**Regionalism through Social Policy: Collective Action and Health Diplomacy in South America**

**Address for correspondence**

Pía Riggirozzi

University of Southampton, Politics & International Relations, Highfield, Southampton, SO17 1BJ, UK

Email: P.Riggirozzi@Soton.ac.uk

**Biographical note**

Pía Riggirozzi is Assistant Professor at the University of Southampton. Her research focuses on political economy of development and regionalism, with an interest in the Americas. She is the author of *Advancing Governance in the South: What Roles for IFIs in Developing States?* (Palgrave, 2009), ‘Region, Regionness and Regionalism in Latin America: Towards a New Synthesis’ (*New Political Economy* 17:4, 2012), *The Rise of Post-Hegemonic Regionalism: The Case of Latin America* (edited with D. Tussie, Springer, 2012); and ‘Post-neoliberalism in Latin America: Rebuilding and Reclaiming the State after Crisis’ (with J. Grugel, *Development and Change* 43:1, 2012). Pía is currently engaged in a collaborative ESRC-DFID funded project that explores regional integration processes and poverty reduction in the South.

**Abstract**

This paper is concerned with the place of social policy as a driver of region-building in South America. The contention is that while much has been written about economic integration, institutions and security communities in regionalism, a discussion of the significance of other regional projects has lagged behind. Social policy, particularly in the Americas, has been neglected as a policy domain in the account of regionalism. Changes in the political economy of Latin America in the last decade suggest that we need to engage afresh with regional governance and social policy formation in the Americas. By looking at the institutions, resources and policy action in the area of health within the Union of South American Nations (UNASUR) this paper reconnects regionalism and social policy and explores two inter-related, yet largely unexplored, issues: the linkages between regional integration and social development beyond the historical hub of trade and finance; and the capacity of UNASUR to enable new policies for collective action in support of social development goals in the region, and to act as a broker of rights-based demands in global health governance. In so doing, the paper contributes towards a more nuanced understanding of regionalism and regionalisation as alternative forms of regional governance.

**Key words:** regional social policy; regionalism; regionalisation; regional health diplomacy; UNASUR, post-trade regional governance

**Regionalism through Social Policy: Collective Action and Health Diplomacy in South America**

Like all forms of governance, regionalism is a form of coordination across and between different policy areas. Regionalism is organised in different forms of institutional architecture that open different kinds of opportunities for political engagement; and thus different types of activism. Regionalism can be seen as the place ‘where politics happen’, a space for policy deliberation and action. Increasingly, the growing capacity of regions to project those actions in different environments of global governance has been recognised in the study of international relations and political economy (Söderbaum *et al* 2005; Bretherton and Vogler 2006). The study of European integration has contributed significantly to our understanding of how and why regions developed as different projects yet can act ‘as one’ in international politics (Söderbaum and Stålgren 2010). However, little research has done on how regional diplomacy manifests and is practiced in regions beyond Europe. This paper seeks to advance this debate by arguing that there are unexplored synergies between regional institutions and social development, and that regional integration processes have potentially significant impacts on human development and poverty reduction. In light of this, the paper considers regional formations as both sites for collective action and pivotal actors providing normative frameworks structuring practices in support of governance norms. Furthermore, the paper looks at how regionalism in South America has moved away from historical economic concerns to embrace a broader agenda driven by social concerns. In this context, the paper asks: What are the possibilities of meso-level institutions to provide normative leadership and direction structuring practices in support of social policy and social development? To what extent do regional organisations from the Global South contest and rework international norms affecting developing countries’ societies? These are important questions that have received some attention within EU studies but have been largely overlooked in the study of regionalism in the Americas. Certainly, regionalism in this part of the world was seen mainly as an economic regime on the path towards neoliberal political economies. As a consequence, despite a wide array of political projects of varying compositions, capabilities and aspirations, expectations of what regional governance can deliver in the Americas have been evaluated primarily in terms of trade liberalisation and trade integration (Carranza 2006; Mansfield and Solinger 2012). It is not surprising then that despite a wealth of literature offering normative references to the capacity of regional frameworks to provide social development, in Latin America this has largely remained as a rhetorical aspect of the way regionalism has unfolded and has been studied (Di Pietro 2003; Grugel 2005). However, a process of political renewal underway in Latin America, and mostly in South America, since the early 2000s, has meant that regionalism may be in the process of ‘catching up’ with social concerns. Loosening the harness of the neoliberal myth as an organising principle of national and regional political economy allowed for new governing arrangements and practices across South America, embraced by a new tide of Left/Left of Centre governments and non-state actors (Panizza 2009). Latin American regionalism is currently experiencing a ‘social turn’ where new motivations to improve redistribution of income and social services at domestic levels are also reclaiming the region for a more ‘positive regionalism’ that introduces rights and inclusion through regional policies (Scharpf 1996).

This paper is concerned with two inter-related yet largely unexplored issues: the linkages between regional integration, social policy and social development; and the ability of regional institutions to embrace, as a bloc, external collective action in defence of social rights. By exploring the policy field of health as governed by the Union of South American Nations (UNASUR), the paper argues that health become a strategic policy driver redefining the terms of regionalism in South America, and hence new forms of regionalisation are unfolding ‘on the edges’ of its most usual approach to market-led integration. The implications of these developments, it is argued, are to be seen in new forms of coordination for the implementation of regional health programmes on the ground, as well as in new forms of regional diplomacy where a more confident region is negotiating as a bloc the terms of global health governance. In other words, the paper proposes to revisit emerging regional formations as they become both sites for collective action and pivotal actors contesting and reworking international norms affecting developing countries. The study of UNASUR health policy offers policy-relevant insights in support of a greater understanding of new processes of regionalisation, substantiating normative studies of regional social policy and ‘unpacking’ processes, networks, and outcomes of regional building and regional diplomacy.

The analysis proceeds in four parts. The first part evaluates the conceptual contributions to global social policy framing the debate. The second looks at the neglected place of social policy in the process of regionalism in Latin America. The third part focuses on UNASUR health governance as both a new mode of regionalism and of regional health diplomacy. The fourth part concludes speculating about the social purpose of regionalism, and the extent to which we can genuinely talk about new responsibilities and rights defining regional governance in South America.

