Health Policy and Planning Advance Access published December 24, 2015

Health Policy and Planning, 2015, 1–12
doi: 10.1093/heapol/czv122
Original article

BRICS countries and the global movement for universal health coverage

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Accepted 14 November 2015

Abstract

This article explores BRICS' engagement in the global movement for Universal Health Coverage (UHC) and the implications for global health governance. It is based on primary data collected from 43 key informant interviews, complemented by a review of BRICS' global commitments supporting UHC. Interviews were conducted using a semi-structured questionnaire that included both closed- and open-ended questions. Question development was informed by insights from the literature on UHC, Cox's framework for action, and Kingdon's multiple-stream theory of policy formation. The closed questions were analysed with simple descriptive statistics and the open-ended questions using grounded theory approach. The analysis demonstrates that most BRICS countries implicitly supported the global movement for UHC, and that they share an active engagement in promoting UHC. However, only Brazil, China and to some extent South Africa, were recognized as proactively pushing UHC in the global agenda. In addition, despite some concerted actions, BRICS countries seem to act more as individual countries rather that as an allied group. These findings suggest that BRICS are unlikely to be a unified political block that will transform global health governance. Yet the documented involvement of BRICS in the global movement supporting UHC, and their focus on domestic challenges, shows that BRICS individually are increasingly influential players in global health. So if BRICS countries should probably not be portrayed as the centre of future political community that will transform global health governance, their individual involvement in global health, and their documented concerted actions, may give greater voice to low- and middle-income countries supporting the emergence of multiple centres of powers in global health.

Key words: Universal health coverage, BRICS, global health governance

Key Messages

- The adoption of Universal health coverage (UHC) as a goal at the country level can be accelerated if major stakeholders in global health governance endorse the goal and act consistently. Most BRICS countries implicitly supported the global movement for UHC, and they share an active engagement in promoting UHC. However, despite some concerted actions, BRICS countries seem to act more as individual countries rather that as an allied group.
- The results also highlighted, a possible disconnect between the external perceptions of BRICS countries toward UHC and the internal debate, particularly for Brazil and Russia.
- These findings suggest that BRICS are unlikely to be a unified political block that will transform global health governance. Yet the documented involvement of BRICS in the global movement supporting UHC, and their focus on domestic challenges, shows that BRICS individually are increasingly influential players in global health.

Introduction

The rapid political, economic, social and health changes of the last decades transformed global health governance. The unprecedented growth of financial resources devoted to global health of the first decade of this century (Murray *et al.* 2011), was accompanied by the proliferation of global initiatives and new actors that have progressively rendered global health governance mechanisms more complex. In this context, the increased economic power of emerging economies like the BRICS countries' (Brazil, Russia, India, China and South Africa), raises questions about the implications of their increased involvement in global health.

Given their emerging economic power, BRICS countries' ability to influence the international arena through economic, diplomatic and strategic alliances has been analysed in a number of sectors and contexts (Shaw *et al.* 2009; Haibin 2012). Recent global health financing stagnation, as a consequence of the economic crisis in most developed countries, further increased interest in the role BRICS countries may play in global health. However, BRICS involvement in global health is still difficult to interpret, particularly, whether these countries act individually or as a unified political block (Yu 2008; Bliss 2011; Hau *et al.* 2012; Harmer *et al.* 2013a,b; Watt *et al.* 2013; Acharya *et al.* 2014; Fan *et al.* 2014; Harmer and Buse 2014; Kickbusch 2014; Kirton *et al.* 2014; Rao *et al.* 2014). A recently published commentary questioned the relevance of BRICS as a group for global health policy (McKee *et al.* 2014). Another article suggested that 'the potentially transformative discourse employed by the BRICS block gives weight to the claim that a paradigm shift in global health is underway' (Harmer and Buse 2014).

One of the major global policy developments of the last few years has been the emergence of a global movement supporting Universal Health Coverage (UHC) (Evans *et al.* 2008; Garrett *et al.* 2010; Latko *et al.* 2011; UNGA 2012; Brearley *et al.* 2013; Sridhar *et al.* 2013; United Nations 2013; World Health Organization 2013; Boerma *et al.* 2014), which is one of the health targets agreed upon in the Sustainable Development Goals (SDG). The UHC concept is the aspiration that all people will obtain the quality health services they need while not suffering financially as a result of seeking healthcare (World Health Organization 2010; Wagstaff and van Doorslaer 2013). Many countries have embraced the goal of UHC, which has become relevant to policy debates and reforms in low- and middle-income countries (Horton and Lo 2006; Kumar 2007; Lagomarsino *et al.* 2008; Li *et al.* 2011; Tangcharoensathien *et al.* 2011; Horton 2012; McKee *et al.* 2013; Marten *et al.* 2014). Around half of the countries in the world are in fact engaged in health reforms that aim to move towards UHC either by extending, deepening or otherwise improving coverage with needed health services and/or financial protection (Boerma *et al.* 2014).

The analysis of BRICS countries engagement in the global movement supporting UHC may provide interesting insights on the role of these countries in global health and on the potential implications for global health governance.

Yet very little is known about BRICS countries' engagement in the global movement supporting UHC. Analyzing and discussing the results of a key informants' survey, this manuscript explores this issue

Methods

The article is based on primary data collected from 43 semi-structured key informant interviews, complemented by a review of BRICS countries' global commitments supporting UHC. The review of commitments for UHC included: (a) Global and regional commitments such as WHO resolutions and declarations of intents in international fora and summits held since 2009; (b) Commitments or declarations of intent made during BRICS Health Ministers Meetings; (c) Informal commitments made in global events where UHC was on the agenda.

