BRICS: Time to Bridge the Gap between Deliberation and Actions on Health Agenda

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Abstract

Health is an indispensable public good. At the national level it has been manifested in the BRICS governments' commitment to scale up health financing, though to a different degree. At the global level it is evidenced by the international community progress on the three health-related Millennium Development Goals. However despite successes in fighting infectious diseases, child and maternal mortality, old risks persist and new challenges emerge, resulting from the 2008 financial crisis, current slack economic growth and growing economic inequality.

The BRICS face these challenges and have begun cooperation on health issues. It is important that they build their emerging health agenda recognizing these challenges, committing to develop sustainable policy solutions, and cooperating with other actors to promote effective health governance for change.

To explore how the BRICS contribute towards global health governance the article first considers the BRICS cooperation (its institutionalization, discourse, and engagement with other international institutions) with a focus on health issues. The authors then look into the BRICS members' national health systems, challenges and goals. The article concludes with expectations of the BRICS future health agenda and its implications for global governance.

Kew words: BRICS, global health governance, global governance functions, commitments, institutionalization, official development assistance, World Health Organisation.

Introduction

Health is an indispensable public good. At the national level it has been manifested in the BRICS and other countries' governments' commitment to scale up health financing. At the global level it is evidenced by the international community's progress on the three health-related Millennium Development Goals, increasingly complex global health architecture, and a steady expansion of funding for global

health in the pre-crisis decade. However despite successes in fighting infectious diseases, child and maternal mortality, old risks persist and new challenges emerge, resulting from the 2008 financial crisis, current slack economic growth and growing economic inequality. The risks of pandemics are exacerbated by hyperconnectivity, migration and antibiotic resistant bacteria (World Economic Forum, 2014, pp. 12, 22, 26, 31-32). The burden of non-communicable diseases is aggravated by demographic decline, unhealthy lifestyles and failure to establish sustainable universal healthcare systems (World Economic Forum and the Harvard School of Public Health, 2011, pp. 9-11). "Today, changes in the global landscape have bred five existential challenges for public health actors: the search for sustainable support; the impact inequitable access to funds has on individual health *(and national health systems – M.L.)*; the increasingly obvious mismatch between the structure of "global health" and its looming priorities; changes in the food supply; and climate change" (Garret, 2013, p. 2).

Since its inception in 2008 the BRICS has gradually matured into a global governance actor, which does not come as a surprise given their increasing weight in the world economy and locomotive power of the world economic growth. However, the BRICS increasing role in the global governance system is not a function of only one variable – their economic growth. Strengthening cooperation of these countries significantly contributes to the BRICS increasing influence. Since the crisis year of 2008 the BRICS members have been broadening and deepening their coordination in different policy spheres, different formats and at different levels.

To explore the BRICS capacity to contribute towards global health governance the article first considers the BRICS cooperation (its institutionalization, discourse, and engagement with other international institutions) with a focus on health issues. The authors then look into the BRICS members' national health systems, challenges and goals. In conclusion the article asserts that as BRICS share common challenges nationally and globally they should build their health agenda and thus contribute to both national development and global governance development, committing to develop sustainable policy solutions, and cooperating with other actors to promote effective health governance.

Research Methods

The study employs quantitative and qualitative analysis drawing on the full set of the BRICS documents accumulated since the institution inception in 2008. The documentary evidence base includes 38 documents adopted at the leaders' summits and ministerial meetings. (Since BRICS inception 11 summits, 51 ministerials and 35 meetings in other formats have taken place).The data was used to carry out a study on several parameters. First, to explore the dynamics of institutionalization, the data on the number of meetings held in various formats and documents adopted on the BRICS ever expanding agenda has been compared.

Second, to compare relative significance and dynamics of priorities in the BRICS agenda content analysis of the BRICS discourse has been carried out on 11 broad

policy areas present on the institution`s agenda. In the content analysis a text unit could be earmarked as implementing only one of the 12 priorities, or uncategorized. Absolute data on the number of symbols denoting a certain priority in the text of the BRICS documents were obtained and translated into relative data calculated as the share of the priority in the total of all texts and expressed in percent. Comparative assessment was based on the relative data of a specific priority share in the total discourse.

Third, to assess BRICS capability for global governance the study has traced the institution performance of the global governance functions of deliberation, direction-setting, decision-making, delivery and global governance development. Deliberation was understood as face-to-face discussions of the members encoded in the collective communiques. Direction-setting was defined as collective affirmation of shared principles, norms and prescriptions. Decision-making was regarded as credible, clear, collective commitments with sufficient precision, obligation and delegation. Delivery was understood as stated compliance with collective decisions. Global governance development was perceived as BRICS capability to use other international institutions and create its own institutions as global governance mechanisms (Kirton, 2013, p. 37-39).

In the content analysis a text unit could be earmarked as implementing only one function. Absolute data on the number of symbols denoting a certain function in the text of the BRICS documents were translated into relative data calculated as the share of the function in the total of all texts and expressed in percent. Comparative analysis of global governance functions performance relied on the relative data of a certain function share in the total or annual discourse.

The data on the share of the function of global governance development in the discourse was substantiated by such indicators of BRICS engagement with international institutions as the number of references and mandates delegated by the BRICS to international multilateral institutions, and the number of instruments and institutions established by the BRICS.

The function of domestic political management is usually perceived as an increase in prestige and public opinion support that comes when a country's actions are publicly acknowledged in the collective documents (Kirton, 2013, p. 36). In the study another dimension is considered. BRICS actions which respond to the member long term priorities, may reap social and economic benefits, and are viewed as beneficial, are regarded as domestic political management.

BRICS Institutionalization and Health Dialogue Evolvement

After the first meeting on the sidelines of the G8 Hokkaido summit when the BRIC leaders agreed on further coordination on vital economic problems, including the financial sphere and food security, the institution's collaborative dynamics have been constantly increasing. Meetings of the BRIC finance ministers and central bank governors have become regular. At the first meeting in São Paulo on 7 November 2008 held just before the G20 finance ministers and central bank governors meeting the BRIC discussed possible scenarios of the financial crisis

development, their countries' policy responses, and committed to continue to undertake all necessary steps to lessen the impact of the crisis on economic activity to sustain medium and long-term growth. In 2009 finance ministers met twice to coordinate positions in the G20. In Horsham (UK) finance ministers called to study the developments in the international monetary system, including the role of reserve currencies and the reforms of the international financial institutions. At the meeting in London the finance ministers and central bank governors set a target of 7% for redistribution of quotas in the IMF and World Bank in favor of developing countries. A practice of meetings for coordination of positions in the G20 and other financial institutions has been established. Finance ministers consult in standalone meetings and on the sidelines of the spring and annual meetings of the IMF and World Bank. So far 18 meetings have taken place and 5 documents have been adopted. Together with the format of cooperation at the level of ministers and deputy ministers of foreign affairs, which emerged before 2008, finance ministers meetings have become an important component of coordination on financial and economic agenda and preparation of BRICS summits.