**REGIONAL GOVERNANCE AND THE STUDY OF REGIONAL SOCIAL POLICY**

Social development and social policy considerations are gaining prominence in the debate about regionalism as countries attempt to address increasing poverty, unemployment and social inequality. At the same time, as globalisation creates greater risks to increasingly porous national borders, social protection becomes critical to managing and participating in processes of global political economic integration. Particularly since the 1990s, there has been a growing consensus that, in an increasingly globalised world, new political thinking and new kinds of policies are necessary to achieve socially-equitable development (Yeates 2002). Moving away from the traditional national focus of social policy, and recognising a wide variety of domains and spaces of policy formation and negotiation, political and academic circles turned attention to forms of governance capable of ensuring an equitable global economic order. Trans-national cooperation in the delivery of social policy was part of this thinking; a perspective that essentially proposes that the causes of, and solutions to, many social issues are not necessarily confined to national institutions, structures and frameworks but are rather entangled in processes that extend beyond the bounds of the nation-state (Yeates and Deacon 2006; Ortiz 2007).

This perspective became particularly persuasive as, since the 1990s, global welfare settlement mechanisms proliferated through donations, technical cooperation, and international aid by international non-governmental organisations and multilateral institutions within the United Nations system. The understanding was that in the absence of state capacity, or willingness, global interventions by private non-governmental organisations and multilateral development agencies, could influence national policy by means of transnational redistribution, supranational regulations, technical advice and cooperation, or through conditional aid (Stubbs 2003: 320; Deacon *et al* 2007: 8). In practice, significant global policy efforts to eliminate world poverty became increasingly instrumental, channelling overseas aid to fund North-South transfers, new forms of finance for development, and campaigning for a global social protection floor. In Latin America, global social policy took mostly the form of compensatory policies, anti-poverty programmes and social investment, advanced by the World Bank and the Intern-American Development Bank to balance the social effects of trade openness, privatisation of public services such as health, education and pensions, and deregulation of the market (SELA 2004; Cornwall and Brock 2005). Controversies around these ‘global social policy’ programmes mounted as they were seen as intervention in response to market or government failures yet disengaged from a broader debate about models of social development and social transformation (Cammack 2004; Deacon *et al* 2010).

At the same time, as regional formations were in ascendancy in the 1990s, increasing cross-border problems such as health pandemics or illegal immigration highlighted the need to coordinate surveillance mechanisms to control transmittable diseases or to correct inequalities and redistribute welfare opportunities (Ortiz 2007: 64). In other words, it became clear that social policy made sense not only to compensate market policies but also because some social harms were inherently cross-border, that is exacerbated or facilitated by regional developments. In Latin America, for instance, new forms of trans-national cooperation emerged in the area of health surveillance and labour migration as well as in specific areas that could boost market competitiveness such as higher education and foreign investment policies (UNU/CRIS 2008; Deacon *et al* 2010). In this context, the debate about regional social policy revolved around effective ways of securing cross-border coordinating and implementing redistributive projects (for example cross-border employment projects, social protection, disaster mitigation funds, vaccination campaigns, food programmes); regulatory frameworks for convergence, and harmonisation of policies, services and potentially rights in the social fields (Threlfall 2003; Deacon *et al* 2007: 4; also te Velde *et al* 2006). For others, coordinating initiatives in regional spaces was seen as means for breaking with traditional models of unilateral transfer of ‘ready-made packages’ conveyed in global development aid (Almeida *et al* 2009).

Despite these conceptualisations, there is little actual empirical research on regional social policy outside the EU context; specifically on how regional policies address social needs, advance inclusion and promote social development. The most comprehensive survey to date mapped the extent to which regional formations were developing social policies across a wide range of sectors, but there is no in-depth examination of the policy formation dynamics in relation to any one sector or any one region (see Deacon *et al* 2010). Studies of individual regions have invariably lacked a specific social policy focus, concentrating instead on institutional contours of regional structures, or on trade, finance and security policies. To deepen our comprehension of the place of social policy in contemporary region building in Latin America, the question is not whether there should be a social policy dimension to regional integration but what kind of policies, for what purposes, through which mechanisms and to what effect such policies have actually been instituted and implemented.

This is not to say that normative policy considerations about the social character of regional integration processes no longer matter. Indeed, the extent to which social policy is to evolve more fully over larger integrative scales and become a core matter of supra-national governance remains a salient matter addressed by academics, and struggled over by policy-makers. But empirical questions about what sorts of political cooperation and institutions are most conducive to promoting regional social policy and poverty reduction have yet to be fully considered. These questions become more pressing in the face of what has been termed ‘post-neoliberal regionalism’ in Latin America (Sanahuja 2012; Riggirozzi and Tussie 2012), offering an intriguing entry point to evaluate regional integration and social development synergies, and to assess the possibilities of regional social policy, be it through cross-border redistribution, cross-border regulation, or through the articulation of cross-border social rights.

In many ways, freeing the region from the hand of the hegemonic engine, material and ideologically, opened opportunities to explore the possibilities to re-create and explore a stronger social regionalism in Latin America.

**WEAK LEGACIES OF REGIONAL SOCIAL POLICY IN LATIN AMERICA**

In the Americas the way regionalism unfolded has been something of a paradox; although the appeal to social and human development has been integral to the regional imaginary and even manifested in formal documents and declarations supporting convergence and harmonisation of policies in the areas of labour rights, education, and health, in practice very little dialogue between trade policies and issues of poverty and inclusion meant that collective action on social goals drifted away from the attention of authorities and consequently regional mechanisms had limited or no influence on policy-making in regards to such issues. It is not surprising then that much of the literature has had a focus on Europe to speculate on the potential of regional cooperation as a platform for rescaling social regulations, redistribution and inclusion. In Latin America delivering social protection, welfare and human development remained seen as the responsibility of (seriously constrained) domestic spending choices, often to mitigate the effects of market reforms or to secure political support of citizens (Lewis and Lloyd Sherlock 2009: 113). At the same time, the political economy of regionalism and development was dominated by debt crisis, austerity, US influence over regional politics across Latin America, and demands for trade and financial deregulation (Gamble and Payne 1996: 251-52; Phillips 2003: 329). This was the case of the Southern Common Market (MERCOSUR) in 1991 grouping Brazil, Argentina, Uruguay and Paraguay; the North American Free Trade Agreement (NAFTA) signed by the US, Canada and Mexico in 1994, and the renewed impetus from resilient projects, like the Community of Andean Nations created in 1969. In these cases it was expected that by loosening the restrictions on finance and trade, new market projects could enhance the capacity of states to manage the pressures of the global order through regionalisation (Phillips 2003).

