Institutional Overlap and Access to Medicines in MERCOSUR and UNASUR (2008-2018). Cooperation before the Collapse?

Andrea C. Bianculli

Institut Barcelona d'Estudis Internacionals (IBEI)

orcid.org/0000-0003-1352-1772

@Andre_Bianculli; https://www.linkedin.com/in/andrea-c-bianculli-99181b2/

Andrea Ribeiro Hoffmann

Instituto de Relações Internacionais, Universidade Católica do Rio de Janeiro (PUC-Rio)

orcid.org/0000-0001-5866-3817

Beatriz Nascimento

Escola Nacional de Saúde Pública Sergio Arouca

Fundação Oswaldo Cruz (ENSP/Fiocruz)

orcid.org/0000-0002-2397-5244

Abstract

The proliferation of international and regional organizations in the last decades led to increasing overlap of memberships and mandates in social policy areas. Whereas the literature has explored the benefits and perils of institutional overlap though neglecting the social policy dimension of such processes, studies on regionalism have focused on single cases of regional organizations. This paper breaks new ground by examining the effects of the overlap in membership, health mandates and institutional mechanisms between the Common Market of the South (MERCOSUR) and the Union of South American Nations (UNASUR) between 2008 and 2018. It focuses on two cases of access to medicines: the creation of the medicine price bank and the price negotiation of high-cost medicines. Our argument is that the overlap was positive, leading to an incipient trend towards cooperation. This was facilitated by the membership structure, the expertise already accumulated in the region and the relations and networks among those involved in health regional cooperation. In all, the article deepens our understanding of the conditions under which regional organizations, even in the context of institutional overlap, can contribute to adequately respond to transnational challenges, which, as global health, are not only persistent, but also profoundly affect our societies.

Keywords

Global health, regionalism, institutional overlap, MERCOSUR, UNASUR

Introduction

Regional cooperation in health has a long tradition in Latin America.[1] However, the regionalism literature has tended to disregard the area of social policies in general, and particularly, health, until very recently. With the turn of the century, the renewed cooperation in the region under centre-left leaning governments stimulated new practices and arrangements in the governance of regional social policy cooperation.

In South America, MERCOSUR was transformed from a (liberal) trade bloc into a multisectoral organization within a new paradigm of development in which social policies, such as health, became a significant dimension in the early 2000s. From about 2015 onwards, priorities were once again towards strengthening economic and trade relations based on flexibility and openness to international markets following the change in governments to the right in Argentina and Brazil, with the election of Mauricio Macri in 2015, and the impeachment of Dilma Rousseff in 2016, and subsequent election of Jair Bolsonaro in 2018, respectively. UNASUR was created in 2008 in a context of change in Latin American regionalism, which resulted from several factors including the global financial and economic crisis of the early 2000s and the surge of the 'left turn'. Differently from MERCOSUR, UNASUR never included trade liberalization as a strategy to development, and started its activities based on a broader definition of development. UNASUR adopted a strong agenda in social policy from the beginning, including health. Most significantly, it established the South American Institute of Government in Health (ISAGS) in 2010, with a permanent seat in Rio de Janeiro. UNASUR activities were abruptly discontinued with the stalemate caused by the inability of its member states to appoint a new Secretary General in February 2017, when Ernesto Samper left this position, in a context of polarization mainly over how to deal with the crisis in Venezuela. By the end of 2019 most of UNASUR member states started the withdrawal process from its treaty, and ISAGS was shut down in June 2019.

Before its collapse, UNASUR shared with MERCOSUR a mandate on health, a phenomenon which is not uncommon in regionalism and regional organizations (Van Langenhove, 2012). However, the proliferation of regional organizations and overlap of mandates has not been explored in depth, and existing studies on overlap show no consensus regarding its effects on regional cooperation. Malamud (2013) argued that the creation of UNASUR was part of a Brazilian strategy to project its power in the region, thereby weakening MERCOSUR.[2] With a focus on trade and economic relations, Gómez-Mera (2015) advanced that the proliferation of regional organizations and arrangements led to legal fragmentation and rule ambiguity by facilitating cross-institutional political strategies that enabled states to behave opportunistically. On a more positive note, Riggirozzi and Tussie (2012) claimed that institutional proliferation was a multifaceted and dynamic process allowing for new mixes and forms of cooperation across different policies. In a similar vein, Sanahuja (2010) saw institutional overlap as opening the door to variable geometry, which adds to the idea that it enables more flexibility to respond to regional and international changing conditions (Herz, 2013).

The concept of 'overlapping regionalism' was systematically analysed through more robust analytical frameworks (Nolte, 2014, 2018; Panke & Stapel, 2016; Weiffen et al., 2013). This literature has paid growing attention to new forms and patterns of regional cooperation in areas such as trade, security, and democracy protection. To our knowledge, social policy has not been explored from these perspectives. In fact, social policies have traditionally been studied in (domestic) comparative politics, and the literature about the provision and regulation of public goods beyond nation-states mostly emphasizes the global level and the activities of United Nations (UN) system organizations. As we have argued in a previous study (Bianculli & Ribeiro Hoffmann, 2016), the regulation and provision of social policies were hardly addressed in the literature of regionalism until very recently (Deacon et al., 2010;

Yeates, 2014). Moreover, most of these studies have more strongly focused on single cases of regional organizations. Thus, less emphasis has been given to cross-organization comparisons and, consequently, to the effects of institutional overlap. This is also surprising because Latin America has a long history of international cooperation on health, and the regional level has become particularly relevant in the 21st century (Buss & Tobar, 2018).

This paper aims to fill this gap by exploring how MERCOSUR and UNASUR have provided norms, standards, and regulations in health, and the effects of their overlapping mandates between 2008 and 2018. Focus in on the illustrative case of the policy area of access to medicines, and the examples of the creation of the medicine price bank and the price negotiation of high-cost medicines. Our main argument is that institutional overlap was positive, leading to an incipient trend towards cooperation in health between both organizations. This was facilitated by the increase in resources, both human and institutional. More specifically, two factors were crucial: the expertise already accumulated in the region and the relations and networks among those involved in health regional cooperation.