In the sphere of agriculture and food security directions for cooperation set at the first summit in the joint statement on global food security, were elaborated in the Moscow declaration of the agriculture ministers on quadrilateral cooperation in the agricultural sector with particular attention to family farming. Despite the fact that only four agriculture ministers meetings took place, elements of accountability in this sphere were established, a working group was created, working procedures for cooperation were agreed, the BRICS Strategic Alliance for Agricultural Research and Technology Cooperation was established, and the Action Plan for cooperation in 2012-2016 was adopted.

Cooperation between trade ministers was launched in 2011. Since then six meetings have taken place. Establishment of a contact group for developing an institutional framework and concrete measures to expand economic cooperation both among the BRICS countries and between BRICS and other developing countries was announced in the 2011 Geneva Declaration. The Strategy for the BRICS Economic Partnership has been drafted and is a subject of consultation between relevant stakeholders.

Health issues had not been included in the BRICS agenda until 2011. Under the Chinese presidency the BRICS policymakers explicitly recognized the forum`s potential for developing national health systems and contributing to global health governance. Thus, in the Sanya Declaration adopted on 14 April 2011 the leaders for the first time committed to "strengthen dialogue and cooperation in the fields of …public health, including the fight against HIV/AIDS" (BRICS Leaders, 2011). In the Action Plan adopted on the same day the leaders agreed to explore several new areas of intra state cooperation, including global health issues, and to host the first health ministers meeting in China in 2011 (BRICS Leaders, 2011). By the time of the Russian second BRICS presidency beginning four standalone health ministers' meetings have been held as well as three meetings on the sidelines of the 65th session of the World Health Assembly in Geneva, each adopting a communique.

At their first meeting on 11 July 2011 the BRICS ministers responsible for health adopted the Beijing Declaration emphasizing the importance of cooperation in the area of public health both within the BRICS and with other countries and international institutions. Highlighting the central role of the WHO in international health cooperation they stressed the need for its reform. The Beijing Declaration contains 13 commitments on different aspects of public health. The actions were primarily aimed at strengthening domestic health systems through technology transfer. Thus the parties prioritized "strengthening health systems and overcoming barriers to access for health technologies that combat infectious and non-communicable diseases, particularly HIV, TB, viral hepatitis and malaria; exploring and promoting technology transfers to strengthen innovation capacity and benefit public health in developing countries; and working with international organizations including WHO, the GAVI Alliance, UNAIDS and the Global Fund to increase access to medicines and vaccines". Recognizing the responsibility for health systems improvement in poorer countries the ministers pledged to "support and undertake inclusive global public health cooperation projects, including through South-South and triangular cooperation" (BRICS Health Ministers, 2011).

The ministers agreed to institutionalize their dialogue on a permanent basis and launch cooperation of the BRICS Permanent Representatives in Geneva in order to "follow-up and implement the health related outcome of the BRICS summit" (BRICS Health Ministers, 2011). A technical working group was established to discuss proposals on further cooperation, including on setting up a BRICS technological cooperation network. It was decided that an opportunity of holding the next meeting in September 2011 in conjunction with the UN High Level Meeting on Non-communicable Diseases should be explored. Thus the dialogue on health was rapidly institutionalized by the BRICS.

The global community welcomed the inclusion of health issues in the BRICS agenda. A telling example is Bill Gates' report to the G20 leaders at the Cannes summit where he stressed the role of the rapidly growing countries, such as BRICS, in promoting development and strengthening public health (Gates, 2011). This statement was especially important as by early 2011 global health funding was dominated by the Gates Foundation and the US Government (Jenks et al, 2013, p. 71). Emergence of BRICS as an actor in global health governance was perceived by its key player as an opportunity to reduce the vulnerability of global health financing stemming from its dependency on a single source or nation.

The decision to hold health ministers` meetings regularly was supported by the BRICS leaders at their summit in New Delhi in 2012. The leaders also highlighted that BRICS countries face a number of similar priorities in the area of public health such as ensuring universal access to health services, access to health technologies, including medicines, reducing costs and the growing burden of both communicable and non-communicable diseases. In this regard they supported the BRICS health ministers meetings institutionalization in order to address "common challenges in the most cost-effective, equitable and sustainable manner" (BRICS Leaders, 2012).

The intention of holding the next BRICS health ministers meeting in September 2011 on the sidelines of the UN High Level Meeting on Non-communicable Diseases was not realized. However, cooperation on health issues among Permanent Representatives of BRICS countries in Geneva was launched as agreed in Beijing Declaration. On 22 May 2012, ministers of health of Brazil, China and South Africa, the Secretary of Health and Family Welfare of the Government of India and the Russian Permanent Representative to the UN Office in Geneva held a meeting on the sidelines of the 65th session of the World Health Assembly in Geneva. The participants reiterated the importance of technology transfer to strengthen developing countries' capacities; discussed the role of generic medicines in promoting universal right to health; and committed to develop cooperation in research and innovation among BRICS countries to improve public health systems. The technical working group meeting was announced, to be held within the next months to discuss a plan to advance BRICS cooperation on health issues and establishment of a technological cooperation network responsible for moving forward joint work on such priorities as "food, pharmaceuticals, health and energy as well as basic research in the emerging inter-disciplinary fields of nanotechnology, biotechnology, etc" (BRICS, 2012).

The BRICS representatives agreed to identify thematic work areas for each country to be discussed and promoted. Procedurally each country "had to identify a nodal officer for each area of work, to work with the lead officer of the country piloting the particular area of work and to come out with a program of work to advance the health related cooperation among BRICS countries, in particular the establishment of the network of technological cooperation" (Stuenkel, 2013). The outcomes of this work were intended to build a basis for the next BRICS health ministers meeting (BRICS, 2012).

As agreed in the Delhi Action Plan adopted on 29 March 2012 (BRICS Leaders, 2012), the second standalone BRICS health ministers' meeting was held on 10-11 January 2013 in New Delhi, focusing both on intra BRICS cooperation and collaboration with other countries. The ministers made 22 commitments, pledging to address the threats of non-communicable diseases, mental disorders, tobacco use, tuberculosis, malaria and HIV; strengthen effective health surveillance; develop bio-technology for health benefits; and contribute to the achievement of health-related Millennium Development Goals. They reiterated the priority of technology transfer "as a means to empower developing countries". Finally, the ministers reaffirmed their commitment on setting up a BRICS network of technological cooperation (BRICS Health Ministers, 2013a). Most of the Beijing Declaration commitments were confirmed by the BRICS health ministers at their New Delhi meeting.