Notwithstanding the emphasis on market-led regionalism, some ‘social clauses’ were introduced in both the Andean Community and MERCOSUR, where the legacy of developmental welfare states steering development projects since the 1940s has been significant (Riesco 2010). In this sense, social policy through regionalism is hardly ‘new’ as some cross-border projects on health, education and labour regulations were supported within the structure of both Andean Community and MERCOSUR. In the Andean Community, two managing bodies, the Hipólito Unanúe Agreement and the Andres Bello Convention, were established to deal with common challenges in the areas of health and education respectively. There are some indicators that suggest that some programmes in both areas have been critical in tackling prevention and control of diseases affecting border areas, and enhancing quality in education. This has been the case of the Bi-National Health Network Zumba-San Ignacio, directed at improving infrastructure and medical equipment in healthcare facilities for the population of the two border cities between Ecuador and Peru; and projects for rural development and nutrition improvement in indigenous communities (SELA 2010: 8; Andolina *et al* 2009). Likewise, in the area of education, policies towards the harmonisation of curricula, mobility of students and professionals, and quality assurance programmes are in place in the Andean Community (*ibid*). In the case of MERCOSUR, one of the social policies that made concrete impact in terms of regulatory policies and regional legislation was health. Health was not a priority in the foundation of MERCOSUR but as the bloc was working towards trade consolidation, issues of disease control and epidemiological surveillance in trans-border activities became a priority, particularly in the triple border shared by Brazil, Argentina and Paraguay, crossed everyday by vast numbers of migrants and thousands of tourists (Holst 2009). This led to the creation of the Health Minister Assembly and the Health Working Group (GTS11) established in 1996 at a ministerial level for the discussion of health policy and strategies of surveillance (MERCOSUR Decision CMC No 03/1995). Regulations dealt mainly with issues related to public health surveillance, control and standardisation of sanitary standards, and common regulations on pharmaceuticals for trade and joint health and safety inspections. But reciprocal social security entitlements related to access to medicines, health services, and reform of national policies and professionalisation of health workers and policy-makers were not addressed by MERCOSUR. This was the case despite the creation of the Fund for Structural Convergence (FOCEM) in 2003. FOCEM is a regional budget to overcome asymmetries in less developed countries. In practice, however, the funds have been assigned mainly to infrastructure programmes to enhance border integration and communication systems, in the understanding that connecting goods to markets, workers to industry, people to services, and the poor in rural areas to urban growth centres, would enhance social development. This, however, was insufficient to address structural problems of poverty and inequality and social determinants of poor health. In other areas such as education and labour rights, agreements have been reached to standardized workers’ rights, and to harmonise quality and recognition of university programmes and degrees but further commitments on harmonisation of policies have been erratic and with mixed commitments in terms of implementation during the 1990s (UNDP 2011).

Institutionally, attempts at enhancing social participation in policy formulation were led by the creation of two consultation forums; the Economic and Social Consultative Forum (the *Foro Consultativo Economico y Social* - FCES), formalised in 1994 within the structure of MERCOSUR as a non-binding social consultation process; and the MERCOSUR’s Social Institute (Instituto Social del MERCOSUR, ISM) in 2006, presented as a hub for research on social policy and policy recommendation. Disappointingly, the FCES remained largely limited in its social focus as it has been comprised mainly by representatives of business groups, trade union federations, and some ‘third sector’ groups dominated by consumer protection bodies. Bureaucratic difficulties and ideological cleavages made the FCES highly ineffective, struggling to find a place within the machinery of social integration (Grugel 2009). The ISM, on the other hand, evolved as an important referent for civil society activism and researchers working on social policy issues, although its reach to the policy circles remained limited.

While these events and institutional initiatives attempted to promote a more genuine social agenda, policy action and regional norms remained plagued by procedural ambiguities and fundamentally held back by financial and economic hardship. Regional social agendas remained embryonic, tied to considerations of economic integration. Other commitments over a range of social policy areas were made but these were working under severely financially constrained conditions and with low levels of coordination for implementation and compliance, affecting the depth and pace of regional social policies (Riesco 2010). Politically, rudimentary institutional structures in both Andean Community and MERCOSUR often delegated decisions over regional policies and politics to restricted processes of inter-governmental negotiation with little or no input from beneficiaries, practitioners and experts. Inter-governmentalism, or rather inter-presidentialism, meant that social policy was often subject to discretionary policy-making, and to the political will of ministers and private providers (Malamud 2005; Sanchez 2007). Consequently, despite declarations and statements of policy intent upon a regional social agenda, the capacity of social actors to penetrate the regional policy debate and negotiation of policies has been severely curtailed by a regional political culture that fenced off from society while responding to market pressures. Economically, the broader social policy system across regionalist projects in the Americas has been limited by a tension difficult to reconcile; that is, efforts to develop a social dimension in regional agreements were often sterilized by structural adjustment programmes, neoliberal reforms, and elite politics (Draibe 2007: 182). In other words, economic and social regional projects in the Americas unfolded at different speeds and bounded by a political decoupling of economic integration and social goals (Carranza 2006: 809). Commitments to regional integration in the area of social policy hence remained as a ‘minimalist strategy’ led by targeted, bi-national, programmes to address specific cross-border problems that ran short in addressing the acute social problem facing Latin American societies in the context of state cut backs and rising levels of deprivation and deteriorating standards of social provision (Birdsall and Lodoño 1998; Grugel 2005).