The paper is organized as follows. The next section discusses the concept of overlapping regionalism and how to study its effects. Then, we outline the research analytical framework and methods. The third section examines the overlap in membership, mandates, and institutional mechanisms in health in MERCOSUR and UNASUR, which is followed by an assessment of the effects of overlapping regionalism on access to medicines. The concluding section reflects on our main insights, and their theoretical and empirical implications indicating avenues for moving ahead academic research.

Analysing the Effects of Overlapping Regionalism

The international order built in the post-war relied on several international and regional institutions. The fact that most countries participated simultaneously in many of these

organizations was assumed as being neutral or positive; for decades, this 'overlap' of membership in organizations with similar mandates was not even an object of research. Adler (1998) was one of the first scholars calling attention to the possible effects of overlapping 'orders.' In so doing, he examined the overlap between security systems of governance and the possible effects of countries participating in systems characterized as balance of power and security communities. More recently, he argued that 'it is theoretically and empirically promising to make the overlap a key subject of research *in its own right*. This means (…) understanding and explaining overlap and inquiring into empirical consequences for regional security governance' (Adler & Greve, 2009, p. 60). Despite Adler's call for further research, and except from scholars working on trade, as Bhagwati and his notion of the spaghetti bowl of free trade agreements (1995), and those studying regime complexity (see interalia Alter & Meunier, 2009), institutional overlap has remained understudied within the regionalism literature until recent years.

Weiffen et al. (2013) explored overlap using the literature on international regime complexity. Their framework distinguishes between two institutional dimensions, membership, and mandate, and two analytical dimensions, configuration, and causes. Memberships are spatial, mandates are functional, and causes can be relational (due to conflict and rivalry among member states) or evolutionary (linked to the mandate, vision for the future). In their framework, the relations and evolutionary dimensions are intertwined in practice, and they explain the emergence and persistence of overlapping institutions with the functional aim of establishing a new arena to find more adequate and efficient solutions to regional problems. Building on the governance literature, Nolte (2014) developed a typology of regional governance complexes based on a series of empirical indicators: organizations proliferation/density, characteristics of proliferation, overlap in members, mandate (core and peripheral areas), centrality, institutional organizations, norms conflict and actor constellation.

According to the combination of these indicators, regional governance complexes are classified as synergetic, cooperative, conflictive, or segmented. Yet, the more relevant insight is that the proliferation of regional organizations does not lead necessarily to fragmentation and/or segmentation, and that the effects of overlapping regionalism must be assessed empirically, case by case. In a more recent paper, Nolte (2018) proposes a series of hypotheses to empirically evaluate the conditions under which institutional overlap can lead to cooperation or competition, thus strengthening or weakening regional cooperation outcomes. He states that 'in confronting the question of the practical consequences of overlap, one should identify cases and episodes in which de jure overlapping results in overlapping activities between at least two organizations (overlap of action)' (op. cit., p.129).

Our research builds on this perspective and applies it to the policy area of access to medicines and two cases: the creation of the medicine price bank and the price negotiation of high-cost medicines. Our main argument is that institutional overlap was positive, leading to an incipient trend towards cooperation. This was facilitated by the increase in resources, both human and institutional, as posed by Nolte (2018). More specifically, two factors were crucial: the expertise already accumulated in the region and the relations and networks among those involved in health regional cooperation in MERCOSUR and UNASUR.

Methods

This research draws on the analytical framework developed by Nolte (2018) to explore the effects of overlapping institutions on cooperation, in the in-depth illustrative case study of the policy area of access to medicines. The empirical analysis consists of a qualitative assessment of the memberships, mandates, agendas, institutional mechanisms, and practices in health to explore to what extent the overlap was harmful or beneficial to cooperation between MERCOSUR and UNASUR. The assessment is done by the

qualitative analysis of the data and the processes of institutionalization and negotiation based on the process tracing method (Bennett & Checkel, 2014).

Data include primary and secondary sources. The primary sources are interviews and official documents. The official documents were systematized in a novel database comprising MERCOSUR and UNASUR rules and regulations. Regarding the interviews, these include semi-structured interviews with public officials working in health in the national ministry and in MERCOSUR, which were conducted in two rounds in 2018 and 2019; and semi-structured interviews with key actors in the national ministries of health and regional institutions involved in the negotiation process of drug prices in MERCOSUR and UNASUR between 2015 and 2018. All the participants in the interviews were granted anonymity. This was especially crucial in the case of the second group of interviews, which were conducted as part of the master's research of one of the authors: to protect the negotiation strategies, only the results have been disclosed (Nascimento Lins de Oliveira, 2019). The research also drew on secondary academic literature and relevant information published in MERCOSUR and UNASUR webpages and the press to triangulate information and further support the analysis.

MERCOSUR and UNASUR: Overlap in Membership and Health Mandates

The Members

Between 2008 and 2018, MERCOSUR and UNASUR evidenced substantial overlap in their membership. MERCOSUR full and associate partners were all full members in UNASUR. Therefore, the overlap included all members, but under different categories of membership (see Table 1).