Informants interviewed

A total of 137 interview invitations were sent via e-mail between May and July 2013, 67 of which were answered (response rate 49%), 43 were acceptances and 24 were refusals (overall positive response rate of 31.4%). Three interviews were conducted at the Rockefeller Foundation Centre in Bellagio during a meeting on the same topic in May 2013. The others were carried out via telephone or videoconference between May and August 2013. All interviews were recorded and fully transcribed, including verbatim quotations, with agreement of the interviewees. The transcript was sent to each interviewee for corrections or updates.

Among the 43 respondents, 18 were female, 9 operated at the global level and 24 operated nationally within BRICS countries. Eleven worked in international organizations (WHO, World Bank, UN etc.), 20 were academics, 9 were affiliated with international NGOs, civil society organizations or non-profit foundations, 2 were from other global health initiatives and 1 was a government representative. Informants working for BRICS Governments had the lowest response rate of all the sectors; in fact 15% of the invitees were from these governments, but only 1 of them responded. The majority of respondents were in senior positions at their organizations, indicating a high level of knowledge and expertise in their area (Table 1).

Respondents were asked to self-assess their area of expertise. Twenty-four respondents considered themselves experts in a single BRICS country: 7 on China; 6 on Brazil; 4 on India; 4 on Russia; and 4 on South Africa. Nineteen respondents reported having expertise on at least two of the BRICS countries and 14 on more than two countries. Overall, 19 respondents considered themselves experts on China, India, and South Africa, 18 on Brazil and 10 on Russia. Area of expertise was used as an interpretative criterion during the analysis phase (Table 1).

Framework analysis and questionnaire

Interviews were conducted utilizing a semi-structured questionnaire that included both closed- and open-ended questions. Question development was informed by insights from the literature on UHC, the main constructs of Cox's framework for action (Cox 1981), and Kingdon's multiple-stream theory of policy formation (Kingdon 1995). Kingdon argues that policy solutions gain momentum when three separate 'streams' come together at the same time: problem (attention lurches to a policy problem), policy (a solution to that problem is available) and politics (policy makers have the motive and opportunity to turn it into policy). These streams develop independently and rely on three processes: problem recognition, formulation of policy proposals and politics. Stream-convergence may occur when a 'window of opportunity' opens, allowing policy entrepreneurs brief moments in time to push attention towards their pet problems or to push their pet solutions. Kingdon affirms that policy entrepreneurs are characterized by: (a) A 'claim to a hearing' based on expertise, ability to speak for others, relevant decision-making position; (b) knowledge for their political connection or negotiation skills; (c) Persistency in diffusing their ideas; (d) knowing how to wait for the moment in which a policy window opens.

Table 1. Invitees and interviewees by gender, sector, BRICS expertise and location

	Invitees		Interviewees	
Gender	***n***	**%**	***n***	**%**
Male	76	55%	25	58%
Female	62	45%	18	42%
Sector				
Academic	56	40.9%	20	46.5%
WHO	14	10.2%	4	9.3%
International Organization	14	10.2%	6	14.0%
Other UN Agency	6	4.4%	1	2.3%
Civil Society	20	14.6%	9	20.9%
Government	20	14.6%	1	2.3%
Other	7	5.1%	2	4.7%
Role				
Director	34	24.8%	8	18.6%
Senior Advisor	9	6.6%	5	11.6%
Sector Lead	9	6.6%	4	9.3%
Senior Editor	6	4.4%	2	4.7%
Professor	45	32.8%	16	37.2%
Fellow	6	4.4%	2	4.7%
Advisor	22	16.1%	6	14.0%
Journalist	1	0.7%	0	0.0%
Politcal secretary	5	3.6%	0	0.0%
Country of expertise				
Brazil	19	13.9%	6	14.0%
China	27	19.7%	8	18.6%
India	24	17.5%	6	14.0%
Russia	10	7.3%	4	9.3%
South Africa	19	13.9%	5	11.6%
Multiple	10	7.3%	9	20.9%
All BRICS	28	20.4%	5	11.6%
Location				
National (BRICS)	83	60.6%	23	53.5%
Global	54	39.4%	20	46.5%

The questionnaire included three sections. Following Cox's theoretical conceptualization of the types of influence, the first section of the questionnaire investigated the main ideas which contributed to the global recognition of UHC and the institutions which promoted this concept. The second section of the questionnaire examined whether UHC was/is an important policy goal for BRICS countries and the countries' conceptualization of UHC. It also gathered information on the 'type of influence' BRICS exerted on UHC, information on 'opportunity seeking' (i.e. whether BRICS countries see UHC as an opportunity to affirm themselves internationally) and information on which institutions have been leading UHC discourse and/or implementation. The third section of the questionnaire focused on whether BRICS were considered active in supporting the UHC movement and how they have influenced it. Following Kingdon's policy entrepreneurs conceptualization, it included questions on BRICS' engagement in promoting UHC at global or regional level, their status in the international community (claim to a hearing), their leadership and their ability to influence the decision-making process.

The closed questions were analysed with simple descriptive statistics (using STATA 12) and the open-ended questions were analysed using a grounded theory approach (Glaser 1992; Bryman and Burgess 1993). The text of open-ended questions was coded manually by the interviewers. The main ideas expressed in every interview were highlighted, looking for similarities and differences in the responses and grouped into similar concepts and categories. Frequency of mention was adopted as the principal discriminator of the concept's importance. To preserve anonymity, this study does not attribute direct quotes to interviewees, but only the country of expertise, whether the responder work at national or global level, and in which sector (Table 1)

Results and discussion

The emergence of UHC as a global health policy and its conceptualization in BRICS countries

The reasons behind the global support for UHC have not been studied yet. According to the interviewees, various ideas and practical necessities have been crucial co-determinants for the global embracement of UHC. From a theoretical point of view, UHC epitomizes a successful synthesis of multiple previous efforts to improve population health by strengthening health systems, enabling universal access to services and protecting citizens from financial hardship. All these ideas, embodied over 35 years ago in the spirit of the 1978 Alma Ata Declaration, fostered a growing consensus around UHC ideology. From a practical point of view, UHC recognition globally occurred only when it was identified as a priority in both high- and low-income countries. High-income countries have been facing tough challenges to maintain the level and the quality of services provided, while ongoing economic development in low- and middle-income countries dictated a need for reorganizing the traditional donor–recipient north–south relationships.

