguay	4,3 (2014)	6,0 (2014)	16,2 (2013)
Uruguay	5,90 (2014)	3,00 (2014)	47,0 (2013)

Source: Own elaboration based on the Pan American Health Organization, Health Information and Analysis Project website (date accessed 17 August 2015). Years are indicated between brackets.

Despite the diversity of domestic health systems, all member-states have increased cooperation in this area during the last years, especially Argentina and Brazil. Both countries have increasingly included health in the agenda of their foreign policies both at the regional and global levels. Two initiatives from these countries, which might have a significant impact on the regional health governance, are worth mentioning. The first is the project developed by the Brazilian Ministry of Health in South America: Integrated System of Health in the Borders (SIS-Fronteira). Created in 2005, it was expanded to the whole border area of Brazil by 2010 (Kölling and Camargo Massaú 2010:47). The creation of SIS-Fronteira suggests that an important factor that might drive future cooperation in the area of health in Mercosur the fact that the Brazilian health system is based on universal access, through the SUS. Illegal immigration and illegal use of the SUS is a practice that is widely acknowledged; in fact, the lack of clear criteria to treat foreigners in SUS is reflected in the diversity of interpretations of the rights to access to health services (Agustini and Ribeiro Nogueira 2010). This leads to the problematic *ad hoc* selectivity on the part of the professionals and informal relations, which become more relevant than formal regulations and hinder the planning of an effective regional health policy. SIS addresses this problem by transferring resources to the border areas to compensate for the additional number of people being attended to in the health system. To estimate local necessities, partnerships with local authorities and federal universities were formed. The first phase of the project covered the Southern borders, with Argentina, Bolivia, Paraguay and Uruguay; the second phase included Northern borders.

The second relevant initiative among Mercosur member-states to the governance of health in the region is the new Migration Law from Argentina (Law 25871), which was approved in December 2003, adopted in January 2004 and finally enacted in May 2010. This new law underscores migration as an essential human right and migrants as subjects of law (Domenech 2007). Furthermore, the state is obliged to guarantee this right based on the principles of equality and universality (Art. 4). Thus, this migration law guarantees access to public services, including health, education, justice, labour, employment and social security, irrespective of their immigration status and even in situations of 'irregularity' (Arts. 7 and 8). Finally, the law is also quite innovative, as it extends the notion of citizenship to Mercosur member-states and associated member-states, thus building on the idea of a 'communitarian identity' (Domenech 2007). Even if the law continues to establish residency according to traditional criteria such as work, study and family ties, through its nationality criteria (Art. 23-l), it authorizes Mercosur citizens to remain in Argentina for a period of up to two years, which can be extended with multiple entries and exits.

4. Health policies in Mercosur: Challenges and opportunities ahead

Mercosur has increased its activism in the area of health, though its role in the provision of policies and regulations remains marginal. While member-states are by far the main actors and decision-makers at the regional level, domestic systems and practices show a great variation.

The value-added of Mercosur for a fair and efficient provision of health regulations and policies is hence questionable. Health at the regional tier of governance has mainly advanced through the RMS and the SGT 11, each of which relies on a complex internal structure. Whereas the RMS works as a political body, the SGT 11 assumes primarily a technical function. In fact, in the absence of consensus, the SGT 11 turns to the RMS to make the final decision. The regional organization lacks coordinating mechanisms to make decisions in this policy area given that all institutions are still intergovernmental.[10] Still, the main challenge to Mercosur's system of health governance is the lack of a project clearly indicating how a regional health policy should look like.

[10] The participation of observer countries has also been uneven. Even if they take an active and continuous role in the RMS, Bolivia has not participated at the SGT 11, and Chile has only been present when discussing specific topics and of particular interest, especially with regard to monitoring borders (Sánchez 2007). On the contrary, in 2003, Venezuela assumed the rotating presidency of the Health Council of Mercosur.

So far, Mercosur has mainly focused on the coordination of services in border areas, the harmonization of rules on health surveillance for the circulation of products, being this essential for the articulation of the common market, and the creation of regulations related to epidemiological surveillance and disease control. The latter are crucial as the flows of people across countries in the bloc intensify. While relevant and necessary, such coordination practices remain geographically restricted and do not affect national health systems (Sánchez 2007:159).