Table 1: Overlapping Membership in MERCOSUR and UNASUR

UNASUR Full members	MERCOSUR Full members	MERCOSUR Associated members
Argentina: member since 2008, suspended participation April 2018, withdrawal process started April 2019	Argentina: member since 1991	
Bolivia: member since 2008, withdrawal process started November 2019		Bolivia: member since 1996, process of accession to become full member since 2013
Brazil: member since 2008, suspended participation April 2018, withdrawal process started April 2019	Brazil: member since 1991	
Chile: member since 2008, suspended participation April 2018, withdrawal process started June 2019		Chile: member since 1996
Colombia: member since 2008, suspended participation April 2018, withdrawal process started August 2018		Colombia: member since 2004
Ecuador: member since 2008, withdrawal process started		Ecuador: member since 2004, interest to become full

March 2019		member declared in 2015
Guyana: member since 2008		Guyana: member since 2013
Paraguay: member since 2008, suspended participation April 2018, withdrawal process started April 2019	Paraguay: member since 1991	
Peru: member since 2008, suspended participation April 2018, withdrawal process started April 2019		Peru: member since 2003
Suriname: member since 2008		Suriname: member since 2013
Uruguay: member since 2008, withdrawal process started March 2020	Uruguay: member since 1991	
Venezuela: member since 2008	Venezuela: joined as associated member in 2004, asked for accession as full member in 2006, accepted in 2012, suspended in 2017[3]	

Source: Own compilation.

However, membership overlap only becomes relevant if there is also an overlap of mandates (Nolte, 2018). Next, we turn to the analysis of MERCOSUR and UNASUR health mandates, agendas, and institutional mechanisms.

Health Mandates, Agendas, and Institutional Mechanisms in MERCOSUR and UNASUR

Along more than 25 years, MERCOSUR has built an extensive regulatory framework in health. This relies on the norms and rules of the Meeting of the Ministers of Health (RMS) and the Working Subgroup 11 on Health (SGT 11). These two institutional instances are informally known as MERCOSUR Health.

Created in 1995, the RMS is the main political body responsible for health policies in MERCOSUR (MERCOSUR/CMC/DEC. Nº 3/95). It oversees the definition of the principles and policies intended to protect public health and the establishment of a common regulatory framework for the harmonization of health policies in MERCOSUR. These add to the implementation of joint programmes and actions in health protection and care, and risk prevention, among others. Decisions in the RMS, which are based on consensus, result in Declarations and Agreements between member and associate member states. These are then proposed as recommendations to the Common Market Council (CMC), the highest decision-making body of MERCOSUR, for final approval as Decisions. The RMS relies on the overall planning of the Coordinating Committee (RMS-CC), responsible for directing the tasks of the various Intergovernmental Commissions (CI).[4]

From a policy perspective, the agenda of the RMS has increasingly expanded in time. First, agreements included issues such as control and eradication of communicable diseases that have considerable indices rates in South America, i.e., dengue, measles, Chagas, and the establishment of information systems, including actions against disasters. With the turn of the century, these agreements further deepened and broadened to comprise tobacco control, information and communication cooperation, harmonization between MERCOSUR and Chile, non-communicable diseases, sexual and reproductive health, technical cooperation, and a special program for HIV/AIDS in prisons. Donation and transplants also gained regional relevance, leading to the creation of the regional program DONASUR and a national

transplant institute in Paraguay. From an international standpoint, MERCOSUR and associate members would ask for observant status at the WHO Conference on the Framework Convention on Tobacco Control and would also share a joint position on Public Health, Innovation, and Intellectual Property. Similarly, MERCOSUR managed to act as a bloc before the International Centre for the Settlement of Investment Disputes (ICSID) to show their regional support to Uruguay in the investment arbitration disputed by Philip Morris.[5] MERCOSUR has also issued joint declarations on sexual and reproductive health in occasion of Cairo+20, and responded to regional and international challenges, as evidenced by the agreements on Zika, dengue and health and environment, and more lately, on health and migration.

The second institutional instance of MERCOSUR Health, the SGT 11, works as a technical body responsible for the harmonization of national legislation and technical standards and the promotion of technical cooperation and joint actions among member states (MERCOSUR/GMC/RES. Nº 151/96). The national coordinators of SGT 11 then take their proposals to the Common Market Group (CMG), the executive body of MERCOSUR, to be approved as Resolutions.

Since 1996, five negotiating mandates have guided SGT 11, under a common thread: the objective of harmonization, starting with the quality parameters of health goods and services, and sanitary control mechanisms, and the harmonization of national legislation (1998, 2001, 2005). In 2001, SGT 11 was mandated to promote the integration of national systems and structures to contribute to the improvements of the quality and security of health products and services. In 2007, the main objective was to promote technical cooperation and to coordinate actions among member states, including for the first time, professional practice. Coordinating actions is also key in the last and still valid mandate (2014), together with the harmonization of technical norms. In all, these objectives are set as crucial to eliminate all technical obstacles

to trade and to strengthening the regional integration project (1998, 2001), and to remove all hindrances to assure comprehensive and high-quality care (2005, 2007). When it comes to the specific actions to be implemented to assure these objectives, these more strongly refer to the harmonization of legislation, coordination of actions between member states, promotion of technical cooperation, and information systematization and sharing through common procedures. As MERCOSUR gained a stronger political and social dimension, the regulatory scope of the negotiating mandates of SGT 11 broadened and deepened, including the implementation of joint working plans with other regional bodies.

Since its foundation, UNASUR framed health mainly as a social right, and a key aspect of the idea of citizenship (Herrero & Tussie, 2015). The South American Health Council (CSS), together with the South American Defence Council, were the first two sectoral councils to be created within UNASUR governance structure, already in 2008. The CSS was composed of the ministers of health, which worked in articulation with a Coordinating Committee whose representatives were part of the International Relations Advisories of the ministries of Health. The CSS and particularly, ISAGS 'capitalized on the international role of Brazil, which over the past decade has taken an increasingly protagonist position contesting global norms regarding access to medicines and right to health in various United Nations bodies and networks of South-South cooperation' (Riggirozzi, 2014, p. 445). This regional activism in health, and in many ways the fact that shared values about the right to health were relatively quickly taken up by UNASUR personnel and policymakers, rests to a large extent on the fact that many of them were part of what was known as *movimento sanitarista* (movement for public health), a health movement that since the 1970s brought activists and professionals together and paved the way for a publicly funded, rights-based health system in Brazil during the country's democratization process and constitutional reform in 1988. The fact that ISAGS was based in Rio de Janeiro was not coincidental, as a key Brazilian institution in the health

networks, Fiocruz, is also based in Rio. Similarly, the Latin American Social Medicine and Collective Health (LASM/CH) is also portrayed as having had a relevant influence on many of UNASUR health principles, i.e., the social and political dimensions of health and the notion of health as a human right (Herrero et al., 2019).