In line with the mechanism agreed in Geneva the BRICS countries' representatives identified thematic areas for further discussion and elaboration of the final communiqué in the reports presented in the first day of the meeting (AniNews.in, 2013). These main thematic areas included: strengthening health surveillance systems; reducing non-communicable disease risk factors through diseases

prevention, health promotion and universal health coverage; strategic health technologies, with a focus on communicable and non-communicable diseases; medical technologies; invention and development of drugs (Pandey, 2013). Renewed commitments on establishing the technical working group and technological cooperation network indicated that there was scope for further progress on these issues. Nevertheless, notwithstanding slow progress and absence of tangible financial commitments BRICS cooperation on health was welcomed by the UNAIDS Executive Director. Addressing the meeting participants Michel Sidibe stressed the unique role of the BRICS countries in disseminating innovation and research in other developing countries and mentioned that "the BRICS are demonstrating how health is increasingly a tool of foreign policy and a vehicle for promoting global health and development for the entire world" (UNAIDS, 2013).

In spite of the health dialogue`s institutionalization and its potential value for the BRICS members, health was not on top of the 2013 BRICS Summit agenda in South Africa. BRICS leaders just noted the meetings of health ministers in Geneva and New Delhi and agreed to hold future ministerials and preparatory meetings in the framework of the South African BRICS presidency (BRICS Leaders, 2013).

At the same time, the BRICS held their second meeting of Permanent Representatives on the sidelines of the 66th session of the World Health Assembly in Geneva in May, 2013, thus setting the precedent for making the meetings regular. In a joint communiqué the BRICS countries' representatives reiterated the technical working group`s focus on the five thematic areas, including, inter alia, strengthening health surveillance systems and reducing non-communicable disease risk factors. They also discussed the World Health Organization report on Monitoring Achievements of the Millennium Development Goals and agreed that in spite of the progress being made, much needs to be done if health-related MDGs are to be achieved by 2015. The BRICS stressed their resolve to "jointly promote access to affordable, safe, efficacious and quality medical products through the use of the Agreement on Trade-Related Aspects of Intellectual Property Rights" and reiterated their traditional commitment to support the WHO as a central institution coordinating the global health agenda. Finally, they emphasized again the importance of technology transfer as a way to strengthen developing countries' capacities in the area of public health (BRICS Health Ministers, 2013c).

As mandated by their leaders, the BRICS health ministers gathered on 6 and 7 November 2013 in Cape Town for a third standalone meeting. Again the emphasis was on strengthening "intra-BRICS cooperation for promoting health of the BRICS populations" (BRICS Health Ministers, 2013b). In the absence of progress on establishing the BRICS network of technological cooperation, the ministers gave it another push. They also adopted the "BRICS Framework for Collaboration on Strategic Projects in Health". The document has not been made public at the time of writing this paper; however, some joint strategic projects in health were proposed by the ministers in their statements following the meeting. Thus, the Indian Minister of Health and Family Welfare Shri Ghulam Nabi Azad mentioned several initiatives: "management of non-communicable diseases, medical

education, pharmaceutical sector, traditional medicines, health research, and…management of communicable disease like HIV, tuberculosis and malaria" (India. Ministry of Health and Family Welfare, 2013). With regard to global health governance the ministers reaffirmed the central role of the WHO in promoting global health, emphasized the importance of supporting maternal and child health, and called on the United Nations member states to "give due consideration to health as an important issue in the discussions of the post-2015 development agenda" (BRICS Health Ministers, 2013b). Dynamics of the BRICS institutionalization has been high. So far 97 meetings have taken place. Alongside the summits, the foreign and finance ministers meetings, there are 16 formats, including cooperation of health ministers, statistical offices, development banks and antimonopoly agencies. The BRICS have adopted more than 40 documents on their constantly broadening agenda. There is a tendency of increase in the number of standalone meetings, adoption of more documents, creation of working groups and other mechanisms of coordination.

This general tendency for BRICS rapid institutionalization is also observed on the health agenda. Three out of six meetings were standalone, BRICS health ministers sought to promote their agenda organizing the work on thematic areas through the technical working group and the BRICS technological cooperation network. Taking into account that six meetings on health resulted in six documents, the quality of health dialogue is relatively high. Moreover, the number of meetings on health issues is the fourth highest of all the BRICS formats after the foreign ministers', the finance ministers' and the central bank governors', and the leaders' meetings.

The Place of Health Issues in the BRICS Discourse

In line with the institutionalization dynamics, the share of health issues in the BRICS discourse has been expanding.

Despite the fact that BRICS is frequently assessed by experts and practitioners as a political forum, economy (24% of the discourse) and finance (almost20%) dominate the agenda. Member states themselves see BRICS as "a major platform for dialogue and cooperation in the economic, financial and development fields", although the share of economy and finance issues has been decreasing as the BRICS agenda has broadened. The share of the discourse devoted to political and security issues is about 10% and includes coordination of the countries' positions on UN reform, global challenges and threats, and consultations on crisis situations in the Middle East and North Africa, including the situation in Syria and the Iranian nuclear program. The share of political issues in the agenda is increasing since numerous crisis situations in the Middle East, North and West Africa need to be addressed. Dialogue on development is strengthening. Substantial contribution towards shaping the BRICS agenda on development was made in the framework of the Brazilian presidency. In 2011 BRICS consolidated its dialogue on agriculture and food security. Environmental protection, issues of access to energy sources, clean technologies, renewable energy, energy effectiveness and energy security are

also included in the BRICS agenda. Thus in 2011 BRICS reaffirmed their intention to strengthen cooperation in order to reach agreements in the framework of the Durban Conference, and to enhance practical cooperation on economic and social adaptation to climate change. Trade and investment cooperation has become an inherent part of the agenda as BRICS leaders consistently express their commitment to the rules of multilateral trading system.

Since 2011 when the BRICS launched their dialogue on health, its share in the discourse has been growing steadily, reaching the average of 9.93% in the forum total discourse. (the shares of discourse devoted to the BRICS priority areas by summit are presented in Figure 1).

The rapid pace of health dialogue institutionalization has not yet been translated into tangible deliverables for global health governance, though the discourse has gradually been transforming from sheer deliberation to decision-making.