One respondent, explained this aspect by simply stating that

> UHC is very relevant for all countries, low-income, middle-income, emerging, and rich countries alike' (BRICS/Global/International Organization).

Another respondent further elaborated on the convergence of middle-income countries' emerging needs and the challenges faced by high-income countries to sustain their 'universalistic' systems

> Actually, one of the most important reasons that contributed for UHC to become a global concept is the economic growth in many of the middle-income countries [. . .] and the need to move away from the traditional vertical donors programs [. . .]. Plus, developed countries have contributed to the debate given the crisis they are facing in their health systems. (BRICS/Global/International Organization)

Analysing BRICS' involvement in the global drive for UHC raises questions on how these countries conceptualize it. This may also be relevant in exploring the extent to which BRICS act as a political block.

According to most respondents (34 out of 43), BRICS countries accept and endorse the conceptualization of UHC. However, analysis reveals that BRICS countries' conceptualization of UHC seems to be driven by specific country needs and focused more on access to quality health services. Respondents displayed some variation in the way UHC is understood or exemplified by different BRICS countries. For instance, the relevance attributed by respondents to the three dimensions of UHC adopted by the WHR 2010—population covered, services covered and proportion of costs covered (financial protection) varied across the five countries (Figure 1). Although other elements, like the importance of a legal framework underpinning the policy, seemed to be relevant for Brazil, Russia, South Africa and India. The reasons for such variability might be partly attributable to the fact that some or many elements in the concept of UHC, though not necessarily with the current acronym, have been used in national debates long before the international recognition of

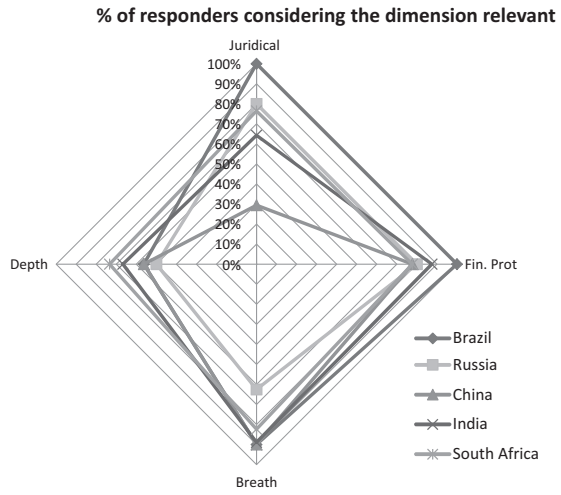

Figure 1 Relevance of UHC concept's dimensions

the terminology. This aspect emerged in particular for the case of Brazil. For example, one respondent noted that,

> In Brazil we do not see any innovation from the principles that were already present. Affordability, not having to pay for care . . . . these concepts were already there. (Brazil/National/Academic)

Another interviewee supported this point for Brazil and, to some extent, for India and China,

> Brazil committed to UHC far before this issue became important at the international level. Their conceptualization stressed the importance of the judicial side, but they did a pretty good job in putting in place the necessary infrastructure to deliver on that entitlement the constitution provided, unlike what happened in other countries. Brazil has therefore been less influenced recently because they did it long before.
>
> India has been pretty influenced recently by global thinking of UHC although it occupied a leading role with the RSBY program, providing people below the poverty line with insurance coverage [.] and with the national rural health mission, they focused on the delivery and primary healthcare side. [. . .] China has been thinking of UHC for quite some time now [. . .] South Africa, has been thinking about how they can raise revenue for health and how they can improve primary care services . (BRICS/Global/NGO)

and another interviewee also pointed out that,

> there were already health reforms underway in these countries that had everything to do with the notion of universal coverage, but when they were started, they weren't referred to in this new fashionable terminology (UHC). So these countries were talking about universal coverage before it became an international fad. (Brazil/China/India/International Organization)

This hypothesis seemed to be supported by the fact that almost one-third of the interviewees had heard about UHC before 2005, the year in which a World Health Assembly resolution (58.33) first used the term (World Health Organization 2005).

BRICS political support to global commitments for UHC

The BRICS largely constitute a political forum, a coalition of countries to strengthen their influence on priority concerns in the international system, coordinate common interests and identify areas for cooperation. They officially supported a number of global commitments to UHC, since the World Health Assembly resolution (58.33) of 2005 (World Health Organization 2005). Four recent (out of eight) global official commitments to UHC were supported by all BRICS but Russia, while the remaining resolutions were supported by only one to three BRICS countries (Table 2). Brazil endorsed all eight official commitments, South Africa supported all but the ministerial conference on Health Systems Financing of 2010, India supported six, China five, and Russia endorsed only four. China has not endorsed the UN resolution on UHC, but supported all the other important commitments. Yet the absence of individual countries' specific commitments to individual commitments does not necessarily indicate an absence of support.

China and India are the only countries who officially made statements on their commitment to UHC in the 65th World Health Assembly. Russia on the other hand, is the only country among the BRICS which has not demonstrated much visible official political support for UHC, except within the BRICS grouping itself, at Rio + 20, and during the meeting on Social Determinants of Health. Nevertheless, the first three BRICS Health Ministers Meeting communiqués (Beijing in 2011, Delhi in 2012 and Cape Town in 2013), and to some extent the last meeting of December 2014 held in Brazil, illustrate BRICS' commitments and declarations supporting the global movement for UHC (Tables 3 and 4).