The content of policies and instruments of UNASUR health agenda reflects this foundational spirit and was institutionally defined in the Quinquennial Working Plan. The plan established five priorities: 1) Coordination of surveillance, immunization and networks for prevention and control of non-infectious diseases and dengue fever; 2) Creation of universal health systems in South American countries; 3) Generation and co-ordination of information for implementation and monitoring of health policies; 4) Coordination of strategies to increase access to medicines and foster production and commercialization of generic drugs, including harmonization of medicine surveillance and registries for members; coordinated policy for pricing of medicines for the purchase from pharmaceutical companies, and external negotiations, and; 5) Development of mechanisms for capacity building and human resources management directed at health practitioners and policymakers for the formulation, management and negotiation of health policies at domestic and international levels. The resources to implement these initiatives from the Quinquennial Plan were allocated through the regular UNASUR budget. Yet, ISAGS could receive extra funds from member states or from the Fund of Common Initiatives (FIC).

The CSS is the main body dealing with health in UNASUR. It has been depicted as one of the most efficient councils of UNASUR due to its 'actorness', i.e., the way how its members were capable of developing a common understandings and group cohesion (Hoffmann, 2019). The activities of UNASUR and ISAGS were implemented at two levels: horizontally, i.e., among member states in the region, and transnationally, as common initiatives at the multilateral level. As Ribeiro Hoffmann and Tabak (2017, p. 8) summarized, at the intra-regional level,

they actively promoted the articulation of ‘networks of national health institutions and public health schools that promote technical education, research and exchange to develop the public health workforce across the region’. In addition, ISAGS played a central role in ‘gathering knowledge and assessing and disseminating data on the health policies of UNASUR countries; benchmarking health policy and targets; and establishing effective mechanisms of diffusion through seminars, workshops, capacity-building and special meetings in support of policy reform by member states.’

Regarding extra-regional diplomacy, UNASUR aimed at reducing cross-border health risks and carving out a space for new forms of collective action within the region, renegotiating the terms of existing health policies in international forums, such as the World Health Assembly of the WHO, which takes place annually in Geneva (Faria et al., 2015; Ribeiro Hoffmann & Tabak, 2017). Between 2010 and 2016, 35 interventions were carried out at the World Health Assembly on behalf of UNASUR countries, on issues such as access to medicines, health as a fundamental human right, WHO reform, Sustainable Development Goals, among others.

Finally, and from a decision-making perspective, UNASUR Health, contrary to MERCOSUR Health, does not rely on the adoption of norms to be then adopted at the national level. Within UNASUR, regional cooperation in health relies on joint declarations and projects (Agostinis, 2019; Hoffmann, 2019).

MERCOSUR and UNASUR: Institutional Overlap and Access to Medicines

Both MERCOSUR and UNASUR had mandates in health and developed robust health agendas during the period analysed, i.e., 2008-2018. MERCOSUR institutional structure expresses two different policy problem definitions: health as policy coordination aimed at providing a regional public good, and health as policy harmonization and closely connected to

the development of the integration process (Bianculli, 2018). This explains the political and regulatory approach to health as led by the RMS and SGT 11, respectively.

UNASUR promoted a different definition of health and relied mostly on declarations, rather than on mandatory rules to be adopted at the national level. The CSS provided a forum for the political concertation of values and aims to be pursued at the national and multilateral levels – with an emphasis on the promotion of health as a human right in the building of public policies (Herrero & Tussie, 2015). Moreover, through ISAGS, UNASUR became a focal point in the production and dissemination of knowledge and coordination of thematic networks with other stakeholders such as national public health institutions, think tanks, epistemic communities, and advocacy groups.

Despite these differences in institutional design and substantive policies, overlap in membership and mandate did not prevent the coordination of activities.

Already in 2012, cooperation between UNASUR and MERCOSUR gained in importance as shown by the key decision passed by the CMC regulating 'Complementation and articulation MERCOSUR – UNASUR'. Based on the 2005 Action Plan to Strengthen Political Concertation in South America adopted by MERCOSUR member and associate states, which also includes strengthening the political convergence between MERCOSUR, CAN and Chile, and cooperation and coordination between MERCOSUR and other regional fora, it is agreed that MERCOSUR will promote the articulation and complementation of policies, agreements, and commitments set in the Forum of Consultation and Political Coordination (FCCP) and in the meetings of ministers and/or other specialized meetings of MERCOSUR, which are monitored by the FCCP, with the initiatives of similar content developed in UNASUR. Thus, they intend to optimize resources, avoid overlap and strengthen the efforts made in the integration schemes in South America (MERCOSUR/CMC/DEC. Nº 24/12).

