BRICS: Emergence of Health Agenda*

M. Larionova, M. Rakhmangulov, A. Sakharov and A. Shelepov

Marina Larionova, PhD – Head, International Organisations Research Institute, National Research University Higher School of Economics, 20 Myasnitskaya, 10100 Moscow, Russia; E-mail: mlarionova@hse.ru

Mark Rakhmangulov – Deputy Director, Global Governance Research Centre, International Organisations Research Institute, National Research University Higher School of Economics, 20 Myasnitskaya, 10100 Moscow, Russia; E-mail: mrakhmangulov@hse.ru

Andrei Sakharov – Researcher, Global Governance Research Centre, International Organisations Research Institute, National Research University Higher School of Economics, 20 Myasnitskaya, 10100 Moscow, Russia; E-mail: agsakharov@hse.ru

Andrey Shelepov – Researcher, Global Governance Research Centre, International Organisations Research Institute, National Research University Higher School of Economics, 20 Myasnitskaya, 10100 Moscow, Russia; E-mail: ashelepov@hse.ru

Health is an indispensable public good. At the national level, it has been manifested in the commitment of the BRICS members of Brazil, Russia, India, China and South Africa to scale up health financing. 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 and reducing child and maternal mortality, old risks persist and new challenges emerge, resulting from the 2008 global financial crisis, current sluggish economic growth and growing economic inequality. The BRICS countries face these challenges and have begun cooperation on health issues. They must 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 toward global health governance, this article first considers BRICS cooperation (its institutionalization, discourse and engagement with other international institutions) with a focus on health issues. It then looks into the members' national health systems, challenges and goals. It concludes with expectations of the future BRICS health agenda and its implications for global governance.

Key words: BRICS, global health governance, global governance, commitments, institutionalization, official development assistance, World Health Organization, global public good

Introduction

Health is an indispensable public good. At the national level, it has been manifested in the commitment of the BRICS members of Brazil, Russia, India, China and South Africa as well as the commitment of other countries 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 (MDGs), the increasingly complex global health architecture and a steady expansion of funding for global health in the decade leading up to the 2008 global financial crisis. However, despite successes in fighting infectious diseases and reducing child and maternal mortality, old risks persist and new challenges emerge, resulting from the financial crisis, cur-

* This article draws on the research project on "Elaborating a Supply-Demand Model to Balance External Demand and National Priorities in the Presidency Proposals for Agenda in G20, G8, and BRICS" Project No. 12-03-00563, with financial support from the Russian Research Foundation for Humanities.

rent sluggish 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 (NCDs) is aggravated by demographic decline, unhealthy lifestyles and failure to establish sustainable universal healthcare systems [Bloom, Cafiero, Jané-Llopis et al., 2011, pp. 9–11]. Today, changes in the global landscape have produced five existential challenges for public health actors: the search for sustainable support, the impact of inequitable access to funds on individual health and national health systems, the increasingly obvious mismatch between the structure of global health and its looming priorities, changes in the food supply, and climate change [Garrett, 2013, p. 2].

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

To explore the BRICS capacity to contribute to global health governance, this article first considers BRICS cooperation (its institutionalization, discourse and engagement with other international institutions) with a focus on health issues. It then looks into members' national health systems, their challenges and goals. In conclusion, it asserts that as the BRICS members share common challenges nationally and globally they should build their health agenda accordingly and thus contribute both to national development and to 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 produced since the first meeting in 2008. The documentary evidence base includes 37 documents adopted at the summits and ministerial meetings. (From 2008 to July 2014, there were 10 summits, 43 ministerials and 27 meetings in other formats.) The data were used within several parameters. First, to explore the dynamics of institutionalization, the data on the number of meetings and documents adopted on the ever expanding BRICS agenda were compared.

Second, to compare the relative significance and dynamics of priorities, content analysis was carried out on 11 broad policy areas on the BRICS agenda. For this analysis, a text unit could be counted as implementing only one priority or uncategorized. Absolute data on the number of characters denoting a particular priority were translated into relative data calculated as the share of the priority in the total of all texts and is expressed in percentages. The comparative assessment was based on the relative data of a priority's share in the total discourse.

Third, to assess BRICS capability for global governance, the study traced the institutional performance of the global governance functions of deliberation, direction setting, decision making, delivery and the development of global governance. Deliberation was understood as face-to-face discussions among the members encoded in the collective communiqués. Direction setting was defined as the 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. The development of global governance was defined as the capability of the

BRICS to use other international institutions and create its own institutions as global governance mechanisms [Kirton, 2013, 37–39].

In the content analysis, a text unit could count as implementing only one function. Absolute data on the number of characters denoting a certain function in the text were translated into relative data calculated as the share of the function in the total of all texts and expressed in percentages. The comparative analysis of the performance of global governance functions used the relative data of that function's share of the total or annual discourse.

On the function of global governance development, the data on the share of discourse was substantiated by such indicators of 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 assessed 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 this study, however, another dimension is considered. BRICS actions that respond to a member's long-term priorities may reap social and economic benefits, and are regarded as domestic political management.