In addition, in the most recent years, Brazil and South Africa participated in all the UHC events that could be identified by researchers, while China and India did not endorse the 2012 Mexico City declaration and Russia did not officially support the Bangkok statement signed at the 2012 Prince Mahidol Award Conference on financing for UHC (Table 4). Brazil, China, India and South Africa participated in some regional events dedicated to UHC (Tables 4 and 5).

BRICS influence in global health arenas and in their regions

Some BRICS seem to explicitly support UHC as a global policy goal. When asked whether BRICS have 'a claim to a hearing' (i.e. a certain weight given to their speeches at international meetings and conferences related to UHC), 95% of respondents answered positively for Brazil, 90% for China, 76% for India, 75% for South Africa and 65% for Russia (Figure 2). Most respondents attributed the reason for this influence to the economic strength of the countries and to their position in the international and geopolitical arenas.

One respondent argued that,

> India and China are definitely heard for economic and size reasons [. . .]. I mean, these countries are all regional hegemons. (India/China/National/Academic)

while another interviewee added,

> Everyone listens to Brazil. They are very strong and highly regarded. [. . .] On the one hand they play with the big guys, while on the other they are the voice of the developing and poor countries. [. . .] South Africa [. . .] is listened to because it is a strong African voice and the African continent cannot be bypassed. [. . .] Russia is trying to become a global leader. India [. . .] is quite influential regionally, especially in WHO terms and it has got some big international thinkers. [. . .] China's case is interesting. China hasn't sought any leadership, but because it's so large

Table 2. Main official global commitments to UHC

Official commitments major topic and key message(s)	BRICS official support Y/N				
	Brazil	Russia	India	China	South Africa
2005 58th World Health Assembly, Geneva WHA58/2005/REC/1. Resolution 58.33 *Resolution on Sustainable health financing, universal coverage and social health insurance* http://apps.who.int/gb/ebwha/pdf_files/WHA58-REC1/english/A58_2005_REC1-en.pdf	Y	Y	Y	Y	Y
2009 62nd World Health Assembly, Geneva WHA62/2009/REC/1 resolution 62.12. **Resolution on Primary health care, including health systems strengthening** (which included UHC of maternal, newborn and child health) http://apps.who.int/gb/ebwha/pdf_files/WHA62-REC1/WHA62_REC1-en.pdf	Y	Y	Y	Y	Y
2010 Ministerial Conference on Health Systems Financing—Key to Universal Coverage Ministerial support of the World Health Report 2010 'Health systems financing: the path to universal coverage' http://www.ghwatch.org/node/72	Y	N	N	N	N
2011 64th World Health Assembly, Geneva WHA64/2011/REC/1 resolution 64.9. Resolution on Sustainable health financing structures and universal coverage http://apps.who.int/gb/ebwha/pdf_files/WHA64/A64_R9-en.pdf	Y	Y	Y	Y	Y
2012 65th session of the World Health Assembly. The Assembly opened with a focus on UHC, with the strong support of many ministers. http://www.ghwatch.org/WHO-Watch/WHA65/Day2	Y	N	Y	Y	Y
2012 67th United Nations General Assembly Resolution A/67/L.36 United Nations General Assembly Resolution on UHC Recognizes the responsibility of Governments to urgently and significantly scale up efforts to accelerate the transition towards universal access to affordable and quality health-care services; 'Sustainable financing mechanisms for UHC: Encourages Member States to Plan, Pursue Transition of National Health Care Systems towards Universal Coverage' http://www.un.org/en/ga/search/view_doc.asp?symbol=A/RES/67/81	Y	N	N	N	Y
2013 Ministerial Meeting on UHC Geneva, February 18–19 Joint WHO/World Bank statement. Top officials from health and finance ministries from 27 countries joined high-level health professionals for discussing ways that countries are progressing towards UHC. http://www.who.int/mediacentre/events/meetings/2013/universal_health_coverage/en/ http://www.who.int/mediacentre/events/meetings/2013/uhc_who_worldbank_feb2013_background_document.pdf	Y	N	Y	N	Y
2013 66th session of World Health Assembly, resolution A66.24 on UHC Importance of educating health workers for universal coverage http://apps.who.int/gb/ebwha/pdf_files/WHA66/A66_24-en.pdf	Y	Y	Y	Y	Y

> and because what China does influences the rest of the world, when China speaks, people listen and try to interpret what they are doing. (BRICS/Global/International Organization)

Brazil, India, China and Russia were considered strongly influential by most respondents, varying between 82 and 91%, with Brazil being the highest and Russia the lowest. South Africa was considered influential in decision-making processes by 75% of the interviewees.

Nevertheless, many respondents felt that although some of them have been encouraged to engage in this 'movement', BRICS have not been influential in the construction of the UHC proposal.

In addition, the influence exerted by BRICS appears to be mainly political. For example, one respondent argued that,

> They all exert political influence. In UHC they are politically influential in getting resolutions adopted. This is what they have done until now. (BRICS/Global/International Organization)

The majority of key informants indicated that BRICS do not engage in joint activities to support UHC and that, in the global health arena, they do not work as a group.