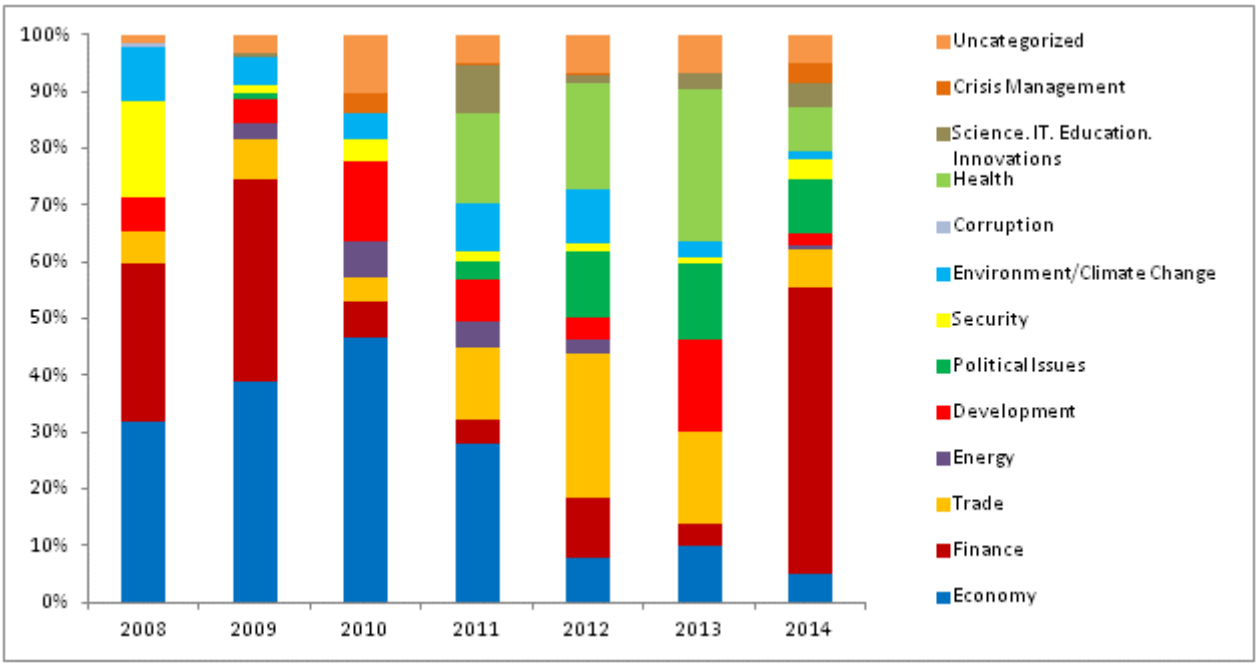

Figure 1. BRICS priorities, 2008-2014, share of characters, %

Global Governance Functions Dynamics: Time to Bridge the Gap between Deliberation and Actions on Health Agenda

With BRICS maturation the balance of global governance functions of deliberation, direction-setting, decision-making, delivery and global governance development in the BRICS documents has changed.

Overall while the deliberation function share has been declining, shares of delivery and decision-making functions have been rising. The 2008 documents are dominated by deliberation (46% of the discourse) and direction-setting (almost 49% of the discourse) functions, while the share of decision-making amounted to only 5%. In 2009 the share of deliberation substantially decreased, and the shares of direction-setting and decision-making rose considerably to 57% and 18% respectively. In subsequent periods the share of the decision-making function continued to grow and reached 38.6% in 2011. Dropping to 21% in 2012, in 2013

the share of decision-making constituted 25%, and jumped to 61.3 % in 2014. The share of delivery increased from 1.76% in 2009 to 4.01% in 2013 and dropped to 0.5% in 2014. Deliberation and direction-setting shares have declined to 18% and 20% of the BRICS 2014 discourse respectively.

The high proportion of the global governance development function in 2010 reflects the BRIC efforts to facilitate the reform of the IMF and World Bank governance to ensure a shift of voting power to emerging economies and developing countries. In addition, the dialogue on concrete steps towards establishing regional currency arrangements between the BRIC countries was launched in 2010. The BRIC members agreed to create agricultural information base system and initiated a number of new sectoral initiatives: cooperation through development banks, statistical institutions, competition authorities; work of the business forum and think tanks.

The balance of global governance functions in the BRICS discourse on health is similar to the general trends. While the share of deliberation has been steadily declining, the shares of direction-setting and decision-making functions have been rising. In 2013 the BRICS health ministers for the first time reported delivery on previously made commitments. The relatively stable share of the global governance development function reflects the BRICS efforts to further institutionalize its dialogue on health through establishment of the technical working group and the BRICS network of technological cooperation. Comparative dynamics of the global governance functions in the whole BRICS discourse and discourse on health is presented in Figure 2.

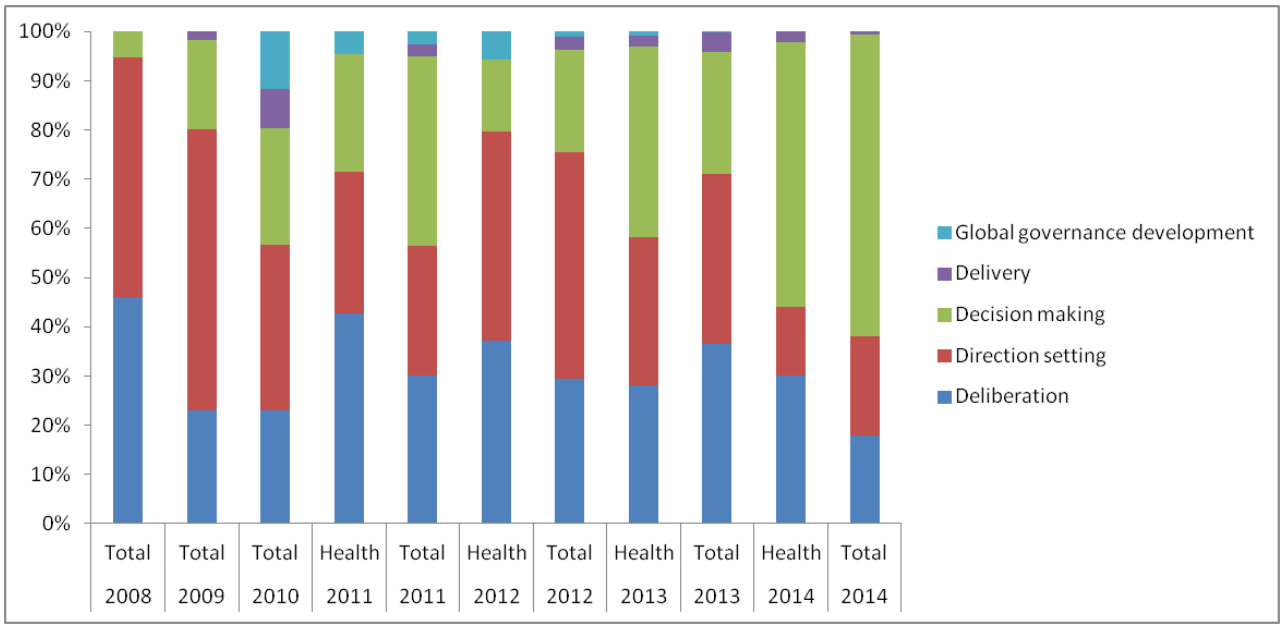

Figure 2. Implementation of global governance functions within the whole discourse and discourse on health in BRICS documents, share of characters, %