The Evolution of BRICS Institutionalization and Health Dialogue

The first BRIC meeting (South Africa not being a member until 2012) took place on the sidelines of the Hokkaido Summit of the Group of Eight (G8) in 2008. The leaders agreed on further coordination on economic problems, including financial issues and food security. Since then the institution's collaborative dynamics have been constantly increasing. BRICS finance ministers and central bank governors now meet regularly. At their first meeting, in São Paulo on 7 November 2008 just before the meeting of the finance ministers and central bank governors of the Group of 20 (G20), the BRIC ministers and bank governors discussed possible scenarios of the developing financial crisis and their countries' policy responses; they 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, the finance ministers met twice to coordinate positions in the G20. On the eve of the G20 finance ministerial in Horsham in the United Kingdom in 2009, BRIC finance ministers called for a study of the development in the international monetary system, including the role of reserve currencies and reform of the international financial institutions (IFIs). A few months later in London, the finance ministers and central bank governors set a target of 7% for the redistribution of quotas in the International Monetary Fund (IMF) and World Bank in favour of developing countries. A practice of meetings to coordinate 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. By July 2014, 14 meetings had taken place and five documents had been released. Together with the format of cooperation at the level of ministers and deputy ministers of foreign affairs, which began before 2008, finance ministerial meetings have become an important component of coordinating the financial and economic agenda and preparing for BRICS summits.

With regard to agriculture and food security, the direction set out in the joint statement on global food security issued at the Yekaterinburg Summit in 2009 were elaborated in the 2010 Moscow declaration of the agriculture ministers on quadrilateral cooperation with particular attention to family farming. Although only three agriculture ministers meetings have taken place, elements of accountability in this sphere have been established, a working group has been created, working procedures for cooperation have been agreed upon, the BRICS Strategic Alliance for Agricultural Research and Technology Cooperation has been established and the Action Plan for cooperation in 2012–16 has been adopted.

Cooperation among trade ministers began in 2011. Since then seven meetings have taken place, including two joint meetings with economy ministers. A contact group for developing an institutional framework and concrete measures to expand economic cooperation both among the BRICS countries and between the BRICS and other developing countries was announced in the 2011 Geneva declaration. The Strategy for the BRICS Economic Cooperation has been drafted and is a subject of consultation among relevant stakeholders.

Health 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, 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, 2011]. By the time of Fortaleza Summit in 2014, three standalone health ministers' meetings had been held, as well as three meetings on the sidelines of the annual World Health Assembly (WHA) in Geneva, each issuing a communiqué.

At their first meeting on 11 July 2011, BRICS health ministers issued the Beijing declaration emphasizing the importance of cooperation in the area of public health both within the BRICS members and with other countries and international institutions. Highlighting the central role of the World Health Organization (WHO), they stressed the need for its reform. The declaration contained 13 commitments on different aspects of public health, 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 NCDs, particularly HIV, tuberculosis, 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 Fight AIDS, Tuberculosis and Malaria to increase access to medicines and vaccines. Recognizing the responsibility for improving health systems in poor 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 health ministers agreed to institutionalize their dialogue on a permanent basis and agreed to appoint 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 setting up a technological cooperation network. They decided to consider holding their next meeting in September 2011 in conjunction with the United Nations High Level Meeting on Non-communicable Diseases. 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 report presented by Bill Gates [2011] to the G20 leaders at the 2011 Cannes Summit, which stressed the role of rapidly growing countries such as the BRICS members in promoting development and strengthening public health. This statement was especially important as by early 2011 global health funding was dominated by the Gates Foundation and the U.S. government [Jenks, Jones, Tortolani et al., 2013, p. 71]. The emergence of the BRICS as an actor in global health governance was considered an opportunity to reduce the vulnerability of global health financing being dependent on a single source or country.

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 public health priorities of their countries such as ensuring universal access to health services, providing access to health technologies including medicines, reducing costs, and managing the growing burden of both communicable and non-communicable diseases. In this regard they supported the institutionalization of their health ministers' meetings in order to address "common challenges in the most cost-effective, equitable and sustainable manner" [BRICS, 2012].

The intention of holding the next BRICS health ministers meeting on the sidelines of the NCD high-level meeting was not realized. However, cooperation on health issues among the BRICS permanent representatives in Geneva was launched as agreed in Beijing. On 22 May 2012, the health ministers of Brazil, China and South Africa, India's secretary of health and family welfare and the Russian permanent representative to the UN in Geneva met on during the 65th session of the WHA. They reiterated the importance of technology transfers to strengthen capacity in developing countries, discussed the role of generic medicines in promoting universal right to health, and committed to cooperate in research and innovation to improve public health systems. The technical working group meeting was announced, to be held within months to discuss plans to advance cooperation and establish a technological cooperation network responsible for moving forward joint work on such priorities as "food, pharma, health and energy as well as basic research in the emerging inter-disciplinary fields of nanotechnology, biotechnology, advanced materials science, etc." [BRICS, 2012].

The BRICS representatives agreed to identify thematic areas for each country to discuss and promote. 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 [see BRICS health ministers, 2012].

As agreed in the Delhi Action Plan adopted on 29 March 2012 [BRICS, 2012], the second standalone BRICS health ministers' meeting was held on 10–11 January 2013 in 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 biotechnology for health benefits; and contribute to the achievement of health-related MDGs. They reiterated the priority of technology transfer "as a means to empower developing countries" [BRICS health ministers, 2013a]. Finally, the ministers reaffirmed their commitment to set up a BRICS network of technological cooperation [BRICS health ministers, 2013a]. Most of the Beijing commitments were confirmed by the BRICS health ministers at Delhi.