Of all the questions posed, one of the most controversial was whether specific initiatives to support UHC had been taken by

Table 3. UHC in the BRICS Health Ministers' meetings

Place, year	UHC commitments
Beijing 11 July 2011	Beijing Declaration commitments: 'We agree to establish and encourage a global health agenda for universal access to affordable medicines and health commodities' 'We are also committed to support other countries in their efforts to promote health for All'. Available from: http://www.brics.utoronto.ca/commitments/2011-health-commitments.pdf
Geneva 22 May 2012	**2012** BRICS Health Ministers' Meeting in Geneva—Margins of WHO Joint Communiqué. 'Stress the importance of UHC as an essential instrument for the achievement of the right to health. Welcome the growing global support for UHC and sustainable development. Support to WHO in taking leadership role in advocating for UHC' Available from: http://www.iri.edu.ar/revistas/revista_dvd/revistas/cd%20revista%2042/documentos/BRICS%20Joint%20Communique%20of%20the%20BRICS%20on%20Health.pdf?option=com_docman&task=doc_download&gid=52&Itemid=21
Delhi 10-11 January 2013	**2013** Second BRICS Health Ministers meeting Delhi Communiqué. 'The Ministers confirmed their support for the United Nations General Assembly Resolution on UHC and committed to work nationally, regionally and globally to ensure that UHC is achieved' Available from: http://www.brics.utoronto.ca/docs/130111-health.html
Cape Town, 7 November 2013	Reiterated their commitment to collaborate on key thematic areas [.]UHC; Recognized and expressed appreciation for the momentum built with regard to UHC and expressed support for the leadership role and broad direction of WHO's Action Plan and further emphasized the importance of providing access to, in particular, quality Primary Health Care services for all. They emphasized the importance of monitoring progress towards UHC. [.] In this regard, the Ministers recognized the importance of strengthening policies and strategies, as well as international cooperation on human resources for health in order to achieve UHC. Available from: http://www.brics.utoronto.ca/docs/131107-health.html
Brasilia, 5 December 2014	Communiqué of the IV Meeting of BRICS Health Ministers Point 14. 'Recognizing that healthcare provides a fundamental contribution to a more inclusive and sustainable development model, and highlighting the importance of ensuring universal access to healthcare, the Ministers welcomed the Report of the Open Working Group on Sustainable Development Goals (OWG-SDG), and expressed their commitment to combine efforts during the Intergovernmental Negotiating Process for the Post-2015 Agenda, to be concluded in September 2015.' Available from: http://brics6.itamaraty.gov.br/category-english/21-documents/242-ivhealth

Table 4. Main global UHC events

Informal Commitments Major topic and Key message(s)	BRICS official support Y/N				
	Brazil	Russia	India	China	South Africa
2011 Rio Political Declaration on Social Determinants Recognition of the need to combat unequal access to health systems and pledges to support social protection floors as defined by countries to address specific needs. Available from: http://www.who.int/sdhconference/declaration/en/	Y	Y	Y	Y	Y
2012 Prince Mahidol Award Conference on financing for UHC: Bangkok Statement on UHC. Moving Towards UHC: Health Financing Matters. http://www.pmaconference.mahidol.ac.th/index.php?option=com_content&view=frontpage&Itemid=1	Y	N	Y	Y	Y
2012 Mexico City Political Declaration on UHC Participants agreed to promote the inclusion of UHC as an important element in the international development agenda. Available from: http://www.who.int/healthsystems/topics/financing/hsf_uc_mexicodeclaration/en/	Y	N	N	N	Y
2012 RIO +20 'The Future We Want' (A/RES/66/288) '[. . .] We pledge to strengthen health systems towards the provision of equitable universal coverage'. Available from: http://imuna.org/ares66288	Y	Y	Y	Y	Y

Table 5. Regional UHC events

Region	Official Commitment Major topic and Key message(s)
Africa	**Supported by South Africa:** **2011** Statement of the First Pan African Health Congress on Universal Coverage Theme: Creating a Movement for Universal Coverage in Health for Africa Participants agreed to: raise awareness on health financing, coordinate their efforts towards achieving UHC, encourage political commitment towards UHC in all African countries, etc. Available from: http://uhcforward.org/sites/uhcforward.org/files/much_in_africa.pdf **2012** Tunis Declaration on Value for Money, Sustainability and Accountability in the Health Sector 'A joint Declaration by the Ministers of Finance and Ministers of Health of Africa' Stated that all States involved in the conference should work towards UHC (and more specifically towards access to services) Recommends to 'take concrete measures in our respective countries in order to enhance value for money, sustainability and accountability in the health sector for reaching the objective of UHC' Available from: http://www.afdb.org/fileadmin/uploads/afdb/Documents/Generic-Documents/Tunis%20declaration%20english%20july%206%20%282%29.pdf **2013** TICAD V Side Event for Health: Challenges for UHC in Africa: What does it take to ensure equitable access and financial protection at the same time? Overview of UHC in Africa: expectations, progress and challenges; discussions on how to increase the financing for UHC in African countries and how to improve its management; conclusion on the role of national leaders and global partners in the promotion of UHC Available from: http://www.jica.go.jp/english/news/press/2013/c8h0vm0000700qj5-att/130603_02_04.pdf
SouthEast Asia	**Supported by China and India:** **2012** WHO South East Asia Regional Office (SEARO)'s Regional Meeting on UHC: Regional Strategy for UHC Resolution The nations involved agreed to strengthen primary care and improve efficiency in service delivery and equity in financial protection. (India does not belong to SEARO but supported the strategy) Available from: http://www.searo.who.int/entity/health_planning_financing/documents/HISEA.pdf
South America	**Supported by Brazil** **2012** 28th Pan American Sanitary Conference—Resolution on Health Technology Assessment and Incorporation into Health Systems (CSP28.R9). 'The countries should work toward achieving universality, access, integrity, quality and inclusion in the health systems available to individuals, families and communities' Available from: http://www.paho.org/hq./index.php?option=com_content&view=article&id=7022&Itemid=39541&lang=en#OfficialDocuments