As the decade ended with alarming poverty indicators across the region, with nearly half of the total population living under poverty and a high percentage in extreme poverty (ECLAC 2011: 11), it does not come as a surprise that episodes of resistance to neoliberalism and social demands erupted in Latin America in early 2000. ‘Reclaiming the state’, as argued by Grugel and Riggirozzi (2012), began with the rejection of a generation of political leaders who were responsible for the introduction of neoliberalism in the 1980s and 1990s, and demands for a new democratic ethos, new responsibilities for the state, and rights of citizens. The context paved the way for the renewal of politics and policies at both national and regional levels. The rise of New Leftist governments across the region – in Venezuela (1998), Brazil (2002), Argentina (2003), Uruguay (2004), Bolivia (2005), Ecuador (2006), Paraguay (2008) and Peru (2011) – was not simply an expression of partisan and symbolic politics, but a more profound acknowledgement that economic governance could not be delinked from the responsibilities of the state to deliver inclusive democracy and socially responsive political economies. In the wake of crises, alternative strategies for development thus led to the adoption of mixed and generally pragmatic combination of welfare and populist policies that secured not only post-crisis governance but also the control of poverty and extreme poverty indexes. This was possible because the rising tide of citizenship demands in Latin America coincided with changing economic landscape in the region. After years of slow growth and recession, Latin American economies were expanding in a genuinely unprecedented fashion in response to rising global demand for minerals, energy and agricultural produces mainly led by emerging markets in Asia (ECLAC 2011: 77). More confident and well-resourced Leftist governments not only developed a new attitude to state-building and inclusion, but also to region-building. This became evident in the aftermath of the Fourth Summit of the Americas, which took place in Buenos Aires in November 2005. The Summit declaration grounded two opposing views: one favouring the US-led hemispheric regionalist project, the Free Trade Agreement of the Americas (FTAA) – mainly supported by the US, Mexico and Canada, and countries especially dependent on preferential US trade agreements; and another dissenting group, including Brazil, Argentina, Venezuela and Bolivia, which declared themselves against a hemispheric trade agreement and refused to commit to future FTAA talks (Saguier 2007). The defeat of the FTAA was an indication that the previously unquestioned association between regionalism and the trade/investment agendas was now open for review.

Although the idea of a unified counter-hegemony to supplant neoliberalism in Latin America is clearly an overstatement, since the early 2000s the region embraced different regional projects at odds with the US-sponsored Washington Consensus. This crystallised in the First Summit of South American Presidents, in 2000, when discussions turned towards renewed commitments on democratic principles and a broader sense of development (Sanahuja 2012). However, it was not until the termination of FTAA negotiations that the South American integration process entered a new phase and dynamism. The Third Summit held in Cuzco, Peru, in December 2004, established the South American Union of Nations (SACN) that was later institutionalised as the Union of South American Nations (UNASUR). The Cuzco Declaration established three main goals: convergence between pre-existing trade-led agreements, specifically MERCOSUR and Andean Community; new commitments to advance physical infrastructure (roads, energy and communications), a plan that was originated in the First South American Summit with the establishment of IIRSA; and political cooperation in health and security (Riggirozzi and Tussie 2012).[[1]](#footnote-1) That same year, a new regionalist project was also led by Venezuela, the Alianza Bolivariana de las Americas (ALBA).[[2]](#footnote-2) Despite ideological and institutional differences, and beyond political symbolism, these regionalist projects embraced new regionally-anchored commitments addressing the needs for human development (Riggirozzi 2012). This is not simply political voluntarism, but also a new opportunity given by geopolitical transformations in the coordinates of trade, production and finance. At the inter-American level, new geopolitical challenges to the US as an hegemonic power meant that Latin American countries, especially South American, found a renewed opportunity to re-direct efforts, rethink loyalties, and redefine consensuses while fostering South-South cooperation in overlooked areas of social development.

In this context, South America became a ready platform for the re-ignition of regionalism incorporating the normative dimensions of a new era, at odds with both the neoliberal core and defiant of US mentoring, redressing how integration projects should respond to the legacies of poverty and create innovative mechanisms orientated to reduce Latin American’s social debt. This was reflected in the UNASUR Constitutive Treaty, signed in Brasilia in May 2008, which explicitly declares human rights as a core value of integration, expressing the need to foster an integrative process in support of social inclusion and poverty eradication.[[3]](#footnote-3) Within this framework, it is also specifically declared the ‘*right to health as the energetic force* of the people in the process for South American integration’ (UNASUR 2009: 14, emphasis added).

**RE-CONNECTING REGIONALISM AND SOCIAL POLICY THROUGH HEALTH**

The re-discovery of the region as a common space for pulling together resources manifested in new commitments for institutional innovation and funding in support of alternative ways of managing economic and human development beyond traditional forms of state-bounded rights. This is not a minor issue in societies with high levels of poverty, exclusion and inequality, and that struggled to mobilise funding for social cohesion programmes. This is even more the case in South America where, after years of sluggish growth and recession, a new cycle economic growth since the early 2000s saw rates of poverty fall sharply in Latin America; by more than 14 per cent between 2000 and 2011 (ECLAC 2011). But despite these records, economic growth remains ambivalent. Around 168 million live in poverty, that is under 30 per cent of the population, subsists with less than two dollars a day, while 66 million live in extreme poverty, earning less than one dollar per day (*ibid*: 14). Amongst this population, the most economically and socially vulnerable, namely indigenous, rural poor, slum residents, migrant workers, face the greatest burden in the poverty-health nexus, suffering infectious diseases and disabilities (*ibid*: 9). Some alarming figures show that in low-income countries, such as Bolivia, Paraguay and Peru, communicable diseases exert the most important influence on quality of life and life expectancy. The incidence of endemic infectious diseases such as malaria, tuberculosis and dengue, and other communicable diseases such as HIV is a significant and growing problem across the region (Barreto et al 2012). This social reality reflects unequal economic and health indicators amongst countries that are also different in terms of their health systems, levels of professionalisation, and technical, scientific and institutional capacities. This bleak situation has been worsened by limited access to medicines, particularly affecting populations in rural and tropical areas, which accounts for what has been identified as neglected diseases and neglected populations across the South (Holveck *et al* 2007). It is in these circumstances, in tandem with new opportunities for mobilisation of ideas and resources brought about by the resurgence of growth since the early 2000s, that the political agenda of UNASUR addressed the regional integration-poverty nexus in support of health equity goals. These goals focus on neglected diseases affecting large populations, which in many cases are located in shared borders; and the way South America is represented in global health governance, as risks, regulatory frameworks and resources are considered to disproportionately affect the developing world (see UNASUR 2011: 15). Ultimately, health governance, as a ‘locus for integration’, not only speaks of a new morality of integration linked to inclusion and human development, but also of a new form of regional diplomacy.