Two years later, this initiative to foster coordination and cooperation was reinforced by the establishment of the 'Guidelines for the Complementation and Articulation UNASUR – MERCOSUR' (MERCOSUR/CMC/DEC. Nº 32/14) in various policy areas. Health became the focal point of the agreement on the 'Complementation and Articulation MERCOSUR-UNASUR in the Bodies and Forums working on Health', signed by MERCOSUR ministers of health in June 2015 (MERCOSUR/RMS/Agreement Nº 01/2015). The latter acknowledged again the MERCOSUR 2005 Action Plan and underscored that UNASUR foundational treaty already established that South American integration should include the achievements of MERCOSUR and CAN as well as the experiences of Chile, Guyana, and Suriname, going beyond simple convergence. Thus, Art.1 demanded signatories to 'promote the articulation and complementation of the policies, agreements and commitments undertaken by the organs and forums that deal with health, with the initiatives of similar content developed in UNASUR to optimize resources, seeking similarity of tasks and strengthening the efforts made in the integration schemes in South America'. Furthermore, member countries were to approve the six guidelines for the complementation and articulation of MERCOSUR-UNASUR established in the Annex (Art. 2). These included the requirement that those matters being dealt with or to be decided upon in both regional organizations should be jointly addressed in a single session. Additionally, the positions of full and associate members and agreements resulting from the agenda of complementation and articulation would be stated in a document to be annexed to the minutes of the joint meeting of MERCOSUR full and associate partners and would be signed by all participating member states and sent by MERCOSUR Pro Tempore Presidency of the body in question to UNASUR Pro Tempore Presidency.

In all, these various agreements and guidelines underscored the relevance of previous expertise, knowledge, and achievements in regional cooperation in health, and the need to

optimize existing resources and spaces for further strengthening collaboration and avoiding the negative consequences of overlap.

To gain a finer understanding of how the overlap in mandates and membership between MERCOSUR and UNASUR worked in practice and thus unravel the actual implementation of the abovementioned agreements and declarations, we explore two cases in the policy area of access to medicines: the creation of the medicine price bank and the price negotiation of high-cost medicines.

The Medicine Price Bank

A medicine price bank is a computerized common database collecting drug prices, which serves as a key information tool that provides procurement prices in the region as a point of reference. To the extent that a medicine price bank offers public and comparative information on the cost of medicines, sharing this type of information not only promotes transparency in public management processes, but more importantly, as it is the case of developing countries, it strengthens states' bargaining power vis-à-vis the pharmaceutical industry and their ability to negotiate more favourable medicine prices. In turn, this enhances access to medicines since high prices are an important component of limited access (Nuñez et al., 2008).

MERCOSUR was a pioneer in this type of initiatives. In 2000, the ministers of health approved the 'Medicines Policy for MERCOSUR, Bolivia and Chile (PMM)' (MERCOSUR/RMS/Agreement Nº 05/00). Three years later, a Plan of Action and Work Plan was set based on the purpose and the guidelines of the PPM. In the following years, the proposal was refined to open the possibility of including other Latin American and Caribbean countries (MERCOSUR/RMS/Agreements Nº 26/04 and Nº 27/04) and to transfer the activities to the Ad Hoc Group on Medicines Policy of MERCOSUR (MERCOSUR/RMS/Agreement Nº 01/05), later named IC on Medicines Policy (CIPM)

under the axis of the RMS. Formed by country focal points, the group defined strategies to finally implement the bank, which would serve as a relevant building block to facilitate price negotiations and joint purchases, enabling international price comparisons among states.

In 2007, the RMS defined a timetable for implementing the MERCOSUR and Associate States Medicine Price Bank (BPMM-EA) and issued a set off joint strategies for the functioning of the price bank (MERCOSUR/RMS/Agreement Nº 13/07). Moreover, this mechanism also envisaged a Capacity Building Plan for Human Resources of Member and Associate States for the Implementation of BPMM-EA. The implementation of this mechanism, however, did not materialize at the scheduled time (MERCOSUL/RMS/CIPM/ATA Nº 02/08 in Ministério da Saúde, 2009), and the delays were mainly related to technical issues for the creation of the virtual platform and changes in the Brazilian ministry of health zil, which was responsible for building the virtual databank and for training the teams from other countries on how to use the system.

In the following years, with the rise of UNASUR, the discussions concerning the creation of a medicine price bank also took space in the agenda of its Technical Group on Universal Access to Medicines (GAUMU). Gradually, GAUMU assumed the leadership in those discussions, considering that this new space comprised all 12 South American countries as effective members, and most of their focal points were already part of MERCOSUR initiatives and mechanisms in the access to medicines field. Thus, GAUMU would build on the expertise and research accumulated in MERCOSUR, and on the relationships and networks developed in the past.

Within UNASUR, the project for the creation of the price bank was financed with resources from the FIC 2012 budget and included the organization of a Workshop for the Implementation of the UNASUR Medicine Price Bank to strengthen the negotiating capacity of health system decisionmakers responsible for managing states parties' public resources

regarding drug procurement processes. The Medicine Price Bank of UNASUR (BPMU) was finally launched at the end of 2016. The countries' focal points defined an initial list of 34 medicines, whose prices paid by each country would be shared among all the others through a virtual platform with restricted access to the focal points of the countries defined by the ministries. The initiative relied on the commitment of these focal points to feed the BPMU periodically. The BPMU would serve as a powerful instrument to mitigate medicine price discrepancies in South America, in addition to serving as input for future joint negotiations. At the time, an estimate made by UNASUR Secretary General stated that if the 12 countries bought the necessary quantities of the 34 medicines listed at the lowest price in the region, the savings would amount to about US$ 1 billion per year.[6]

The Price Negotiation of High-Cost Medicines

Definitions of high-cost medicines abound and vary. Yet, these can be defined as those medicines having a direct cost equal to or greater than 40% of the home allowance where there is a patient who has been prescribed to take them. Given their high cost, it is the state who is expected to provide them (Marín & Polach, 2011).

In 2008, this issue was already addressed as part of the agenda of MERCOSUR as shown by the guidelines of two of the CIPM meetings and on the IC on HIV/AIDS (CIVIH), both commissions under the axis of the RMS. This also became part of an agreement signed by the bloc's health ministers (MERCOSUR/RMS/Agreement Nº 10/08). All mentioned documents highlighted the importance of joint action among countries to strengthen their negotiation capacity and thus, improve public purchases of medicines and reduce public expenses (MERCOSUL/RMS/CIPM/ATA Nº 02/08 in Ministério da Saúde, 2009).