In line with the mechanism agreed to in Geneva, the BRICS representatives identified thematic areas for further discussion and elaboration of the final communiqué in the reports presented in the first day of the meeting [ANI News, 2013]. These main thematic areas included strengthening health surveillance systems; reducing NCD risk factors through prevention, health promotion and universal health coverage; strategic health technologies, with a focus on communicable and non-communicable diseases; medical technologies; and the invention and development of drugs [Pandey, 2013]. Renewed commitments on the technical working group and technological cooperation network indicated that there was scope for further progress on these issues. Nevertheless, notwithstanding slow progress and the absence of financial commitments, BRICS cooperation on health was welcomed by Michel Sidibé, executive director of UNAIDS. Addressing the meeting participants, he 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 BRICS members, health was not on top of the agenda under the 2013 South African presidency. At the Durban Summit, the leaders just noted the meetings of health ministers in Geneva and Delhi and agreed to continue holding ministerials and preparatory meetings [BRICS, 2013].

In May 2013, the BRICS permanent representatives held their second meeting at the 66th session of the WHA, thus setting the precedent for meeting regularly. In a joint communiqué, they reiterated the technical working group's focus on the five thematic areas, including, inter alia, strengthening health surveillance systems and reducing NCD risk factors. They also discussed the WHO report on Monitoring Achievements of the Millennium Development Goals and agreed that, despite the progress being made, much needs to be done if health-related MDGs were to be achieved by 2015. The health ministers [2013b] stressed their resolve to "jointly promote access to affordable, safe, efficacious and quality medical products through the use of TRIPS [Agreement on Trade-Related Aspects of Intellectual Property Rights] flexibilities" and reiterated their traditional commitment to support 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 country capacity in the area of public health.

As mandated by their leaders, the BRICS health ministers gathered on 6–7 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, 2013c]. In the absence of progress on establishing the network of technological cooperation, the ministers gave it another push. They also adopted the BRICS Framework for Collaboration on Strategic Projects in Health. Some joint strategic projects were proposed by the ministers in their statements following the meeting. The Indian Minister of Health and Family Welfare, Shri Ghulam Nabi Azad, mentioned several such initiatives: "management of Non-Communicable Diseases, Medical Education, Pharmaceutical Sector, traditional medicines, Health Research and ... management of communicable disease like HIV, TB [tuberculosis] and Malaria" [India, Ministry of Health and Family Welfare, 2013]. With regard to global health governance, the ministers reaffirmed the WHO's central role in promoting global health, emphasized the importance of supporting maternal and child health, and called on the UN member states to "give due consideration to health as an important issue in the discussions of the post-2015 development agenda" [BRICS health ministers, 2013c].

The dynamics of BRICS institutionalization has been high. By July 2014, 80 meetings had taken place. Alongside the summits and the foreign and finance ministers' meetings, there are 14 formats, including health ministers, statistical offices, development banks and antimonopoly agencies. BRICS members have produced almost 40 documents on their constantly broadening agenda. There is a trend of increasing the number of standalone meetings, releasing more documents, and creating more working groups and other mechanisms of coordination.

This general tendency for rapid institutionalization is also observed on the health agenda. Three of six meetings were standalone ones. 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. With six meetings on health resulting in six documents, the quality of health dialogue is relatively high. Moreover, the number of meetings on health is the fourth highest of all the BRICS formats, after the foreign ministers, the finance ministers and central bank governors, and the leaders themselves.

The Place of Health in the BRICS Discourse

In line with the dynamic of institutionalization, health's share of the BRICS discourse has been expanding.

Despite the fact that the BRICS is frequently assessed by experts and practitioners as a political forum, economy (24% of the discourse) and finance (more than 20%) dominate the agenda. Members themselves see the BRICS [2011] 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 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 several crisis situations in the Middle East, North and West Africa need to be addressed. Dialogue on development is strengthening, particularly under the 2014 Brazilian presidency. In 2011 the 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 were also included in the agenda. Thus in 2011 BRICS members reaffirmed their intention to strengthen their cooperation in order to reach agreements in the framework of the Durban climate change conference, and to enhance practical cooperation on economic and social adaptation to climate change. Cooperating on trade and investment 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 the dialogue on health, its share in the discourse has been growing steadily, reaching the average of 9.37% of the total (see Figure 1).

However, the rapid pace of the institutionalization of the health dialogue has not yet been translated into real deliverables for global health governance, although the discourse has gradually been shifting from sheer deliberation to decision making.