Other forms of cooperation, increasingly ambitious, but also more contentious, that should be assessed, include attempts to harmonize domestic legislation and regulations, and to provide mechanisms that contribute to overcoming internal difficulties, and promoting health as a regional public good. This implies moving beyond negative integration through the removal of obstacles to trade and the free movement of health products and services, to the harmonization and coordination of norms and standards, or the mutual recognition of each other's regulatory processes and standards. In all, this is expected to be a more complex task because moving into 'positive integration' that introduces rights and inclusion through regional policies reaches deep into domestic governance arrangements (Scharpf 1996). Whereas, as stated, member-states exhibit relevant differences in the ways in which health is regulated, guaranteed and provided at the national level, this is further complicated by the fact that just as in the case of education, health policy can be understood as a purely market product or as a public good (Bianculli 2013).

A final challenge for Mercosur derives from the choice on the part of member states to use this regional institution as a locus for cooperation in health. The Union of South American Nations (UNASUR) ranked health among its main areas of activities, being this tackled not just as a sanitary problem due to transborder relations, but rather as a right to be pursued in interregional relations and global governance diplomacy (Buss and Ferreira 2010; Riggirozzi 2014). In terms of membership, UNASUR includes all Mercosur full and associated member-states plus Suriname and Guyana. There are no clear-cut reasons why member-states would prefer to advance health cooperation in Mercosur instead of UNASUR. In fact, the Andean Health Organization-Hipólito Unanue Agreement[11] is currently moving towards greater articulation with this recently created regional organization, to promote South-

[11] The Hipolito Unanue Agreement is a specific health instrument established by the Andean Pact – now Andean Community – already in 1971. Thus, it is the first formal initiative of regional health cooperation in Latin America.

American cooperation in this policy field further. In all, UNASUR seems to be better positioned to work as an umbrella organization to such initiatives and to promote deeper forms of cooperation when consensus exists. Whereas UNASUR brings together all of Mercosur's full and associated member-states, this relatively new organization is deploying a strong health agenda, which includes its involvement with health-focused multilateral institutions, such as the PAHO and the WHO.

When comparing the agendas of both organizations, we see that they share the same normative consensus in terms of advancing a model of health governance based on universal access and the right to health. However, within UNASUR, health receives a higher prioritization in the overall agenda of activities. Despite the social turn, Mercosur is still a customs union, which negotiates trade agreements with external actors, and where trade related governmental and non-governmental actors interact and seek to have an influence. UNASUR does not have a trade agenda so far (Briceño-Ruizo and Ribeiro Hoffmann 2015). In turn, this relieves UNASUR from potential conflicts of interest in more economic related health policies.

The biggest advantage of UNASUR is, however, its stronger institutionalization in the area of health and success in attracting experts and epistemic communities to collaborate closely with the organization. The penetration of UNASUR in the society and health experts networks through, for instance, the South American Institute of Health Governance (ISAGS), created in 2008 (Yeates and Riggirozzi 2015) seems to be much stronger, enhancing hence the chances of implementation of norms and policies and effective transformations at the domestic level.

In all, UNASUR might offer a better institutional space for the whole of South American countries to promote a regional approach to health. The intense engagement of UNASUR together with an extended membership might turn this into a more promising venue to develop and cooperate more effectively, and thus address the policy and regulatory gaps in the area of health in the region. Thus, health governance would rely on relatively powerful and coordinating institutions, whilst solving the current overload within Mercosur. Apart from the multiple political and technical bodies, health policy today involves a great variety of issues and work programs, all of which is expected to create significant coordination problems and in turn, hinder further policy and regulatory outputs.

5. Conclusion

Recent developments in Latin America, but also in other regions, show the increased awareness of the limitations of pursuing free trade policies and the key driver of economic development and the need to include a social or development dimension in the processes of regional integration (Deacon et al 2007; Holst 2009). Still, there is a broad array of policy options as to how to include or promote the social dimension of regional integration.