Within UNASUR, the CSS Five-Year Plan calls for joint negotiations when purchasing high-cost medicines as a necessary strategy to address and overcome the access barrier. One of the

activities of the plan corresponding to GAUMU was to promote new negotiations of prices and purchases of medicines and joint supplies, considering mechanisms to overcome the obstacles or barriers faced in previous experiences. It is worth noting that joint negotiations had already been carried out on two occasions in the region (2003 and 2005), under the lead of the Andean countries, and with the participation of other South American countries.

In 2015, the topic of joint negotiations was again underscored in MERCOSUR agenda as demanded by the health ministers during their joint meeting in Brasilia (Nascimento Lins de Oliveira, 2019). It was then agreed that MERCOSUR would have to deploy a common strategy to face the problem of high prices through joint purchases, which is latter changed to joint negotiations of 'prices' instead of 'purchases.' Interestingly, in this same meeting, the already mentioned MERCOSUR/RMS/Agreement Nº 01/2015 was signed, thus establishing clear guidelines for the complementation and articulation between MERCOSUR and UNASUR in health fora. As an outcome of this meeting, an Informal Working Group (GTI) was created to design the joint strategy and mechanisms for using public purchasing power for the joint acquisition of medicines at more equitable prices. The initiative was led and financed largely by Brazil, who, together with Argentina, hosted face-to-face meetings between June and September 2015. In these meetings, representatives of the countries defined the criteria for choosing the drugs that would be traded and the negotiation strategies to be pursued thereof. Argentina, Bolivia, Brazil, Chile, Colombia, Ecuador, Paraguay, Peru, Suriname, Uruguay, and Venezuela were part of this group - but not all representatives participated in all meetings. The most active countries were Argentina, Brazil, Chile, Paraguay, Suriname, and Uruguay (Nascimento Lins de Oliveira, 2019).

In September 2015, two important meetings took place: The First Extraordinary Meeting of Ministers of Health of MERCOSUR and the IX Regular Meeting of UNASUR, both held in Montevideo, Uruguay on the same day. Within the scope of MERCOSUR, the ministers

created the Ad Hoc Committee for the Negotiation of Prices of High-Cost Medicines in MERCOSUR Member and Associate States (CAHPM) (MERCOSUR/RMS/Agreement Nº 05/15). This Committee was constituted by representatives of the national ministers of health – almost all who were already in the GTI – and expressed the formalization of the process. The document was signed by the authorities of the 11 countries present; only Guyana did not send a representative to the meeting.

Within the scope of UNASUR, the CSS signed Declaration 01/2015, which formalized adherence to MERCOSUR/RMS/Agreement Nº 05/15. Ministers approved that the joint negotiations would be conducted by CAHPM and purchases would be made individually by countries through the Strategic Fund of the PAHO. The decision to involve MERCOSUR and UNASUR in the dynamics of the negotiation resulted from political and pragmatic reasons. First, the countries involved were essentially the same given their overlapping memberships; and secondly, the focal points for access to medicines in the countries were practically the same in the corresponding instances of MERCOSUR and UNASUR. In all, unifying the two organizations was a way to avoid duplication of efforts and financial resources (Nascimento Lins de Oliveira, 2019), and a way of building on existing capacities and networks. UNASUR took advantage of the fact that it was a mechanism with 12 effective members and with strong political alignment and greater insertion in multilateral spheres in the global health field, such as PAHO and WHO. MERCOSUR main strength was its institutionalization and legal structures leading to binding decisions.

The first face-to-face negotiation round with the industry took place in November 2015, when CAHPM negotiated four medicines. A ceiling price was reached for darunavir 600 mg of US $ 1.27 per pill, which represented a considerable reduction in relation to the lowest price previously obtained in the region (US$ 2.98 - Brazilian price). The new ceiling price would result in savings of almost US$ 20 million for the countries participating in the process (Pan

American Health Organization, 2016). Also, it ended up becoming the lowest price worldwide and started to be adopted as the reference price of the Global Fund to fight HIV, tuberculosis, and malaria (Nascimento Lins de Oliveira, 2019; Vargas de Moraes, 2018). Another achievement of this round was the commitment, assumed by the pharmaceutical company that owns the patent right of sofosbuvir, to guarantee the lowest price payed in the region to all South American countries.

The BPMU was never implemented in its full capacity as some countries failed to provide the bank with the needed information at the required intervals, which means that there was no complete information on all 34 drugs in all 12 countries. In early 2018, as UNASUR crisis accelerated, the instrument gradually ceased to be used and was ultimately interrupted; UNASUR member states suspended their participation in the organization and were thus unable to continue any initiative developed within its scope.

The joint negotiations of high-cost medicines based on MERCOSUR institutional framework survived the suspension of UNASUR. In 2018, the Pro Tempore Presidency of Paraguay in MERCOSUR brought the topic of joint price negotiations back to the list of priorities in the health regional agenda. The CAHPM meetings were resumed in the second half of 2018 and, in November of that same year, MERCOSUR announced the joint negotiation of tacrolimus - an immunosuppressant widely used in cases of organ transplants[7] - as a result of the second face-to-face round of joint negotiations. Two further face-to-face meetings were held in 2019, according to the minutes of the RMS meetings. However, information on new price agreements has not been broadly released - the CAHPM's reports are confidential and are only available to the health ministers and their technical advisors within the scope of MERCOSUR.

In the two cases mentioned, it is worth highlighting the importance of articulations and interpersonal networks built between the focal points for access to medicines, both in

MERCOSUR and UNASUR. Interviews with those focal points indicate that those bonds allowed the building of mutual trust that created a favourable environment for interaction and, consequently, collective action. In addition, the expertise of these professionals allowed the correct identification of the needs of their countries and the instrumentalization of the resources available in each bloc to satisfy these needs.