The number of concrete commitments[1] made by the BRICS leaders at the summits has been consistently increasing. The average number of commitments in 2009-2014 totaled 38.5, which is significantly lower than the G20 average for the period of 2009-2013. In Fortaleza the BRICS leaders agreed the highest number of commitments (68) in the history of the institution.

Despite the high dynamics of BRICS health dialogue institutionalization and its expanding share in the discourse, the number of concrete commitments made by the BRICS leaders at their summits remains low. The commitment to "strengthen dialogue and cooperation in the field of … public health, including the fight against HIV/AIDS" was registered in the Sanya Summit (BRICS Leaders, 2011). At the summit in New Delhi the BRICS leaders made another commitment on health and mandated their health ministers to address the issues of "universal access to health services, access to health technologies, including medicines, increasing costs and the growing burden of both communicable and non-communicable diseases", which they described as common challenges for all BRICS countries (BRICS Leaders, 2012). The 2014 summit also yielded only one commitment on health stating BRICS determination to ensure sexual and reproductive health and reproductive rights for all. ***Thus, the BRICS leaders have made only three commitments on health issues so far, which constitutes around 1% of the total number of the BRICS commitments, being one of the lowest figures among all major issue areas.*** At the same time, the number of commitments made by the BRICS leaders in other areas has been consistently increasing. Overall 15 commitments were registered in the BRIC Leaders 2009 Joint Statement, and 31 commitments were made at the summit in Brasilia in 2010. The BRICS agenda considerably expanded and in 2011 the number of commitments agreed by the leaders amounted to 38. In 2012 it dropped to 32, but in 2013 and 2014 rose significantly to 47 and 68 respectively. Compared to health, the dynamics of commitments in other areas has been more positive. Commitments on development, international cooperation, and international institutions' reform were made at each of the BRICS summits. The BRICS also regularly make commitments on energy, climate change, macroeconomic policy, regional security and terrorism. One or two commitments were made in areas which are less conventional for the BRICS agenda, such as information and communication technologies, human rights, accountability, culture, sport, and nuclear non-proliferation. The dynamics of all BRICS commitments is presented in Figure 3.

[1] A commitment is defined as a discrete, specific, publicly expressed, collectively agreed statement of intent; a promise by summit members that they will undertake future action to move toward, meet or adjust to an identified target. More details are contained in the G8 and G20 Reference Manual for Commitment and Compliance Coding (available at http://www.g8.utoronto.ca/evaluations/compliancemanual-110922.pdf).

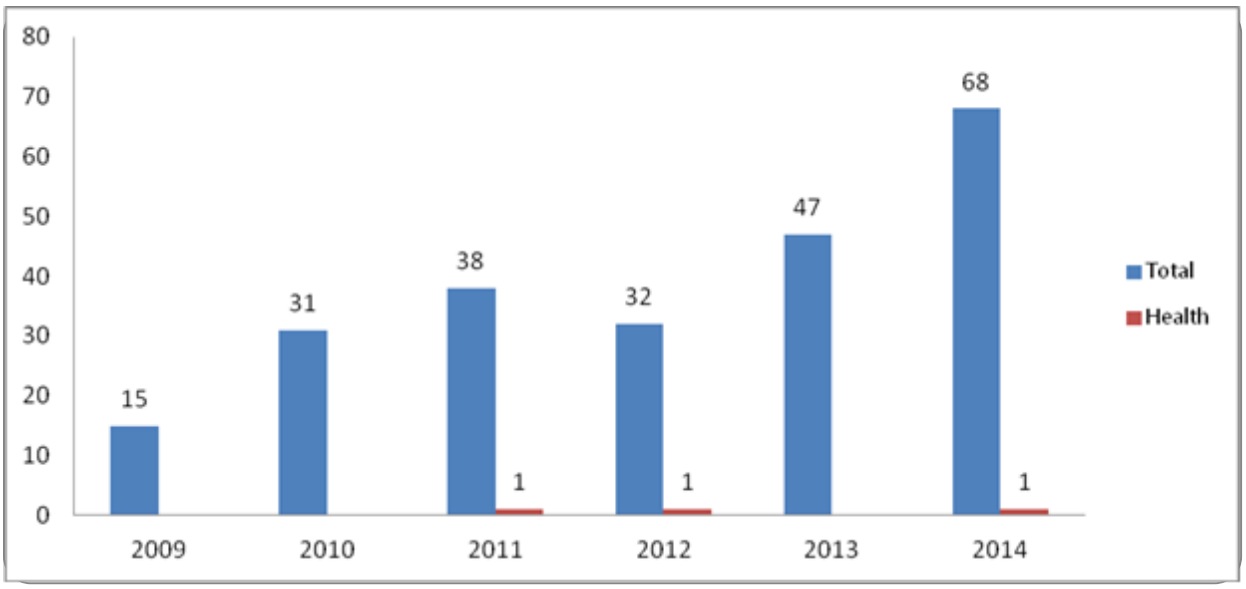

Figure 3. BRICS commitments, 2009-2014

There is an obvious gap between the BRICS deliberation and actions on health agenda, which has to be bridged, if the members wish to maximize their cooperation for strengthening their national health systems and promoting global health. The latter also requires productive engagement with relevant international institutions.