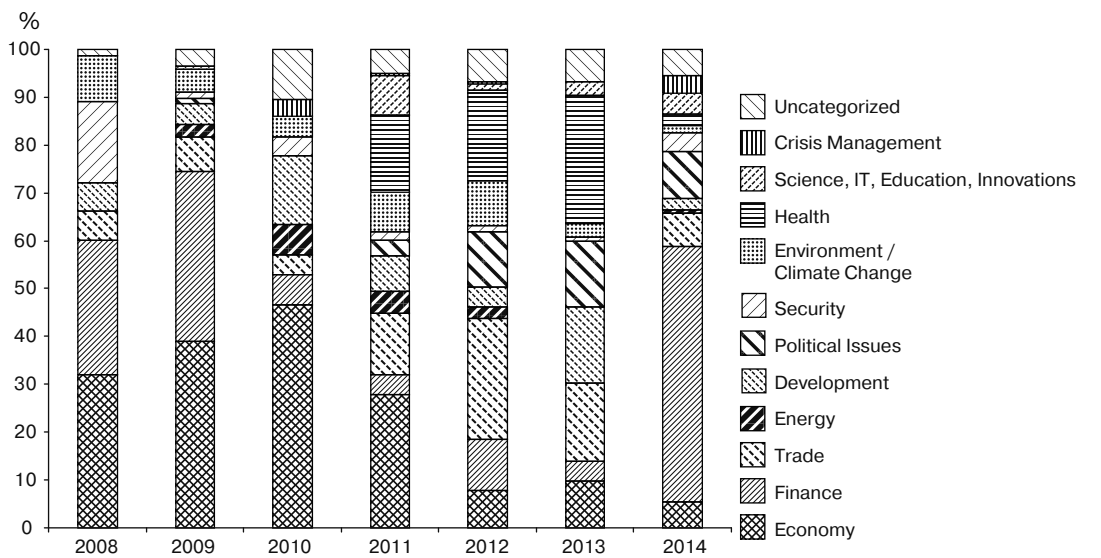

Figure 1. BRICS Priorities, 2008–14, % of characters

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

As the BRICS has matured, the balance of the functions of global governance – deliberation, direction setting, decision making, delivery and the development of global governance – in the BRICS documents has changed.

Overall, while the deliberation share has been declining, the shares of delivery and decision making have been rising. The 2008 documents are dominated by deliberation (46%) and direction setting (almost 49%), 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 decision making continued to grow and reached 38.6% in 2011. Dropping to 21% in 2012, the share of decision making constituted 25%, and jumped to almost 62% in 2014. The share of delivery increased from 1.76% in 2009 to 4.01% in 2013 and dropped to 0.4% in 2014. Deliberation and direction setting shares have declined to 17% and 21% of the 2014 discourse respectively.

The high proportion of the development of global governance in 2010 reflects the BRIC efforts to facilitate the reform of the IMF and World Bank to shift voting power to emerging economies and developing countries. In addition, the dialogue on concrete steps to establish regional currency arrangements among the BRIC countries was launched that year. BRIC members agreed to create agricultural information base system and initiated a number of new sectoral initiatives: cooperation through development banks, statistical institutions and competition authorities, as well as the 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 have been rising. In 2013 for the first time the BRICS health ministers reported delivery on previously made commitments. The relatively stable share of the global governance development reflects the BRICS efforts to further institutionalize the health dialogue through the establishment of the technical working group and the network of technological cooperation. The dynamics of the global governance functions in the whole BRICS discourse and discourse on health are compared in Figure 2.

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

Despite the high dynamics of the BRICS health dialogue and its expanding share in the discourse, the number of concrete commitments made by the leaders at their summits remains low (see Figure 3). At Sanya, they committed to strengthen their dialogue and cooperation on public health [BRICS, 2011]. At Delhi, they 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 of them [BRICS, 2012]. Thus, by July 2014, the BRICS leaders had made

[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/compliance).

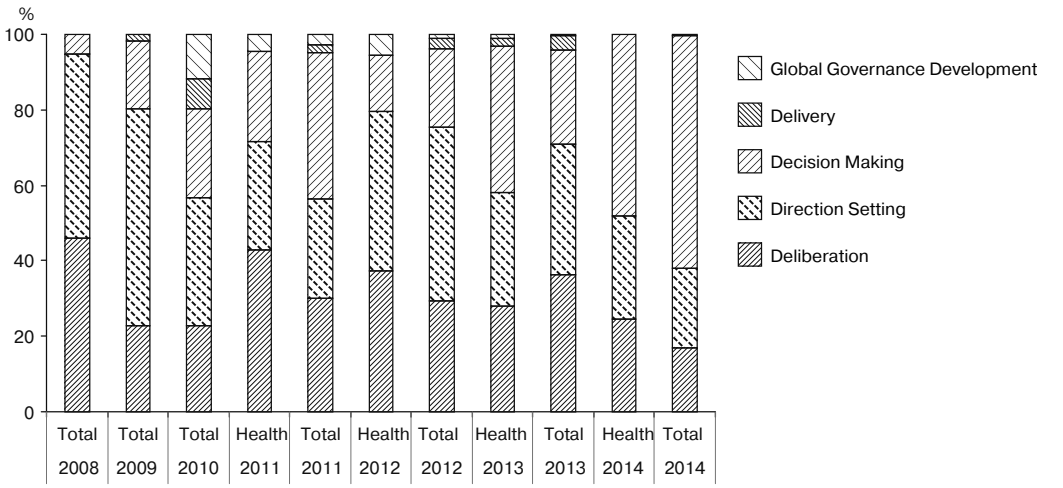

Figure 2. Comparison of BRICS Global Governance Functions on Health and in General

only two commitments on health issues, which constitutes 1.23% of the total BRICS commitments – one of the lowest figures among all major issue areas. At the same time, the number of commitments in other areas has been consistently increasing. Overall, the 2009 joint statement contained 15 commitments, and 31 commitments were made at Brasilia in 2010. The agenda considerably expanded, and in 2011 the number of commitments 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 IFI reform were made at each summit. The BRICS also regularly makes commitments on energy, climate change, macroeconomic policy, regional security and terrorism. One or two commitments were made in areas that are less conventional for the BRICS agenda, such as information and communication technologies, human rights, accountability, culture, sport and nuclear non-proliferation.