Concluding Remarks

This article has analysed the effects of the overlapping membership and mandates in the issue area of health in MERCOSUR and UNASUR between 2008 and 2018. During this period, the social dimension of regionalism was strengthened by centre-left leaning governments, and the agenda on health was advanced in both organizations.

We have empirically explored the agenda on access to medicines, and found that as argued in the literature, the overlap of organizations enhances resources both human and institutional, thus promoting cooperation and agreements. In effect, the overlap between MERCOSUR and UNASUR in the policy area of access to medicines triggered a series of agreements among both organizations, and the setting up of concrete joint mechanisms, including the creation of the medicine price bank within UNASUR, and the rounds of joint price negotiations of high-cost medicines within MERCOSUR. Collaboration between both organizations was facilitated by their membership structure, and the reliance on extended resources, both human and institutional. Moreover, two other elements were crucial: the expertise already accumulated in the region through previous experiences and strategies – including their failures and successes – and the relations and networks among those involved in health regional cooperation over time, and which in the case of MERCOSUR and UNASUR coincided. The attempt to create a medicine price bank and to engage in joint price negotiations of high-cost medicines was a remarkable example of cooperation among regional organizations in Latin America, which

enhanced their negotiation capacity vis-à-vis external actors, thus, showing the potential of optimization of existing resources to ameliorate access to medicines in the region.

The findings of this case study contribute to the understanding of the conditions under which regional organizations might contribute to solving problems in issue areas such as health. Whether overlapping mandates lead to cooperation and division of labour, or competition and duplication of efforts and waste of resources is relevant for member states and other stakeholders to choose the institutional mechanisms to best achieve their interests. Our empirics show that the overlap of resources favoured cooperation between MERCOSUR and UNASUR. To a certain extent there was also certain complementarity between the two organizations in terms of the membership and institutionalization. All South American countries were at that time part of MERCOSUR, either as full or associate members; yet, in UNASUR they were all full members, which in turn gave more stability to the mechanism. In institutional terms, the previous expertise and research of MERCOSUR in this policy area were certainly relevant, including its institutionalization.

We do not claim that overlap fostered cooperation between MERCOSUR and UNASUR in other policy areas, or even other policy subfields in health. Further research is required to assess the effects of institutional overlap; avenues for research include more cross-organization analyses, and cross-policy areas as well. As regional agendas broaden and policy making gains in complexity, we need to go beyond functional analysis. Thus, there is space for comparatively assessing the effects of institutional overlap across policy areas, i.e., health and education, and also across sub policy fields.

References

Adler, E. (1998). Seeds of peaceful change: the OSCE's security community-building model. In E. Adler & M. N. Barnett (Eds.), *Security Communities: Vol. Cambridge*. Cambridge University Press.

Adler, E., & Greve, P. (2009). When security community meets balance of power: overlapping regional mechanisms of security governance. *Review of International Studies*, *35*(S1), 59–84.

Agostinis, G. (2019). Regional Intergovernmental Organizations as Catalysts for Transnational Policy Diffusion: The Case of UNASUR Health. *JCMS: Journal of Common Market Studies*, *57*(5), 1111–1129.

Alter, K. J., & Meunier, S. (2009). The Politics of International Regime Complexity. *Perspectives on Politics*, *7*(1), 13–24.

Bennett, A., & Checkel, J. (2014). Process Tracing: From Metaphor to Analytic Tool. In *Strategies for Social Inquiry*. Cambridge University Press.

Bhagwati, J. (1995). US Trade Policy: The Infatuation with Free Trade Agreements. In J. Bhagwati & A. O. Krueger (Eds.), *The Dangerous Drift to Preferential Trade Agreements*. AEI Press.

Bianculli, A. C. (2018). From free market to social policies? Mapping regulatory cooperation in education and health in MERCOSUR. *Global Social Policy*.

Bianculli, A. C., & Ribeiro Hoffmann, A. (2016). Regional Organizations and Social Policy: The Missing Link. In *Regional Organizations and Social Policy in Europe and Latin America A Space for Social Citizenship?* (pp. 1–22).

Buss, P., & Tobar, S. (2018). Health Diplomacy in the Political Process of Integration in Latin America and the Caribbean. In *Oxford Research Encyclopedia of Global Public Health*. Oxford University Press.

Deacon, B., Macovei, M. C., Van Langehove, L., & Yeates, N. (2010). *World-Regional Social Policy and Global Governance. New research and policy agendas in Africa, Asia, Europe and Latin America*. Routledge.

Faria, M., Giovanella, L., & Bermudez, L. (2015). A Unasul na Assembleia Mundial da Saúde: posicionamentos comuns do Conselho de Saúde Sul-Americano . In *Saúde em Debate* (Vol. 39, pp. 920–934).

Gómez-Mera, L. (2015). International Regime Complexity and Regional Governance: Evidence from the Americas. *Global Governance: A Review of Multilateralism and International Organizations*, *21*(1), 14–19.

Herrero, M. B., Loza, J., & Belardo, M. B. (2019). Collective health and regional integration in Latin America: An opportunity for building a new international health agenda. *Global Public Health*, *14*(6–7), 835–846.

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

Herz, M. (2013). Regional Governance. In T. Weiss & R. Wilkinson (Eds.), *International Organization and Global Governance* (pp. 236–250). Routledge.

Hoffmann, A. M. (2019). *Regional Governance and Policy-Making in South America*. Palgrave Macmillan.

Malamud, A. (2013). Overlapping Regionalism, No Integration: Conceptual Issues and the Latin American Experiences. In *EUI Working Paper: Vol. RSCAS 201*. Robert Schuman Centre for Advanced Studies; Global Governance Programme-42.

Malamud, A., & Gardini, G. L. (2012). Has regionalism peaked? The Latin American quagmire and its lessons. *International Spectator*, *47*(1), 116–133.