Analysis of the BRICS performance on global governance development function was substantiated by the data on references to international organization in all documents. These included a list of 42 international institutions. The BRICS members consistently emphasize their commitment to multilateral diplomacy and cooperation with international and regional organizations. The most frequently mentioned institution in BRICS documents is the UN. BRICS countries stress its central role in addressing global challenges and threats, and call for a comprehensive reform of the UN including the Security Council. The G20 comes second in terms of the number references made in the BRICS documents, which is not surprising given that the BRICS members coordinate their positions on the G20 agenda priorities. Since the reform of the Bretton Woods institutions remains in the focus of BRICS countries, references to the IMF and the World Bank make up approximately 12% and 6% respectively. References to the WTO in the examined period documents amount to 10%. The number of references to other international institutions in the BRICS documents varies. 65 references have been registered in 2009 BRICS documents. The figure dropped to 31 in 2010, but then increased twofold in 2011 reaching 61. It fell again to 54 in 2012 and amounted to 104 during the South African BRICS presidency. In 2014 this figure peaked at 106.

Within the health policy area the intensity of the BRICS engagement with international institutions is very stable. Overall 48 references to the World Health Organization were registered in the period of 2009-2014. The number of references to other institutions involved in health governance, particularly the UN, has grown steadily during the examined period. Thus, health is an area

where the BRICS countries frequently refer to other relevant international institutions contributing to developing global governance on health. However, this alignment of positions does not translate into engagement.

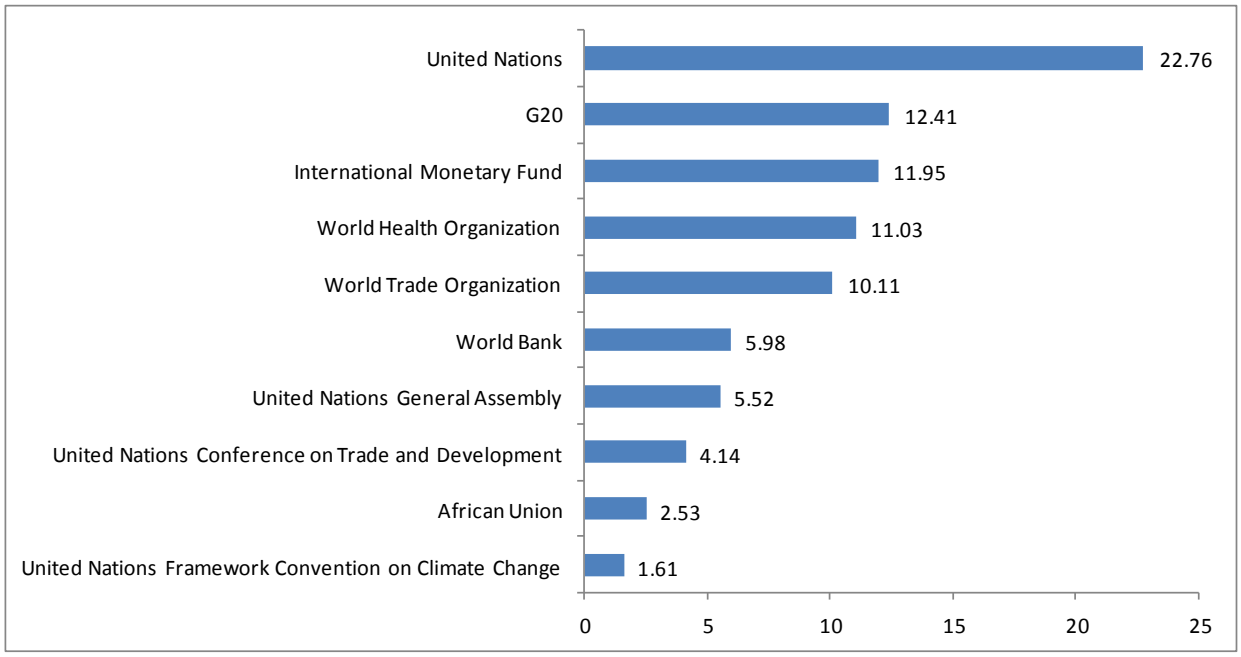

Figure 4. References to international institutions in BRICS documents, 2009-2014, share of the total, %

However, it should be noted that the BRICS coordination with multilateral institutions considerably differs from the engagement of the G8 and the G20 with international organizations. The G8/G20 engagement with international institutions is characterized by three modes of interactions: cooperation; delegation of mandates to implement decisions made at the summits; support of international institutions' actions or expression of a collective stance on specific issues. BRICS practices the latter type. Cooperation within the framework of key global governance functions or delegation of mandates to implement decisions made in BRICS summits has not been registered so far.

To enhance their impact on global health agenda, the BRICS member states should strengthen cooperation with international and regional institutions, including through consultations in deliberation, direction setting and decision making, securing tangible support of the BRICS actions and possible delegation of mandates to implement commitments.

BRICS Health Agenda: A Case for Domestic Political Management[2]

The BRICS countries are critical stakeholders in globalization and Global Public Goods (Jenks et al, 2013, p. iv) including health. However, they still face significant health challenges of their own. Hence there is a predominance of the

[2] The chapter uses the latest available data from the OECD Health at a Glance 2013 Report. The 2012 data on India and China, available in the OECD Health at a Glance: Asia-Pacific 2014 Report is not included to ensure data comparability across all BRICS members.

forum decisions aimed at building their national health systems capacities through intra BRICS cooperation. While not ducking the responsibility for participation in global health governance, the BRICS would make a major contribution to creating the global public good of health by ensuring effective, innovative and inclusive national health systems. They still have a long way to go in this regard. Despite increasing health expenditures, scaling up innovation and cooperation in recent years, the BRICS countries lag behind the OECD average in many aspects of healthcare, such as access to medical goods and services, inpatient and outpatient care, etc.

Notwithstanding rapid economic expansion of the recent years Brazil continues to suffer from the ramifications of inequalities. Disproportionate regional and ethnic concentration of poverty significantly limits vulnerable groups' (such as black population of the Brazilian Northeast) access to quality healthcare and undermines their nutritional security. In addition, Brazil is currently combating the spread of such ailments as HIV/AIDS, malaria, tuberculosis, as well as non-communicable diseases – diabetes, high blood pressure, etc. Lifestyle diseases like obesity and alcohol/substance abuse have become prominent in Brazil as well. The country has also been subject to frequent outbreaks of yellow fever, dengue and dengue hemorrhagic fever, and Severe Acute Respiratory Syndrome (SARS) (UNHCO, *Health Report Brazil*). Despite these problems, however, life expectancy for both men and women increased by three years between 2000 and 2012, accounting for a faster than the regional average growth rate. Other key health indicators also show positive dynamics – maternal and infant mortality are declining to the regional average values, access to clean water and sanitation is being improved (WHO, 2015). In 2011 Brazil's total health expenditure was at 8.9% of GDP – the highest among the BRICS countries and close to the OECD average of 9.3% of GDP (OECD, 2013). Per capita health expenditure has risen from $940 in 2009 to $1043 in 2011, which within the BRICS was second only to Russia's result (Global Health Strategies Initiatives, 2012). However, it is still far below the OECD average of $3322 (OECD, 2013). A constitutional obligation in domestic policy, healthcare is one of the focus areas of Brazil's international cooperation. The country's foreign health assistance amounts to one-sixth of its total international assistance (which is estimated at $400 million – $1.2 billion in 2010). Brazil mainly engages in technical assistance activities on such issues as HIV/AIDS prevention and treatment, food security and access to healthcare in South America, the Caribbean and lusophone countries drawing on its national experience (Global Health Strategies initiatives, 2012).