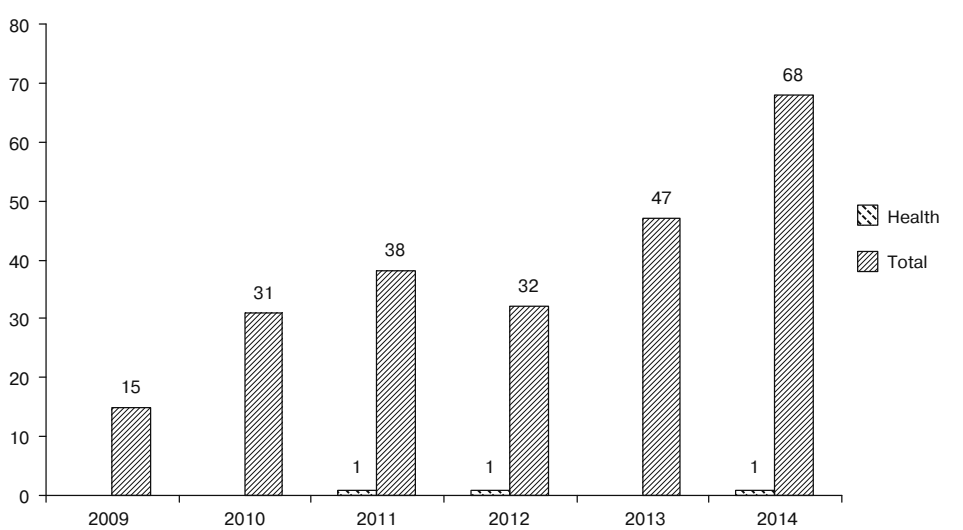

Figure 3. BRICS Commitments, 2008–14

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

The analysis of the performance on the development of global governance was substantiated by the number of references to international organizations in the BRICS documents. There were references to 42 such institutions (see Figure 4). BRICS members consistently emphasized their commitment to multilateral diplomacy and cooperation with international and regional organizations. The most frequently mentioned institution was the UN, whose central role was stressed in addressing global challenges and threats. The BRICS called for a comprehensive reform of the UN, including the Security Council. The G20 comes second in number of references, which is not surprising given that the BRICS members coordinate their positions on the G20 priorities. Since the reform of the Bretton Woods institutions remains 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. In 2009, there were 65 references, which dropped to 31 in 2010, but then doubled in 2011 to 61. It fell again to 54 in 2012 and peaked at 104 during the South African presidency.

On health, the intensity of the BRICS engagement with international institutions is very stable. Between 2009 and July 2014 there were 39 references to WHO. The number of references to other institutions involved in health governance, particularly the UN, grew steadily. Thus, health is an area where the BRICS countries actively cooperate with other relevant international institutions contributing to developing global health governance.

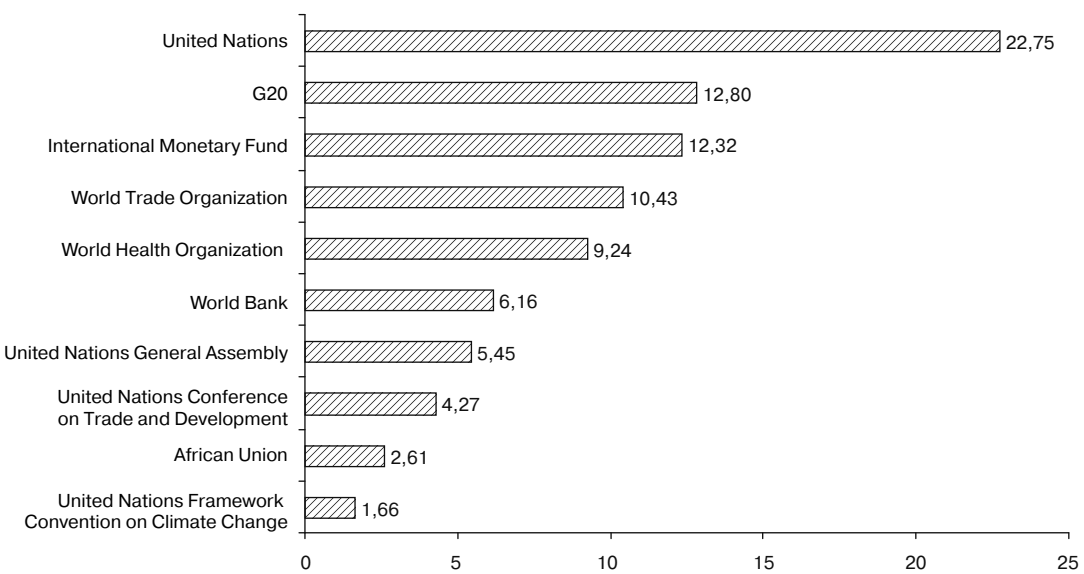

Figure 4. References to International Institutions in BRICS documents, 2009–14, %

However, BRICS coordination with multilateral institutions differs considerably from the engagement of the G8 and the G20 with international organizations. G8/G20 engagement is characterized by three types of interactions: cooperation, delegated mandates to implement decisions made at summits, and support of international institutions' actions or expression

of a collective stance on specific issues. The BRICS practises only the third type. Up to July 2014, there have been no cases of BRICS cooperation with international organizations, and no BRICS documents contained any mandates.