***Regional Health Diplomacy in UNASUR***

While the experience of health in MERCOSUR and the Andean Community was determined by an environment marked by financial dependency, economic austerity and cut in social spending throughout the 1990s, UNASUR embraced social policies in a different political and economic environment. As a consequence, while previous regionalist arrangements were limited in tackling social policies, UNASUR established a new normative framework structuring regional cooperation and ‘guiding’ policy in response to social issues. In this context, health took centrality not only as a sanitary problem of trans-border relations but also and fundamentally as a right to be sought in intra-regional relations and in global governance diplomacy (Buss 2011). In other words, while previous regionalist attempts by MERCOSUR and CAN tackled specific needs for trans-border epidemiological control and surveillance in response to increased traffic of trade and people, UNASUR seeks to both reduce cross-border sanitation risks and to 'broker’ new policies and renegotiating the terms of existing health policies in international forums and *vis a vis* pharmaceuticals.

This points directly to a new role of the South American regional formation as it intervenes in one of the most political complex tensions between the interests of the pharmaceutical industry, national health systems, and citizens’ access to medicine (Geyer 2009). A troubling area in this policy domain is effectively that of property rights where patents on pharmaceutical products through Trade Related Aspects of Intellectual Property Rights (TRIPS), part of the normative of the World Trade Organisation (WTO), can pose restrictions for access to medicines. Numerous public health experts, academics and practitioners have expressed concerns over time about how access to medicines has been hampered by unfavourable trade negotiations and the impact of TRIPS limiting availability and increasing prices of drugs in favour of the pharmaceutical sector (Oliveira *et al* 2004). Although the TRIPS Agreement allows developing countries to override drug patents by issuing ‘compulsory licences’ to manufacture generic drugs in exceptional cases, for instance when drugs are not sufficient or affordable domestically, these flexibilities have sometimes been curtailed (So 2004). Restrictive bilateral frameworks have been applied to a number of US and EU-sponsored FTAs with Central America, Chile, Peru and Colombia, curtailing the flexibilities for compulsory licensing and parallel imports of medicines at lower prices than other countries, hence circumventing the WTO framework (*ibid*: 813)

In the struggle for access to medicines, South American countries had previously enrolled in collective bargaining for price reductions in the procurement of pharmaceuticals for national health programmes, particularly in response to the escalation of HIV in Brazil in the 1990s (SELA 2008: 56). But these inter-ministerial initiatives were rather *ad hoc* and severely limited by the realities and pressures of economies highly dependent on international cooperation and international funding, often demanding fiscal austerity and ‘less state’ through privatisation and deregulation of markets, including health (Almeida *et al* 2010). As a consequence, South America failed to build permanent and effective regional institutions promoting health rights, and creating opportunities for societies to access, enjoy and reproduce those rights. UNASUR picked up this challenge embracing new commitments in three interrelated policy levels: (i) institutional, as a regulatory actor; (ii); project-led, responding to regional needs; and (iii) diplomatic, engaged in extra-regional relations.

Institutionally, the launching of UNASUR in 2008 was marked by the establishment of two key sectoral councils which, together with infrastructure, became the main pillars of the new regionalism: the South American Health Council and the South American Defence Council. In addition, supporting these Councils two permanent think-tanks were created at the launching of UNASUR: the South American Institute of Health Governance (Instituto Sudamericano de Gobierno en Salud, ISAGS), in Rio de Janeiro, Brazil; and the Centre of Strategic Studies, in Buenos Aires, Argentina (interview with ISAGS Chief of Cabinet, 29th August 2012). The Health Council works at the ministerial level to consolidate South American integration in the health field through policies and an agenda proposed by members in combination with thematic Technical Groups. In 2009 UNASUR health Council approved a Five Year Plan (Plan Quinquenal) outlining actions towards the implementation of projects and regulatory frameworks, allocation of financial resources, and capacity building on five programmes:

 (1) Coordination of surveillance, immunisation, 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 coordination of information for implementation and monitoring of health policies;

 (4) Coordination of strategies to increase access to medicines and foster production and commercialisation of generic drugs, including harmonisation of medicines’ surveillance and registries for members; coordinated policy for pricing of medicines for the purchase from, and external negotiations;

 (5) Development of mechanisms for capacity building and human resources management directed at health practitioners and policy makers for the formulation, management and negotiation of health policies at domestic and international levels (UNASUR 2009b).

ISAGS has been a key institution supporting these goals through the creation and coordination of policy-oriented and informative research and the dissemination of knowledge, training and capacity building.[[4]](#footnote-4) ISAGS was articulated by a leading Brazilian research institution, the Oswaldo Cruz Foundation through its Centre of International Relations on Health. This research institute responded to the newly created UNASUR by proposing an agenda that considered health not simply as a public policy issue but also as a problem of regional and global governance. Indeed, it was proposed that a new institution helped improving the quality of policy-making and management within the Ministries of Health in UNASUR members. According to its Chief of Staff, this is an institution that emerged as a laboratory for new approaches and new strategies for health governance both within and outside the region (interview with author, 29th August 2012). UNASUR Health Council, and ISAGS in particular, capitalised 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 South-South cooperation (Buss 2011; Nunn *et al* 2009). But regional activism in health, and in many ways the fact that shared values about the right to health was relatively fast taken-up by UNASUR personnel and policy makers, rests to a large extent to the fact that many of them were part of what was known as *movimiento* *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 systemin Brazil during the country’s democratisation process and Constitutional reform in 1988 (Melo 1993: 149, Shankland and Cornwall 2007). Moreover, subsequent involvement of *sanitarista movement’s* representatives in official positions within the Ministry of Health, created opportunities for government officials, social reformists and academics to develop a network that in turn was instrumental in the constitution of UNASUR Health and ISAGS – resembling in many ways what Haas (1992) identified as ‘epistemic communities’ (interviews with ISAGS Chief of Cabinet, 29th August 2012; and with former Pan-American Health Officer, 12 June 2012).