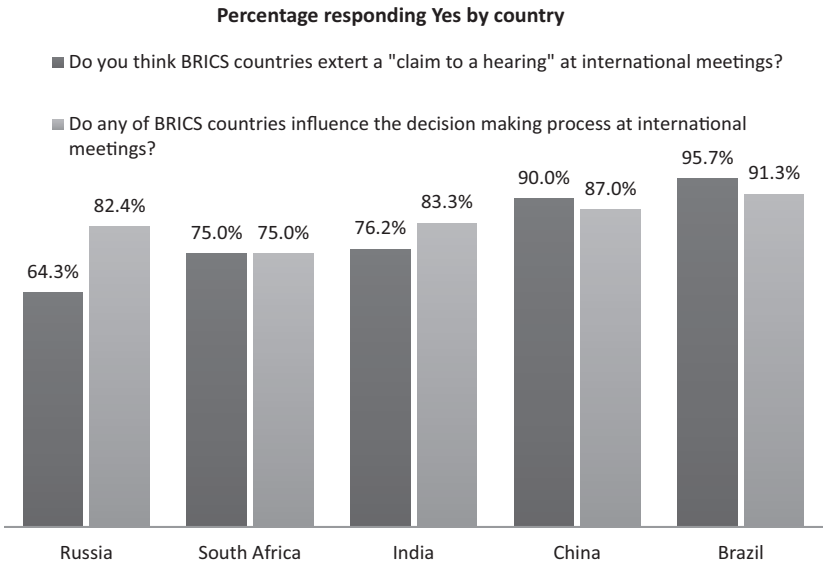

Figure 2 Capability of BRICS countries to exert a 'claim to a hearing' and to influence decision making at international meetings

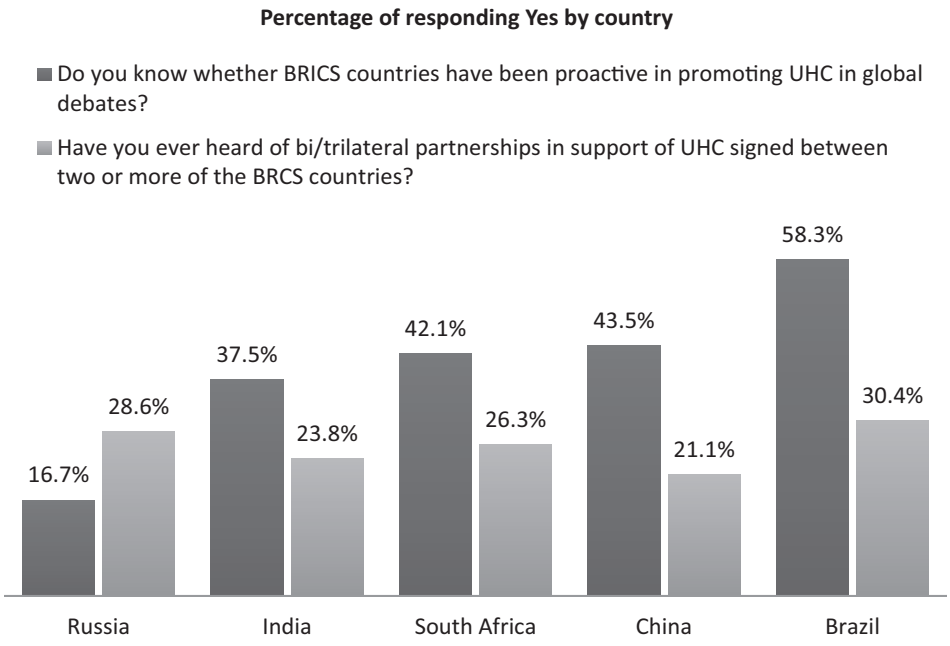

Figure 3 BRICS countries proactivity in promoting UHC global debates

BRICS at global level. Slightly more than half of the respondents considered Brazil to be proactive in supporting UHC in the international arena, while only around 43% in the case of China and South Africa, and 37.5% for India (data for Russia were missing). Yet, only a few informants were aware of joint initiatives and partnerships between two or more BRICS countries in support of UHC (between 20 and 30%; Figure 3).

Moreover, among those that answered positively to the existence of partnerships between BRICS countries for UHC, very few were able to mention precise examples.

BRICS might contribute to the global movement for UHC by influencing other countries in their region or continent. According to most respondents BRICS seem to have some influence on countries in their regions regarding the support to UHC: 95% of respondents argued this for Brazil, China and South Africa, 80% for Russia and 70% for India. Their engagement is, however, different. 65% of respondents considered Brazil proactive in exercising its regional influence, while only 50% identified China as proactive; approximately one-third identified India and South Africa as proactive, and only around 20% of respondents considered Russia an active promoter of UHC.

Regional leadership may be linked to domestic achievements. Beside its economic weight, Brazil's legitimacy as a leader for UHC may derive from its [mt]20 years of experience with universal access to care guaranteed—at least formally—by the constitutionally established Unified Health System ('Sistema Unico de Saude—[SUS]).

The leadership of Brazil in the region was critical in the construction of the South American Health Council in 2009, which started a process of integration in the domain of health that became a strategic policy driver redefining the terms of regionalism in South America (Riggirozzi 2014). Brazilian leadership was also instrumental to the international presence and joint action of UNASUR countries in international health governance contexts (i.e. at the WHA) (Buss and Ferreira 2011; Riggirozzi 2014). The South American Health Agenda's Five-Year Plan (2010–2015) includes the promotion of 'Universal and equitable Health Systems' and 'Universal access to medicines and medical products'.

According to some respondents, also China and India displayed a regional sphere of influence mainly by disseminating their experience to neighbouring countries, although only the example of the Indian insurance scheme *Rashtriya Swasthya Bima Yojna* (RSBY), promoted in Bangladesh, Nepal and Vietnam (Reddy 2012) was actually documented.