Marín, G. H., & Polach, M. A. (2011). Medicamentos de alto costo: análisis y propuestas para los países del Mercosur. *Revista Panamericana de Salud Publica*, *30*(2), 167–176.

Ministério da Saúde. (2009). *Mercosur Policy of Medicine: Essential documents*.

Nascimento Lins de Oliveira, B. (2019). *Acesso a medicamentos e Cooperação Sul-Sul: um estudo de caso das negociações con-juntas de preços de medicamentos de alto custo na América do Sul*. Fundação Oswaldo Cruz.

Nolte, D. (2014). Latin America's new regional architecture: A cooperative or segmented regional governance complex? In *RSCAS Working Paper Series* (Issue EUI RSCAS; 2014/89; Global Governance Programme-126).

Nolte, D. (2018). Costs and Benefits of Overlapping Regional Organizations in Latin America: The Case of the OAS and UNASUR. *Latin American Politics and Society*, *60*(1), 128–153.

Nuñez, M. C., Garcia Serpa Osorio de Castro, C., & Oliveira, M. A. (2008). *Manual: Metodología para la evaluación de las negociaciones de precios de antirretrovirales en países de América Latina y Caribe*.

Pan American Health Organization. (2016). *Hepatitis B and C in the Spotlight. A public health response in the Americas*.

Panke, D., & Stapel, S. (2016). Exploring overlapping regionalism. *Journal of International Relations and Development*, *21*, 635–662.

Ribeiro Hoffmann, A., & Tabak, J. (2017). Discussing Global Health and Access to Medicines in the UN System: The Case of the Union of South American Nations (UNASUR). *The Hague Journal of Diplomacy*, *12*(2–3), 178–196.

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

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

Sanahuja, J. A. (2010). La construcción de una región: Suramérica y el regionalismo

posliberal. In M. Cienfuegos & J. A. Sanahuja (Eds.), *Una Región en Construcción, UNASUR y la integración en América del Sur* (pp. 87–136). Fundació CIDOB.

Van Langenhove, L. (2012). Why We Need to 'Unpack' Regions to Compare Them More Effectively. *The International Spectator*, *47*(1), 16–29.

Vargas de Moraes, R. (2018). La actuación internacional del Ministerio de Salud en el tema del acceso a medicamentos. In *Salud y Política Externa: los 20 años de la Oficina de Asuntos Internacionales de Salud (1998-2018)* (pp. 329–350). Ministerio de Salud, Oficina de Asuntos Internacionales de Salud.

Weiffen, B., Wehner, L., & Nolte, D. (2013). Overlapping regional security institutions in South America: The case of OAS and UNASUR. *International Area Studies Review*, *16*(4), 370–389.

Yeates, N. (2014). The Socialization of Regionalism and the Regionalization of Social Policy. In A. Kaasch & P. Stubbs (Eds.), *Transformations in Global and Regional Social Policies* (pp. 17–43). Palgrave Macmillan.

Acknowledgements

We especially thank Anna van der Vleuten for her comments on an earlier version of the paper, as well as the editorial board and two anonymous reviewers of Global Public Health for their excellent suggestions.

Funding

This article is part of the project 'Regional social regulation in Latin America: A new agenda for development? Prospects and challenges (SociAL-Reg) (CSO2015-66411-P), which is funded by the Spanish Agencia Estatal de Investigación (AEI).

[1] Regional cooperation in health goes back to the late 19th century. The Pan-American Health Organization (PAHO) is the world's oldest international public health organization; it was founded in 1902 and was incorporated into the Inter-American System as a specialized health agency after the creation of the Organization of American States (OAS) in 1948. It also serves as the Regional Office for the Americas of the World Health Organization (WHO). In 1971, the Meeting of Ministers of Health of the Andean Region (REMSAA), under the then Andean Pact, created the Andean Health Organization (Organismo Andino de Salud - Convenio Hipólito Unanue / ORAS CONHU) to promote health through the coordination and support of the actions of member states. ORAS CONHU is set up as an intergovernmental body, bringing together Bolivia, Colombia, Chile, Ecuador, Peru, and Venezuela. It works under the direction of REMSAA, which is also responsible for the election of the Executive Secretary of the ORAS CONHU. These add to other regional organizations that have incorporated a health agenda, and which comprise the Andean Community, the Amazon Cooperation Treaty Organization (ACTO), the Central American Integration System (SICA) and the Caribbean Community (CARICOM).

[2] See also Malamud and Gardini (2012).

[3] Venezuela was suspended for failure to implement MERCOSUR obligations, including commitments to democracy.

[4] There are 11 IC working on tobacco control, blood and blood products, implementation of the International Health Regulations (IHR), food and nutrition security, donation and transplants, price negotiation of high-cost medicines, medicines policy, sexual and reproductive health, no communicable diseases and environmental and worker's health (MERCOSUR/RMS/AGREEMENT N° 05/18).

[5] Personal interview with legal counsel and representative, Argentine Ministry of Health in MERCOSUR and UNASUR, Buenos Aires, 13 August 2018. See also ICSID Award, 'Philip Morris Brands Sàrl, Philip Morris Products S.A. and Abal Hermanos S.A. v. Oriental Republic of Uruguay, ICSID Case No. ARB/10/7 (formerly FTR Holding SA, Philip Morris Products S.A. and Abal Hermanos S.A. v. Oriental Republic of Uruguay), retrieved July 27, 2020 from https://www.italaw.com/sites/default/files/case-documents/italaw7417.pdf.

[6] Coello, C. 'Crean el banco de precios de medicamentos de Unasur', edicionmédica, Retrieved July 29, 2020, from https://www.edicionmedica.ec/secciones/gestion/crean-el-banco-de-precios-de-medicamentos-de-unasur-89131.

[7] MERCOSUR, 'Medicamentos más baratos para el MERCOSUR'. Retrieved July 29, 2020, from https://www.mercosur.int/medicamentos-mas-baratos-para-el-mercosur/.