Russia's population has been in decline since 1990, when it peaked at 148.3 million (WorldDataBank, Russian Federation, 2015) This trend was caused by a fall in fertility and birth rates, together with a high death rate. While the first two are common to other countries going through social, economic and political transition, the death rate in Russia has been significantly higher. Heavy alcohol and tobacco consumption played a key role in the life expectancy decline in the early 1990s. The figures for deaths caused both by non-communicable (including

cardiovascular), and communicable diseases (infectious and parasitic diseases, tuberculosis) have increased since 1990. The figures for deaths caused both by circulatory diseases have increased from 618.7 per 100,000 people in 1990 to 801 in 2009. Communicable diseases death toll has also increased – infectious and parasitic diseases caused 12.1 deaths per 100,000 people in 1990 while in 2009 this figure amounted to 24.0 per 100,000. Tuberculosis was a cause of death for 7.9 in 100,000 people in 1990, and for 16.8 per 100,000 in 2009 (Popovich et al., 2011). HIV/AIDS remains a threat – in 2009 HIV/AIDS prevalence rate among adults amounted to 1% (CIA, n. d.). However, with increased health spending by the government, there are also signs of improvement in the overall health situation in Russia. Average life expectancy increased by six years in the period from 2000 to 2012. Infant and maternal mortality rates are declining. Since 2009 population has been growing steadily though slowly (WorldDataBank, Russian Federation, 2015). Russia spent 6.2% of GDP on health in 2011 (OECD, 2013) – an improvement over 5.4% of GDP allocated on healthcare in 2009 (OECD, 2011). Substantially behind Brazil (8.9%) and South Africa (8.5%), as well as the OECD average of 9.3% of GDP, Russia still has the highest per capita health expenditure among the BRICS countries – $1316 in 2011 (OECD, 2013). This figure has risen since 2009, when it amounted to $1040 (Global Health Strategies initiatives, 2012). However, it is just about one-third of the OECD average ($3322).

Health is one of the priorities in Russia's international assistance actions. In 2007-2011 more than 28% of Russia's ODA was disbursed in this sphere. However, the level of health spending is quite volatile ranging from 104.2 million US$ in 2007 (50% of total ODA) to 61.2 million US$ in 2011 (13%) (UK G8 Presidency, 2013).

India has undergone extraordinary socioeconomic and demographic changes during the second part of the 20th century. The country's total population has almost tripled, while urban population increased 4.6-fold between 1951 and 2001. In recent decades India has demonstrated a steady increase in a number of public health indicators: life expectancy at birth has risen from 58.5 years in 1990 to 66.3 years in 2012, access to drinking water reached 93% (OECD, 2014). However, despite admirable progress in addressing communicable diseases such as polio, changes in Indian society and lifestyles led to a surge in non-communicable diseases, which are already responsible for about 53% of all deaths. Up to 64% of the country's population, especially in rural areas, still suffer from lack of access to adequate sanitation (OECD, 2014). Inequality is a great concern in India. High gender inequality results in elevated incidence of selective gender abortions, which caused the female-to-male ratio in the 0–6-year age group to decline from 0.945 in 1991 to 0.914 in 2011. Maternal, newborn and child death figures in India are among the highest in the world. Although infant mortality rates have declined from 83 per 1000 live births in 1990 to 44 in 2011, and maternal mortality ratio has reduced from 570 per 100,000 live births in 1990 to 212 in 2007–2009, both indicators remain high in comparison to the other BRICS countries (WHO, 2013b). Insufficient budgeting exacerbates the situation. In 2011 India's total health

expenditure to GDP ratio was the lowest within the BRICS at 3.9% (OECD, 2013). This indicator has experienced a decline since 2009, when it amounted to 4.2% of GDP (OECD, 2011). India also has the lowest per capita health expenditure among the BRICS countries – $141 in 2011 (OECD, 2013), a small improvement over the 2009 result of $130 (Global Health Strategies initiatives, 2012).

Facing serious challenges at home, India does not prioritize health within its foreign development assistance agenda. Health assistance amounts to a small fraction of the total foreign development assistance expenditure (approximately $600 million in 2010) and includes a limited number of bilateral projects focused on infrastructure, human resources, capacity building and education (Global Health Strategies Initiatives, 2012).

China has experienced strong productivity and economic growth, significant demographic change and socioeconomic transformation since the launch of the 1978 reform. The country has made great progress in improving people's health, particularly in the control of communicable diseases. However, major outbreaks of HIV/AIDS, hepatitis and tuberculosis as well as the importation of serious non-endemic diseases remain a risk in the environment of ever-growing mobility of people and goods. Thus, control efforts for these diseases are important issues for China (WHO, 2013a). Despite 30-fold rise in health spending over the last 20 years (5.2% of GDP in 2011) (OECD, 2013), changing lifestyles resulted in a sharp increase in deaths caused by non-communicable diseases, namely malignant neoplasms, heart diseases, cerebrovascular diseases and chronic lung diseases, responsible for a majority of deaths in China. Regional inequalities remain a detrimental factor in public healthcare. For example, the maternal mortality ratio in the country's western regions is still higher than in eastern and central China. Rapid industrialization has caused environmental damage, such as air pollution, water contamination, and soil pollution – resulting in health problems and eventually increasing the prevalence of certain diseases (WHO, 2013a). As China's rapidly growing urban areas experience high environmental pressures from air-polluting industries, lung cancer becomes one of the most frequent causes of cancer fatalities – up to 30 percent (OECD, 2014a). Alcohol consumption is increasing at rates above global average (from 3.4 liters per capita annually in 1990 to 5.8 in 2010), which is also attributed to the country's fast economic growth and elevated household income level. To tackle with these problems China has increased its total health expenditure from 4.6% of GDP in 2009 (OECD, 2011) to 5.2% in 2011 (OECD, 2013). This represents a largest absolute increase in health spending among the BRICS countries. Per capita health expenditure also surged from $310 (Global Health Strategies initiatives, 2012) to $432 during the same period (OECD, 2013). Both figures, however, remain far below the OECD average.