Internal debate on health policies and BRICS interest in UHC

Most respondents believe that the recent health system changes have been influenced by a UHC goal in all BRICS countries except Russia, although the consensus among respondents was slightly weaker (Figure 4). All respondents claimed that UHC has been high on the recent political agendas of China, India and South Africa, while the debate regarding UHC in Russia is limited. In fact, since 1993, the Russian health system, based largely on Mandatory Health Insurance, has been undergoing changes (Marten *et al.* 2014) that do not seem to be connected to a political will to achieve UHC.

In Brazil universal access to health services has been a fundamental, implicit right within the country since the right to health was enshrined in the Constitution at the end of the 1980s and the 'SUS' was established in 1990. Since that time, health policies have been demanding rights-based universal health services and there has continually been strong support from a powerful epistemic community of activists, academics, politicians and bureaucrats (Shankland and Cornwall 2007; Russo and Shankland 2014). The 'SUS' and Brazil's health sector reforms continue to be a focus of discussions in academia, social movements and others forums. When asked whether UHC was considered an important goal of the Brazilian domestic

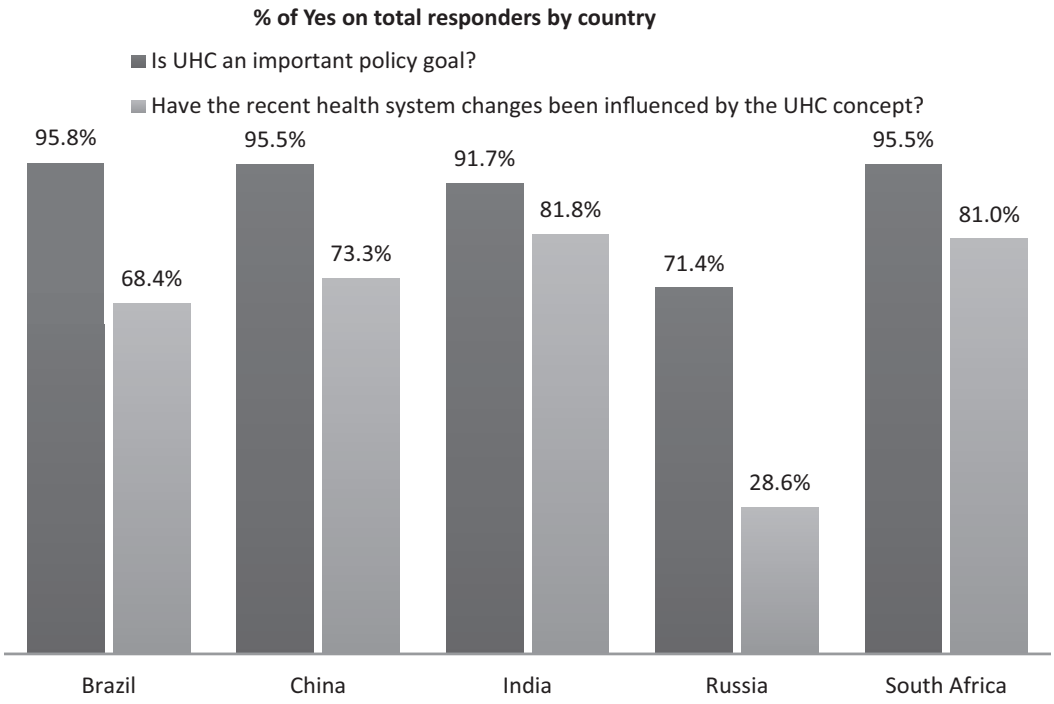

Figure 4 UHC as policy goal in BRICS countries

agenda most interviewees claimed that the concept was of little use for dealing with the problems faced by the Brazilian health system, because its principles had been already embraced during the 1990s reform.

The recent health sector reforms in China, India and South Africa can indeed be considered consistent with the UHC concept. In China, health reforms between 2003 and 2008 focused on extension of coverage and promotion of equitable access, particularly for rural populations (Yip *et al.* 2003). In 2009, the Chinese government announced a national Reform Plan which would lead to achieving nearly universal coverage by 2020 (Qingyue and Shenglan 2013).

In India, during the past decade, national-level reforms have been introduced via two innovative schemes aimed at: (a) improving the supply of services in rural areas (The 'National Rural Health Mission', in 2005); and (b) providing insurance coverage for hospital care to the most poor (the RSBY, 2007) (Duran *et al.* 2014). In 2010, a High Level Expert Group on UHC, set up by India's Planning Commission, proposed a number of health sector reforms dedicated to moving towards UHC that were then partly utilized by the planning commission's 12th Five-Year plan document on health. This subsequently informed another policy document for UHC issued in 2013 by the National Advisory Council. In addition, multiple States in India launched State Government initiatives, mainly aimed at preventing individuals from facing catastrophic healthcare expenditures.

South Africa seem to be lagging behind other countries in the path toward UHC (Marten *et al.* 2014). Although the move towards UHC is currently on the political agenda, the South African health system is still considered to be inequitable with a pro-rich distribution of health services, not only due to heavy reliance on the private sector but also because of inequity in access to public sector services (Ataguba and McIntyre 2012). In 2011 the government published a 'National Health Insurance green paper' which proposed a plan for strengthening the health system, establishing a National Health Insurance and re-engineering Primary Health Care. Reforms have been started in 11 'pilot districts' (out of 52 in total) and the rollout of the others has been programmed over the next 12 years.