Unlike the EU framework for health policy which is regulated in accordance with supranational institutions (i.e. the Commission and the Parliament) and observed by means of ‘soft law’ (Geyer 2009), the UNASUR Health Council and the South American Institute of Health Governance remain highly intergovernmental. This presents a potential challenge to the transformative capacity of regional social policy as in a way regional institutions can’t expect implementation in Latin America. There are real limitations in terms of policy reform and compliance in the absence of enforcement mechanisms and supranationality (Malamud 2005). This is a significant element in a region that presents different health systems, with a mix of private and public health care system (ISAGS 2012). Creating regulatory frameworks for the harmonisation of health and other social policies is politically sensitive as it often leads to distributional conflicts that governments are unwilling or unable to face. It is not surprising then that UNASUR’s goal of advancing universal health systems across the region is moving at a slow speed. However, while reforming national health legislation is still a challenge, it would be a mistake to think that the absence of the supranational structure rules out other ways of advancing regional governance. In the articulation of health policy, UNASUR developed as a normative space for policy deliberation and as framework structuring practices in support of common regional goals, and conveyed through regional mechanisms of norm diffusion and networking activities, policy training and capacity building. For instance, echoing the Five Year Plan, ISAGS plays a key role as ‘knowledge broker’ gathering, assessing and disseminating data on health policies of countries; benchmarking health policy and targets; and establishing effective mechanisms of diffusion through seminars, workshops and special meetings in support of policy reform by demand of member states. In practice, these activities, in collaboration with the UNASUR’s Technical Group on Human Resources Development and Management, have been significant for the creation of new institutions such as Public Health Schools in Peru, Uruguay, Bolivia and Guyana (Agencia Fiocruz de Noticias 2012). Similarly, ISAGS acts as a *‘training hub’* engaging with policy makers that fill in ministerial positions, negotiators that sit in the international fora, and practitioners that liaise with the general public, providing technical assistance and capacity building, strengthening skills and institutional capacity through a range of activities in support of professionalisation and leadership. For instance, ISAGS supported Ministry of Health officials in Paraguay and Guyana for the implementation of national policies regarding primary attention and preparation of clinical protocols in these poor countries, and more recently echoing the challenges of creating universal health systems, ISAGS supported reforms towards the universalisation of the health sector in Colombia, Peru and Bolivia (ISAGS 2013). The politico-institutional framework fostered by UNASUR is also manifested in its support of theme-specific networks of country-based institutions to implement projects on non-communicable diseases, such as cancer and obesity; to combat the propagation of HIV/AIDS, and to undertake extensive vaccination programmes against H1N1 influenza and Dengue Fever across the region (PAHO 2010; UNASUR 2011). UNASUR health has also been critical in addressing counter-cholera efforts in Haiti after the earthquake in 2010, and other infrastructure programmes, such as the so-called ‘roof for my country’, aimed to build just under a thousand houses, surgeries and schools (UNASUR 2010).

More recently, UNASUR has been instrumental in the establishment of two projects to promote harmonisation of data for public health decision-making across the region: a ‘Map of Regional Capacities in Medicine Production’ approved by the Health Council in 2012, where ISAGS, as ‘*industrial coordinator’*, is identifying existing industrial capacities in the region to coordinate common policies for production of medicines; and a ‘Bank of Medicine Prices’, a computerised data set revealing prices paid by South American countries for drug purchases, and thus providing policy-makers and health authorities a common background and information to strengthen the position of member states in purchases of medicines vis-à-vis pharmaceuticals. These frameworks, set out within the fourth goal of the Action Plan, improve information and generate conditions for better access to health and, at the same time, are a more efficient use of public resources. Based on this, joint negotiation strategies, as a purchase cartel, are also in place to enhance the leverage vis-à-vis pharmaceutical companies. UNASUR Health Council is also seeking new ways of coordinating industrial capacity for the production of generic medicines, potentially in coordination with the Defence Council. This was confirmed in a seminar organised by UNASUR and the Ministry of Defence in Argentina, in April 2013, where a proposal for the creation of a South American Programme of Medicine Production in the field of Defense, was discussed (UNASUR CEED 2013).

Although this institutional framework is not supported by formal mechanisms of enforcement, the mobilisation of human and knowledge resources, as well as funded projects resemble what Hameiri and Jayasuriya (2011) identified as ‘regulatory regionalism’, as these institutions are developing new commitments for coordination of policy-making and implementation of regional social goals, benchmarking best practices, setting parameters, and creating new spaces for cooperation in support of domestic policy choices and practice. From this perspective, impact should not be reduced to a mere institutional evaluation of harmonisation of health systems across the region but seen in the capacity of UNASUR to provide a framework for norm-diffusion, led by institutionalised networks and epistemic communities structuring practices that can effectively align regional aspirations and domestic policy-making and practices through the mobilisation of knowledge and material resources, and the professionalisation of health workers and policy makers.

These practices are also reaching outside the region through south-south cooperation and UNASUR leadership in health diplomacy. The leadership of Brazil in the region is undoubtedly critical for these developments as it has been instrumental in promoting an international presence of UNASUR, yet policy positions for international discussions concerning the impact intellectual property rights on access to medicines or the monopolist position of pharmaceutical companies on price setting and generics have been particularly driven by Ecuador and Argentina, echoing new regional motivations for redistribution and rights (interview with International Cooperation officer at the Ministry of Health in Ecuador, 30 July 2012; former UNASUR Health Council delegate from Ecuador, 6th August 2012; and former Coordinator of Technical Group for Access to Medicines, 2nd August 2012). UNASUR is establishing as a legitimate and pro-active actor advancing a new regional diplomacy to change policies regarding representation of developing countries in the executive boards of the WHO and its regional branch the Pan-American Health Organisations. UNASUR also led successful discussions on the role of the WHO in combating counterfeit medical products in partnership with the International Medical Products Anti-Counterfeiting Taskforce (IMPACT), an agency led by Big Pharma and the International Criminal Police Organisation (Interpol) and funded by developed countries engaged in intellectual property rights enforcement. Controversies focused on the legitimacy of IMPACT and its actions seen as led by technical rather than sanitary interests, unfairly restricting the marketing of generic products in the developing world (interview with Senior Official at the Ministry of Health in Ecuador, 30th July 2012). At the 63rd World Health Assembly in 2010, UNASUR proposed that an intergovernmental group replaced IMPACT to act on, and prevent, counterfeiting of medical products. This resolution was approved at the 65th World Health Assembly in May 2012. The first meeting of the intergovernmental group was held in Buenos Aires, Argentina, in November 2012. In the course of this meeting, UNASUR also lobbied for opening negotiations for a binding agreement on financial support and research enhancing opportunities in innovation and access to medicines to meet the needs of developing countries. More recently, led by Ecuador, UNASUR presented for discussion an action plan for greater recognition of rights of disabled people within the normative of the WHO. Finally, UNASUR is seeking recognition to act through regional, rather than national, delegates at the World Health Assembly, just as the EU negotiates as a bloc across a wide range of agenda items (interview with Senior Government Cabinet Official and former UNASUR delegate, 29th August 2012).