China's total foreign assistance expenditure was estimated at $3.9 billion in 2010. However, health spending comprises only a limited amount of that sum. China's health assistance focuses on health infrastructure, human resources development

and malaria control in Africa and South East Asia (Global Health Strategies initiatives, 2012).

South Africa is the largest and the most industrialized economy on its continent. However, it still experiences setbacks in public health due to the legacy of apartheid. Despite the fact that South African spending on medical services is almost 10 times higher than the regional average, inequalities within the country persist – a number of health indicators, such as, access to clean drinking water, sanitation and childcare are significantly lower in rural areas than in urban ones (UNHCO, *Country Profile South Africa*). HIV is a huge problem for South Africa – HIV/AIDS prevalence among adults is one of the highest in the world at 17.3 percent as of 2011 (CIA, n. d.). Infectious diseases are responsible for a majority of deaths in South Africa (UNHCO, *Country Profile South Africa*). The country has the lowest life expectancy among the BRICS countries – 51.6 years (Global Health Strategies initiatives, 2012). In 2000-2012 average life expectancy increased only by one year, compared to the regional average of seven years. In terms of maternal and infant mortality rates South Africa fares much better than its neighbors, but much worse than most of the BRICS members, except India (WHO, 2015b). South African Republic spent 8.5% of GDP on health in 2011 (OECD, 2013). The ratio has been stable since 2009 (OECD, 2011). Per capita health expenditure has risen from $860 in 2009 (OECD, 2011) to $942 in 2011 (OECD, 2013). South African healthcare system faces significant funding gaps, with only 56% of those in need having access to medicines.

However, despite domestic problems South Africa does allocate resources to health assistance – in 2006 it pledged $20 million over 20 years to the GAVI Alliance. The country continues to collaborate on health-related initiatives through IBSA (India, Brazil, South Africa), including a partnership with India in the area of HIV/AIDS, tuberculosis and malaria vaccine research (Global Health Strategies initiatives, 2012).

Similar socioeconomic processes, which have defined the pattern of the BRICS countries' development for several decades, condition a number of common health challenges they face. Among them are: regional inequalities in access to and quality of healthcare, high incidence of non-communicable and lifestyle diseases, and HIV/AIDS. Given these countries' sizeable populations, successful resolution of their domestic healthcare problems would be a significant contribution to global health and development. Shared challenges are a good foundation for consolidating cooperation to help build sustainable national healthcare systems and use the institution potential for domestic political management.

Conclusion

The BRICS recognize the value of their cooperation for resolution of shared challenges. The analysis indicates that the BRICS dialogue on health has positive dynamics. The members have institutionalized their cooperation on health through regular ministerial meetings, adoption of specific action plans and creation of

special working mechanisms and institutions. The dialogue is maturing moving from deliberation to direction-setting and decision-making. The share of the discourse devoted to health is steadily growing. However, commitments are made mainly by the ministers. Engagement with relevant international organizations is limited to the expression of a collective stance on specific issues or support of certain actions and does not include substantive cooperation through consultations and delegation of mandates. To make a tangible contribution to global health governance the BRICS should elevate health agenda to the leaders' level, strengthen decision-making and delivery, and change the mode of their cooperation with relevant institutions from expressing their collective stance to productive cooperation involving the relevant institutions such as the UN and the WHO in the full chain of global governance functions.

With only one leaders' commitment pledging to ensure sexual and reproductive health, the Fortaleza summit has not made a breakthrough in putting health on top of the institution agenda. However, a positive trend can be detected given the highest number of socioeconomic commitments in the BRICS history and a mandate to National Institutes of Statistics and the Ministries of Health and Education to develop joint methodologies for social indicators. This is another small step towards building BRICS cooperation on health and bringing health firmly into the institution agenda.

	Number of commitments							Share of commitments, %						
Issue Area	2009	2010	2011	2012	2013	2014	Total	2009	2010	2011	2012	2013	2014	Total
Energy	5	9	1	2			17	33.33	29.03	2.63	6.25	0.00	0.00	7.36
Finance		3	1			6	10	0.00	9.68	2.63	0.00	0.00	8.82	4.33
Climate change		1	6	3	1	1	12	0.00	3.23	15.79	9.38	2.13	1.47	5.19
Macroeconomic Policy		1	5	1	5	7	19	0.00	3.23	13.16	3.13	10.64	10.29	8.23
Trade		3	5	9	4	4	25	0.00	9.68	13.16	28.13	8.51	5.88	10.82
International Cooperation	1	2	5	3	6	8	25	6.67	6.45	13.16	9.38	12.77	11.76	10.82
Socioeconomic	1	1	3	2		7	14	6.67	3.23	7.89	6.25	0.00	10.29	6.06
Development	1	5	1	3	11	11	32	6.67	16.13	2.63	9.38	23.40	16.18	13.85
Natural disasters	1	1	1				3	6.67	3.23	2.63	0.00	0.00	0.00	1.30
Food and Agriculture	3		1	1		1	6	20.00	0.00	2.63	3.13	0.00	1.47	2.60
Information and Communication			2			1	3	0.00	0.00	5.26	0.00	0.00	1.47	1.30
Science and Education	1	1	1			2	5	6.67	3.23	2.63	0.00	0.00	2.94	2.16
Health			1	1		1	3	0.00	0.00	2.63	3.13	0.00	1.47	1.30
Human rights			1		1	2	4	0.00	0.00	2.63	0.00	2.13	2.94	1.73
Accountability			1				1	0.00	0.00	2.63	0.00	0.00	0.00	0.43
Regional security	1		1	4	8	6	20	6.67	0.00	2.63	12.50	17.02	8.82	8.66
Terrorism			1	1	2	2	6	0.00	0.00	2.63	3.13	4.26	2.94	2.60
Culture		1				3	4	0.00	3.23	0.00	0.00	0.00	4.41	1.73
Sport		1					1	0.00	3.23	0.00	0.00	0.00	0.00	0.43
IFI Reform	1	2	1	2	8	1	15	6.67	6.45	2.63	6.25	17.02	1.47	6.49
Nonproloferation					1		1	0.00	0.00	0.00	0.00	2.13	0.00	0.43
Crime and Corruption						4	4	0.00	0.00	0.00	0.00	0.00	5.88	1.73
Environment						1	1	0.00	0.00	0.00	0.00	0.00	1.47	0.43
Total	15	31	38	32	47	68	231	100	100	100	100	100	100	100

Table 1. BRICS commitments, 2008-2014

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