The rationale for BRICS country interest in UHC is hard to assess. Yet most responders mentioned that, at least in the case of China, India and South Africa, it appears to be driven by national needs. This is translated in the way that reforms are ascribed to a long-term aim to walk towards UHC and are shaped by the individual context of these countries. One respondent argued that,

> In South Africa[...] UHC is addressed within the mindset of HIV/AIDS. Therefore, how to provide UHC becomes how to provide ARVs. On the India side, it is actually the agility of the system and its infrastructure that matters. [...] China is looking to the benefit package and financial protection to resolve the problems they are living with. (BRICS/National/Academic)

Another respondent said about South Africa

> the private insurance schemes cover 16% of the population, but 44% of total healthcare expenditure is through these private insurance companies, so you can imagine how skewed the distribution of health workers is through the private and public sectors. [...] so there is this massive inequality and the big challenge is how to create an integrated pool of public funds to ensure that everyone has access to good quality care (South Africa/National/Academic).

Similarly, another respondent commented,

> Differences in financing and accessing health services between urban and rural areas are a major issue in China when promoting UHC (China/National/International Organization)

In Brazil, China, India and South Africa, support for UHC may be also driven by their political and economic agendas. A few informants argued that UHC could become the global policy field where BRICS countries' influence might, indirectly, become relevant in terms of balancing the power between big corporations originating in the North and those of emerging economies and to gain relevance in the global development political arena. This is an interesting, though questionable, view which it was not possible to further investigate in this study.

Interpretation and implications

The influence that BRICS and other emerging countries may exert on the global UHC debate, whether as a coordinated group or as individual countries, may offer insights on their overall role in determining the global health agenda. Despite several limitations, which include a relatively small sample that cannot be considered representative of all major stakeholders involved in the global movement supporting UHC, and low engagement of BRICS countries' government representatives, this study provides insights and raises questions for further study on the role the BRICS countries are increasingly playing in the global health arena.

BRICS countries' largely supported the global political commitments to UHC. Although many responders do not believe the BRICS have been influential in the construction of the UHC concept, this political support indicates these countries may have played an important role in the surge of the global UHC movement. However, BRICS countries do not share the same level of political involvement, with Brazil, China and South Africa constantly on the front lines and the others, notably Russia, lagging behind.

Most responders believed China, India, South Africa and to some extent Brazil, are implicitly supporting the global movement for UHC largely in response to internal needs. The results also highlighted a possible disconnect between the external perceptions of BRICS countries toward UHC and the internal debate, particularly for Brazil and Russia.

Despite the fact that support to UHC was mentioned in all BRICS Health Ministers Meetings, a shared strategy cannot be documented, nor perceived, beyond minimally, in that most countries actively engage in the promotion of UHC. The results of the stakeholders' interviews are consistent with this observation. Interviewed informants agreed that, in the global health arena, BRICS countries act more as individual countries rather than as an allied group, possibly limiting collaboration internal to the group to the engagement in bilateral agreements.

BRICS countries thus, more individually than as a block, seem to be influential in supporting the UHC movement having a claim to a hearing in global health arenas and promoting UHC in their region.

Although their internal health challenges seem to drive them to give more emphasis to specific issues, the UHC conceptualization is largely accepted in BRICS countries. The fact that the recent reforms in some of these countries—namely China, India and South Africa—were inspired by the UHC concept further indicates their engagement in the UHC movement individually if not as a block. Furthermore, BRICS's specific health challenges and needs may even influence the way UHC will continue to be supported at global level in the future—starting from how it will be reflected in practice in the context of the recently agreed SDGs.

Although this study provides some interesting suggestions, understanding how BRICS countries exert influence and their potential interest in playing a more active role remains unclear. The main reason for BRICS' 'claim to hearing' is still undoubtedly linked to their economic weight. This may imply that they, either individually or as a group, might become increasingly influential players shaping the global health agenda. However, the case of Brazil offers a different interpretation, given that, despite a lower economic weight and position, Brazil has the capacity to somehow channel 'the voice' of poorer countries. This may be linked to the fact that Brazil's global advocacy for UHC is consistent with the domestic policy, in which the right to health and the 'universalistic' approach are founding principles of the longstanding 'SUS', established constitutionally at the end of the 1980s.

Conclusion

BRICS involvement in the movement supporting UHC is documented and reflected in political support to most global commitments for UHC. Yet despite several recent political initiatives, including four BRICS Summits and three BRICS Health Ministers Meetings, the evidence of BRICS' acting as a political block in relation to UHC remains weak. In fact, in supporting the UHC movement, BRICS seems to act more as individual countries rather that as an allied group and driven by domestic needs.

These findings suggest that BRICS are unlikely to be a unified political block that will transform global health governance. Yet the documented involvement of BRICS in the global movement supporting UHC, and their focus on domestic challenges, shows that BRICS individually are increasingly influential players in global health. So if BRICS countries should probably not be portrayed as the centre of future political community that will transform global health governance, their individual involvement in global health, and their documented concerted actions, may give greater voice to low- and middle-income countries supporting the emergence of multiple centres of powers in global health.

Supplementary data

Supplementary data are available at *HEAPOL* online

Acknowledgements

We would like to thank the participants of the meeting convened in May 2013 by the Global Health and Development group at Bocconi University and hosted by the Rockefeller Centre in Bellagio, Italy, for the insightful discussions and for their availability to share their knowledge. Alphabetically listed: Celia Almeida, Dina Balabanova, Gerald Bloom, Kirill Danishevski, Victoria Fan, Lara Gautier, Yan Guo, Yanzhong Huang, Julia Kulik, Martin Mckee, Sergey Shishkin, Claudia Maria Travassos, Vim Van Damme, Nicola Watt and Rob Yates. We would also like to thank Dondald de Savigny for the helpful comments provided on this manuscript, Lara Gautier for her support in reviewing the global commitments for UHC and for her inputs in preparation of the study, and Andrew Harmer for his initial contribution to define a theoretical framework. All responsibilities for the manuscript rest with the authors.

Funding

This research was funded by Fondazione Cariplo as part of the project 'Understanding economic, political and social contribution to Global Health of newly emerging countries' (project code 2011-1679).

Conflict of interest statement. None declared.

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