To enhance their impact on the global health agenda, BRICS members should strengthen their cooperation with international and regional institutions, including through consultation, substantial support of their actions and the possible delegation of mandates to implement commitments.

BRICS Health Agenda: A Case for Domestic Political Management

The BRICS countries are critical stakeholders in globalization and global public goods including health [Jenks, Jones, Tortolani et al., 2013, p. iv]. However, they still face significant health challenges of their own. Hence decisions aimed at building their national health systems capacities through intra BRICS cooperation dominate their discussions. Without avoiding the responsibility for participation in global health governance, the BRICS would make a major contribution to the global public good of health by ensuring effective, innovative and inclusive national health systems. Despite increasing health expenditures, scaling up innovation and cooperation in recent years, the BRICS countries lag behind the average of the members of the Organisation for Economic Co-operation and Development (OECD) in many aspects of health care, such as access to medical goods and services, and inpatient and outpatient care.

Notwithstanding its recent rapid economic expansion, Brazil continues to suffer from the ramifications of inequalities. The disproportionate regional and ethnic concentration of poverty significantly limits the access of vulnerable groups (such as black population in the northeast region of the country) to quality healthcare and undermines their nutritional security. In addition, Brazil is combating the spread of infectious diseases as HIV/AIDS, malaria and tuberculosis, as well as NCDs such as diabetes and cardiovascular disease. Lifestyle issues such as obesity and alcohol or substance abuse have become prominent in Brazil as well. The country has also been subject to frequent outbreaks of yellow fever and dengue [United Healthcare Organization (UNHCO), 2012a]. 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 gross domestic product (GDP) [OECD, 2013, p. 157]. Per capita health expenditure rose from $940 in 2009 to $1,043 in 2011, which within the BRICS was second only to Russia [OECD, 2013, p. 155; Global Health Strategies initiatives (GHSi), 2012, p. 14]. However, it is still far below the OECD average of $3,322 [OECD, 2013, p. 155]. A constitutional obligation in domestic policy, health care 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) [GHSi, 2012, p. 6]. Brazil mainly engages in technical assistance on such issues as HIV/AIDS prevention and treatment, food security, and access to health care in South America, the Caribbean and lusophone countries drawing on its national experience [GHSi, 2012].

Russia's population has been in decline since 1992, when it peaked at 148.3 million. 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, and continues to have a negative impact on life expectancy, especially for men of working age. A large number of deaths from external causes are linked to alcohol consumption and unhealthy lifestyles. The figures for deaths caused both by non-communicable (including cardiovascular) and communicable dis-

eases (parasitic and infectious, including tuberculosis) have increased since 1990. The number of deaths caused by circulatory diseases increased from 618.7 per 100,000 people in 1990 to 801 in 2009 [Popovich, Potapchik, Shishkin et al., 2011, p. 11]. The death toll from communicable diseases 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 [Popovich, Potapchik, Shishkin et al., 2011, p. 11]. 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, Potapchik, Shishkin et al., 2011, p. 11]. HIV/AIDS remains a threat – in 2011 there were 67,317 new cases of HIV/AIDS reported, 4,736 more than the year before [WHO, Regional Office for Europe 2013; United States Central Intelligence Agency (CIA) , 2014]. Russia spent 6.2% of its GDP on health in 2011 [OECD, 2013, p. 157] – an improvement over 5.4% in 2009 [OECD 2011, table 7.2)]. Substantially behind Brazil (8.9%) and South Africa (8.5%) in 2011, as well as the OECD average of 9.3%, at $1,316 Russia still has the highest per capita health expenditure among the BRICS countries [OECD, 2013, pp. 157, 155]. This figure has risen since 2009, when it amounted to $1,040 [GHSi, 2012, p. 14]. However, it is just about one third of the 2013 OECD average.

Health is one of the priorities for Russia's international assistance. Between 2007 and 2011 more than 28% of Russia's official development assistance (ODA) was disbursed in this sphere (authors' calculation). However, the level of health spending is uneven, ranging from $104.2 million in 2007 (50% of total ODA) to $61.2 million in 2011 (13%) [G8, 2012, p. 46; 2013].

India underwent extraordinary socioeconomic and demographic changes during the second part of the 20th century. Its total population almost tripled, while urban population increased 4.6-fold between 1951 and 2001 [WHO, 2013]. Despite admirable progress in addressing communicable diseases such as polio, changes in Indian society and lifestyles led to a surge in NCDs, already responsible for about 53% of all deaths. Inequality is also 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 1,000 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, 2013]. 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, p. 157]. This indicator has experienced a decline since 2009, when it amounted to 4.2% of GDP [OECD, 2011, table 7.2]. India also has the lowest per capita health expenditure among the BRICS countries – $141 in 2011, a small improvement over the 2009 result of $130 [OECD, 2013; GHSi, 2012, p. 14].

Facing serious challenges at home, India does not prioritize health on its foreign development assistance agenda. Health assistance amounts to a small fraction of the total foreign development assistance expenditure (approximately $680 million in 2010) and includes a limited number of bilateral projects focused on infrastructure, human resources, capacity building and education [GHSi, 2012, p. 8].