The presence of UNASUR in this type of health diplomacy, and its coordinated efforts to redefine rules of participation and representation in the governing of global and regional health, and production and access to medicine vis-à-vis international negotiations, are indicative of a new rationale in regional integration in Latin America based on international leadership and long-term policy making. These actions create new spaces for policy coordination and collective action where regional institutions become an opportunity for practitioners, academic and policy makers to collaborate and network in support of better access to healthcare, services and medicines. In sum, health as governed by UNASUR is embracing new responsibilities in the provision of social policies, while developing qualities of leadership negotiating more confidently as a bloc vis-à-vis external actors, such as pharmaceutical, and representing regional (health) interests in institutions of global governance, such as the WHO. What these practices suggest is that broader goals of social policy and development are becoming a salient element redefining the terms of region building and creating new opportunities for collective action in support of social inclusion and rights through regional diplomacy. Although it would be an overstatement to claim that UNASUR, in the (niche) area of health, represents a coherent attempt to articulate a rights-based governance model advancing regional social policies, it can be argued that it has created the conditions for rights and socially oriented policies at national and international levels.

**THE SOCIAL PURPOSE OF REGIONALISM: IMPLICATIONS FOR FURTHER ANALYSIS**

Although regional formations have mostly been associated with, and studied from, the perspective of trade concerns, they are far from passive objects in either debates or practices pertaining to issues of social poverty, inequality and social development. They are indeed likely to become more active and significant in the future. As illustrated by the developments in the policy domain of health, UNASUR is advancing a more prominent role in the definition and achievement of regional social developmental goals. Regional health governance in South America is an expression of a new alignment between national socio-economic goals; regional mobilisation of resources and collective action; and regional (health) diplomacy. This is possible as UNASUR health established a new normative structure and practices through formal institutions and informal networks engaging state and non-state actors involved in the formulation, negotiation and implementation of health policies. These developments it was argued reconnect national motivations, models of political economy and regional integration, breaking at the same time with presumptions of external determinants of region building and the regionalism-globalisation relationship. We are thus able to move beyond arguments about the relative importance of economic globalisation as a structure of constraints for developing regions to speculate about how regional social policy, as a policy endeavour and as social justice, can be articulated by regional structures designed to produce a rights-based models of governance and regional diplomacy.

The implications of these developments are twofold. In the first place, they confirm that regional formations are significant actors in on-going attempts to address and mitigate trans-border social issues and harms, contributing with innovative normative frameworks, formal and informal networks, and different mechanisms of socialisation and practices, engaging actors that potentially have a significant impact on national policy making and management. As UNASUR engages in wider social policy goals, it offers new grounds to advance a wider appreciation of the significance of the regional integration-social development nexus. The analysis of UNASUR health, and potentially other areas of social policy, addresses a substantial gap in the scholarly and policy literatures on regionalism that privilege issues of trade, finance and state security to the neglect of other normative frameworks and practices. Second, UNASUR health provides new grounds to speculate what region *is* and *is for* in terms of policy deliberation and collective action, and as actor vis-à-vis external influences. The governing of health in South America offers a compelling story about regional collective action, where the regional space is an arena for the definition of regional consensus and policy deliberation. At the same time, the region can be an actor in support of national strategies for social inclusion and in representation of regional goals in external environments through negotiations and regional diplomacy.

Of course this process is not free from contradictions. All politics engender struggles that in the case of region building in South America were defined by a strong tendency of inter-governmental politics at the expense of autonomous power to enforce legislation on the member states. Scholars concerned with supranationalism and secession of sovereignty as an indicator of deep regionalism has referred to this as a failure in MERCOSUR and its capacity to foster policy harmonisation (Dàbene 2009; Malamud and Gardini 2012). The argument developed here suggests that policy reform is highly contentious and that is seen in UNASUR’s promotion of universal health systems, where the prospects of legal harmonisation and reform of domestic policies are advancing at a slower pace than other goals. Nonetheless, it has also been suggested that while it is still difficult and politically more sensitive to harmonise policies and reform national institutions, such as health systems, UNASUR developed as a normative structure with innovative mechanisms of policy diffusion and capacity building that can affect incentives and policy horizons of policy makers and practitioners, while structuring new practices, within and outside the region, in support of better access to medicines and health services. In other words, although there are strong reasons to assume that in the absence of supranational institutions effective forms of enforcement and implementation of politically sensitive policies cannot be expected, at least in Latin America, UNASUR’s inter-governmental and expert networks model of regional governance in the area of health has the capacity to steer a process of ‘guided convergence’, where institutionalised training, capacity building, leadership formation, and network activities can support the work in national Ministries and health systems, and that of officials articulating and negotiating health policies internationally. This is another way by which regional structures can exercise power and authority, that is through the mobilisation of normative power, expert power, and regulatory frameworks that can significantly impact on the work of staff within Ministries of Health, on health practitioners’ approach, and on the broader society.

Likewise, intervening in the international arena through actively campaigning for better access to medicines and representation of developing countries in global health governance means that regional formations, such as UNASUR, can challenge ‘established corridors of diffusion’ contesting old and brokering new health norms in alignment with specific regional concerns and health needs. Regional formations can be international actors grafting strategies of crisis management across developed and developing countries. This is particularly relevant as we are witnessing the resurgence of emerging forms of 'nationalisms' and rescaled forms of social protection in Latin America, while by contrast the Eurozone crisis is generating a backlash against the failure of social democratic models..

There is still a ‘glass half empty’ story that can potentially limit the potential of regional social policies in the South. This relates to the lack of mechanisms for the incorporation of social actors in the definition of social agendas. The lack of an institutionalised broader dialogue renders ambiguous the transformative capacity of UNASUR in terms of participatory regionalism. The work of ISAGS offers a new structure for broader political influence as regional epistemic communities and professional associations are engaged in knowledge creation and diffusion, policy formulation, lesson drawing, training and capacity building in support of professionalisation of policy makers and practitioners and the implementation of policies through working groups. But while these activities can potentially downplay the excessive inter-governmentalism that underpins current regional developments and traditional forms of hyper-presidentialism, they are limited to the area of regional health. A more fundamental re-enactment of state-society relations, capable of shaping policy preferences in other areas of policy is still uncertain. As such, it could be argued that the paradox of current regionalism in South America is something that the repoliticisation of the region, fostered by new populist forces, has an ambivalent impact on regional democracy despite the unprecedented commitment with social development.