When it comes to the case of health policy in Mercosur, this paper showed that some initiatives were taken in its early stage, with the creation of the Meeting of Health Ministers (RMS) in 1995 and the Health Working Group (SGT-11) in 1996. While both formulate proposals to the decision-making bodies of Mercosur – the CMC and the GMC – they have contributed to the development and expansion of a regional health agenda, which includes the harmonization of domestic legislations, creation of common guidelines, and technical cooperation in the areas of health products, health surveillance and health care services. The creation of the Meeting of Ministers and Authorities of Social Development and the ISM reinforced the relevance of health policy in the process of regional integration. The main achievements in terms of bloc-wide agreements in health are mechanisms of disease control and epidemic prevention, but cross-border accessibility of health services, portability of social protection and equal social and labour conditions, while important are not a Mercosur priority yet. Mercosur still primarily deals with coordination of services in the border areas to allow for the creation of the common market, on the one hand, and as a reaction to the increasing transit – both legal and illegal –of persons and the necessity to regulate access to health. Generic pharmaceuticals have also been part of the bloc's agenda since the 2000s, building on the policies developed at the national and international levels by both Argentina and Brazil. Whereas the RSM has prioritized the production and marketing of marketing of generic drugs to treat HIV / AIDS (Tobar and Sanchez 2005), generic pharmaceuticals became part of the Negotiating mandate ('*pauta negociadora*') of the SGT 11 already in 2007 (Mercosur/GMC/RES. Nº 13/07).

So far, Mercosur has failed to promote a regional regulatory approach tailored to its member-states; the main hindrance for an effective health approach is the lack of a clear definition of the model to be pursued to achieve integration in the regulation and provision of health services. Moreover, domestic health systems are very different, and this limits the possibility of achieving consensus on common norms and standards. Actually, member-states

have favoured different approaches, as shown by Brazil, who has implemented a system to manage its borders, though this remained as a domestic project. Argentina has recently modified its migration law, which establishes the economic, social, political and cultural rights of migrants, and gives preferential treatment to nationals of Mercosur. However, the impact of such law is still to be seen. Clearly, regional integration in the area of health policy can vary across a wide range of institutional and regulatory mechanisms, ranging from minimalist strategies to deeper measures leading to the construction of a regional social citizenship. The specific institutional path to the chosen remains a highly political and contentious issue. The left turn has placed social inclusion and welfare at the centre of public policymaking at the domestic level to expand social citizenship rights. Yet, similar developments at the regional level require new mechanisms through which state and non-state actors may frame demands for public policies and public goods, and in turn, citizenship rights and practices as well.

To sum up, Mercosur has so far failed to offer a promising platform to substantially improve the provision of health regulations and policies in the region. Despite the stronger activism of the 2000s, Mercosur's initiatives are still timid. Furthermore, more recently this agenda seems to have lost it *raison d'être* given the activism of UNASUR in this area, a relatively new regional organization that includes all of its full and associated member-states. In fact, UNASUR seems to be a better institutional choice for South American countries to promote a regional approach to health. Other regional groupings are already attempting a greater articulation with UNASUR, as shown by the experience of the Andean Health Organization. The intense engagement of UNASUR together with an extended membership might turn this into a more promising venue to develop and cooperate more effectively, and address thus the policy and regulatory gap in the area of health in the region.

These developments also reveal the challenges posed by overlapping memberships and mandates. While overlapping regionalism in general deserves further research, and certainly goes beyond the objective of this research, its consequences and policy implications are far from clear. However, and building on how both Mercosur and UNASUR have built their agendas, it could be argued that certain specialization seems to be emerging spontaneously. UNASUR has built a strong regional health policy and has led relevant initiatives at the international level, whereas Mercosur stands as a less relevant actor in this policy domain. Contrariwise, in the case of higher education, UNASUR's agenda is less developed; it has mainly followed that of Mercosur, which stands as the main provider of standards and norms

in the region. This example suggests that these organizations and their overlapping might over time lead to a division of labour according to issue areas, but more research should be conducted, including about how the member states belonging to both Mercosur and UNASUR negotiate their commitments around health within the respective regional bodies. Furthermore, and when it comes to Mercosur, a question remains open as to the extent to which further initiatives in the regulation and provision of health at Mercosur level can overcome domestic resistances. Here there is an issue about the extent to which Mercosur as a regional organization can provide effective leadership in support of health and the extent to which it can develop its social agenda beyond trade-driven integration mandates.

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