China has experienced strong productivity and economic growth, significant demographic change and socioeconomic transformation since the launch of its 1978 reforms. The country has made great progress in improving people's health, particularly in the control of communicable diseases [WHO, 2014]. 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, 2014]. Despite 30-fold rise in health spending over the last 20 years [OECD, 2013], changing lifestyles resulted in a sharp increase in deaths caused by NCDs, namely malignant neoplasms, heart diseases, cerebrovascular diseases and chronic lung dis-

eases, 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, 2014]. China has increased its total health expenditure from 4.6% of GDP in 2009 to 5.2% in 2011 [OECD, 2011, table 7.2; 2013, p. 157]. This represents the largest absolute increase in health spending among the BRICS countries. Per capita health expenditure also surged from $310 to $432 during the same period [GHSi, 2012, p. 14; OECD, 2013, p. 155]. Both figures, however, remain far below the OECD average.

China's total foreign assistance expenditure was estimated at $3.9 billion in 2010 [GHSi, 2012, p. 9]. 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 [GHSI, 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, 2012b]. HIV is a huge problem for South Africa – HIV/AIDS prevalence among adults was one of the highest in the world at 17.3 percent in 2011 [CIA, 2014]. Infectious diseases are responsible for a majority of deaths in South Africa [UNHCO, 2012b]. The country has the lowest life expectancy among the BRICS countries – 51.6 years [GHSi, 2012, p. 14]. South Africa spent 8.5% of its GDP on health in 2011, a rate that has been stable since 2009 [OECD, 2013, p. 157; 2011, table 7.2]. Per capita health expenditure has risen from $860 in 2009 to $942 in 2011 [OECD, 2013, p. 155; GHSi, 2012, p. 6]. The South African healthcare system faces significant funding gaps, with only 56% of those in need having access to medicines [GHSi, 2012, p. 75].

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 [GHSi, 2012, p. 75]. 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 [GHSi, 2012].

Similar socioeconomic processes, which have defined the pattern of the BRICS countries' development for several decades, affect a number of common health challenges. Among them are regional inequalities in access to and quality of health care, high incidence of noncommunicable and lifestyle diseases, and HIV/AIDS. Given the sizeable populations of these countries, the successful resolution of their domestic healthcare problems would contribute significantly 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 members recognize the value of their cooperation to resolve their shared challenges. The analysis in this article indicates that their dialogue on health has positive dynamics. Members have institutionalized their cooperation on health through regular ministerial meetings, adoption of specific action plans and the creation of special working mechanisms and in-

stitutions. 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 ministers. The implementation of global governance development function is limited to the expression of a collective stance on specific issues together with other international organizations and does not include substantive cooperation through the delegation of mandates. To contribute substantially to global health governance, the BRICS should elevate health agenda to the leaders' level, strengthen decision making and delivery, and change the pattern of members' cooperation with relevant institutions from the expression of a collective stance to productive cooperation that involves relevant institutions such as the UN and WHO in the full chain of global governance functions.

With only one leaders' commitment pledging to ensure sexual and reproductive health, the 2014 Fortaleza Summit did not make a breakthrough by putting health on the top of its agenda [BRICS, 2014]. However, a positive trend is evident by the highest number of socioeconomic commitments in BRICS history and a mandate to members' national institutes of statistics and the ministries of health and education to develop joint methodologies for social indicators. This is another small step toward building BRICS cooperation on health and bringing health firmly into the institution agenda.

Table 1. BRICS commitments, 2008–14

Issue Area	Number of commitments							Share of commitments, %						
	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
Nonproliferation					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

References

ANI News (2013) Second BRICS health ministers' meet begins in Delhi. 10 January. Available at: http://www.aninews.in/newsdetail2/story93803/second-brics-health-ministers-039-meet-begins-in-delhi.html (accessed 26 November 2014).

Bloom D., E. T. Cafiero, E. Jané-Llopis et al. (2011) The global economic burden of noncommunicable diseases. September. Geneva: World Economic Forum. Available at: http://www3.weforum.org/docs/WEF_Harvard_HE_GlobalEconomicBurdenNonCommunicableDiseases_2011.pdf (accessed 26 November 2014).

BRICS (2011) Sanya declaration. Sanya, 14 April. Available at: http://www.brics.utoronto.ca/docs/110414-leaders.html (accessed 26 November 2014).

BRICS (2012) Fourth BRICS summit: Delhi declaration. Sanya, 29 March. Available at: http://www.brics.utoronto.ca/docs/120329-delhi-declaration.html (accessed 26 November 2014).

BRICS (2013) BRICS and Africa: partnership for development, integration and industralisation. Durban, 27 March. Available at: http://www.brics.utoronto.ca/docs/130327-statement.html (accessed 26 November 2014).

BRICS (2014) The 6th BRICS summit: Fortaleza declaration. Fortaleza, Brazil, 15 July. Available at: http://www.brics.utoronto.ca/docs/140715-leaders.html (accessed 26 November 2014).

BRICS health ministers (2011) BRICS health ministers' meeting: Beijing declaration. Beijing, 11 July. Available at: http://www.brics.utoronto.ca/docs/110711-health.html (accessed 26 November 2014).

BRICS health ministers (2012) Joint communiqué of the BRICS member states on health. Geneva, 22 May. Available at: http://www.brics.utoronto.ca/docs/120522-health.html (accessed 26 November 2014).

BRICS health ministers (2013a) BRICS health ministers' communiqué. Delhi, 11 January. Available at: http://www.brics.utoronto.ca/docs/130111-health.html (accessed 26 November 2014).

BRICS health ministers (2013b) Joint communiqué of the BRICS member states on health on the sidelines of the 66th WHA. Geneva, 20 May. Available at: http://www.brics.utoronto.ca/docs/130520-health.html (accessed 26 November 2014).

BRICS health ministers (2013c) Third health ministers meeting: Cape Town communiqué. Cape Town, 7 November. Available at: http://www.brics.utoronto.ca/docs/131107-health.html (accessed 26 November 2014).

G8 (2012) Camp David accountability report: actions, approach, results. 19 May. Available at: http://www.g8.utoronto.ca/summit/2012campdavid/g8-cdar.html (accessed 26 November 2014).

G8 (2013) Lough Erne accountability report – data tables. ODA for health, 2008-11. 17 June. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/207289/Figure_3.1___3.2_G8_ODA_for_health__2008-11.csv/preview (accessed 26 November 2014).

Garrett L. (2013) Existential challenes to global health. August. Center on International Cooperation, New York University. Available at: http://cic.nyu.edu/sites/default/files/garrett_challenges_global_health.pdf (accessed 26 November 2014).

Gates B. (2011) Executive summary: a report by Bill Gates to G20 leaders. November. Bill and Melinda Gates Foundation. Available at: http://www.gatesfoundation.org/What-We-Do/Global-Policy/G20-Report (accessed 26 November 2014).

Global Health Strategies initiatives (2012) Shifting paradigm: how the BRICS are reshaping global health and development. New York, Available at: http://www.ghsinitiatives.org/downloads/ghsi_brics_report.pdf (accessed 26 November 2014).

India. Ministry of Health and Family Welfare (2013) Year End Review. New Delhi, 31 December. Available at: http://pib.nic.in/newsite/PrintRelease.aspx?relid=102221 (accessed 26 November 2014).

Jenks B., B. Jones, B. Tortolani and A. Kubitschek Bujones (2013) United Nations development at a crossroads. Center on International Cooperation, New York University, August. Available at: http://cic.nyu.edu/content/united-nations-development-crossroads (accessed 26 November 2014).

Kirton J. J. (2013) *G20 governance for a globalized world*. Farnham: Ashgate.

Organisation for Economic Co-operation and Development (2011). Health at a glance 2011: OECD indicators. Paris. doi: 10.1787/health_glance-2011-en.

Organisation for Economic Co-operation and Development (2013). Health at a glance 2013: OECD indicators. Paris. doi: 10.1787/health_glance-2013-en.

Pandey K. (2013) BRICS nations discuss ways to achieve health goals through collaboration. New Delhi: Society for Environmental Communications, 10 January. Available at: http://www.downtoearth.org.in/content/brics-nations-discuss-ways-achieve-health-goals-through-collaboration (accessed 26 November 2014).

Popovich L., E. Potapchik, S. Shishkin et al. (2011) Russian Federation: health system review. *Health Systems in Transition* 13(7), pp. 1-190. Available at: http://www.euro.who.int/__data/assets/pdf_file/0006/157092/HiT-Russia_EN_web-with-links.pdf (accessed 26 November 2014).

Stuenkel O. (2013) Does intra-BRICS cooperation make sense? The case of public health. *Post-Western World* [blog], 27 May. Available at: http://www.postwesternworld.com/2013/05/27/does-intra-brics-cooperation-make-sense-the-case-of-public-health (accessed 26 November 2014).

UNAIDS (2013) BRICS ministers of health call for renewed efforts to face HIV and global health challenges. Geneva, 11 January. Available at: http://www.unaids.org/en/resources/presscentre/featurestories/2013/january/20130111brics (accessed 26 November 2014).

United Healthcare Organization (2012a) Country profile Brazil. Available at: http://www.unhco.org/country-profile-brazil (accessed 20 February 2014).

United Healthcare Organization (2012b) Country profile South Africa. Available at: https://web.archive.org/web/20131015185255/http://www.unhco.org/country-profile-south-africa/ (accessed 26 November 2014).

United States Central Intelligence Agency (2014) Country comparison: HIV/AIDS – adult prevalence rate. Washington DC, Available at: https://www.cia.gov/library/publications/the-world-factbook/rankorder/2155rank.html (accessed 26 November 2014).

World Economic Forum (2014) Global risks 2014, ninth edition. Geneva. Available at: http://www3.weforum.org/docs/WEF_GlobalRisks_Report_2014.pdf (accessed 26 November 2014).

World Health Organization (2013) Country cooperation strategy at a glance: India. WHO/CCU/13.01/India. Geneva. Available at: http://www.who.int/countryfocus/cooperation_strategy/ccsbrief_ind_en.pdf (accessed 26 November 2014).

World Health Organization (2014) Country cooperation strategy at a glance: China. WHO/CCU/14.03/China. Geneva. Available at: http://www.who.int/countryfocus/cooperation_strategy/ccsbrief_chn_en.pdf (accessed 26 November 2014).

World Health Organization. Regional Office for Europe (2013) Key effects on HIV epidemic in Russian Federation and progress in 2011. Copenhagen, Available at: http://www.euro.who.int/__data/assets/pdf_file/0004/188761/Russian-Federation-HIVAIDS-Country-Profile-2011-revision-2012-final.pdf (accessed 26 November 2014).