Likewise, the extent to which regional institutions can close the gap of unequal development in South America is still to be seen and much more interdisciplinary work and coordination amongst UNASUR Councils is needed to create positive synergies between regionalism and poverty reduction. While health entered the agenda of UNASUR as rights to social development, it has undeniable strategic element, medicines, that leverage international negotiations and thus make the sector of international significance. The risk is that UNASUR health governance, as a normative structure and as an agent of diplomacy, does not spill over to other areas of social policy (i.e. migration, education, labour regulations, the environment and indigenous populations) that need to evolve more fully over larger integrative scales and become a core matter of regional governance. These areas, like health, are politically sensitive and denote patterns of inequality and ‘limited’ citizenship. But unlike health these areas do not have as yet a place in the new institutional architecture of UNASUR, or occupy a visible place in its regional diplomacy.

At the moment, Latin America is a continent of contradiction where diversity in motives, ideologies and leadership aspirations are driving alternative (post-neoliberal) models of integration. Despite the much longer route to walk in terms of social policy and regionalism, UNASUR Health enabled opportunities for collective action, and embraced itself, as a bloc, global activism brokering new and reworking existing norms related to access to health and representation of developing countries in the institutions of global health governance. This is a clear distinction from previous regional integration experiences in Latin America where building fixed and effective social regional institutions remained a rhetorical aspiration. As such, this regional experience has implications for how we think about regionalism and regional governance beyond the EU, bringing up new analytical and political questions about how regional sites can become pivotal for collective action and for contention politics in three different ways: (i) by creating normative frameworks structuring inter-governmental and expert networks model of regional governance; (ii) by facilitating the re-allocation of material and knowledge resources in support of public policy and policy implementation; and (iii) by enabling representation and claims-making of actors in global governance. Accordingly, regional social policy is about setting new parameters as much as creating spaces of cooperation for the design and implementation of policies, at different levels of authority, enabling social development. Those interested in regionalism and social development cannot afford to ignore these issues and recognise the value of new regional formations enacting social goals.

**REFERENCES**

Agencia Fiocruz de Noticias. (2012). UNASUR promotes health systems in South American nations. Retrieved from <http://isags-unasul.org/noticias_interna.asp?lang=2&idArea=2&idPai=4387>.

Almeida, C.; Pires de Campos, R., Buss, P., Ferreira, J. & Fonseca, L. (2010). Brazil’s conception of South-South structural cooperation in health. *Saúde* *Global e Diplomacia da Saúde*, 4 (1), 23-32.

Andolina, R., Laurie N., & Radcliffe, S. (2009). *Indigenous development in the Andes: Culture, power, and transnationalism*. Durham/London: Duke University Press.

Barreto, S., Miranda, J., Figueroa, J., et al. (2012). Epidemiology in Latin America and the Caribbean: Current situation and challenges. *International Journal of Epidemiology*, 41 (2), 557–571.

Birdsall, N. & Lodoño, J. (1998). No trade-off: Efficient growth via more equal human capital in Latin America. In N. Birdsall, C. Graham and R. Sabot (eds.) *Beyond tradeoffs: Market reforms and equitable growth in Latin America*. Washington, DC: Brookings Institution Press, 111-45.

Bretherton, C. & Vogler, J. (1999). *European Union as a Global Actor*. London: Routledge.

Buss, P. (2011). Brazil: Structuring cooperation for health. *The Lancet*, 377 (9779), 1722-1723.

Cammack, P. (2004) What the World Bank means by poverty reduction and why it matters. *New Political Economy*, 9 (2), 189-211.

Carranza, M. (2006). Clinging together: Mercosur's ambitious external agenda, its internal crisis, and the future of regional integration in South America. *Review of International Political Economy*, 13(5), 802–829.

Cornwall A., & Brock, K. (2005). What do buzzwords do for development policy? A critical look at ‘participation’, ‘empowerment’ and ‘poverty reduction’. *Third World Quarterly*, 26 (7), 1043-1060.

Dabène, O. (2009). *The politics of regional integration in Latin America: Theoretical and comparative explorations*. New York: Palgrave Macmillan.

Deacon, B., Ortiz, I. & Zelenev, S. (2007). Regional social policy. *DESA Working Paper* No.36.

Deacon, B., Macovei, M., Van Langenhove, L. & Yeates, N. (2010). *World-regional social policy and global governance: New research and policy agendas in Africa, Asia, Europe and Latin America*. London: Routledge.

Di Pietro, L. (2003). La dimensión social del Mercosur. Recorrido institucional y perspectivas. Paper presented at workshop Integración Regional y la Agenda Social, BID-INTAL, Buenos Aires, November 12-13.

Draibe S. (2007). Social cohesion and regional integration: the MERCOSUR social agenda. *Cuaderno de Saúde Pública*, 23 (2): 174-183.

ECLAC. (2011). *Social panorama of Latin America.* Santiago: CEPAL.

Fidler, D. (2004). Germs, norms and power: Global health's political revolution. *Law, Social Justice & Global Development Journal*. Retrieved from <http://www2.warwick.ac.uk/fac/soc/law/elj/lgd/2004_1/fidler/>

Gamble A. & Payne, A. (Eds). (1996). *Regionalism and world order.* London: Palgrave/Macmillan.

Geyer, R. (2009). The politics of EU health policy and the case of direct-to-consumer advertising for prescription drugs. *The British Journal of Politics and International Relations*, 13 (4), 586-602.

Grugel, J. (2005). Citizenship and governance in Mercosur: Arguments for a social agenda. *Third World Quarterly*, 26 (7), 1061-1076.

Grugel, J. (2009). New regionalism, new rights? Latin American regionalism as an opportunity structure for civic activism. Working paper 19, Buenos Aires: FLACSO/Argentina.

Grugel, J., & Riggirozzi, P. (2012). Post-neoliberalism in Latin America: Rebuilding and reclaiming the state after crisis. *Development and Change*, 43 (1), 1-21.

Hameiri, S., & Jayasuriya, K. (2011). Regulatory regionalism and the dynamics of territorial politics: The case of the Asia-Pacific region. *Political Studies*, 59 (1), 20-37.

Haas, P. (1992). Introduction: Epistemic communities and international policy coordination. *International Organization*, 46(1), 136.

Holst, J. (2009). The potential of regional Trade Agreements for Extending Social Protection in Health: Lessons Learned and emerging challenges. *Open Health Services and Policy Journal, 2,* 84-93

Holveck, J., Ehrenberg, J., Ault, S., Rojas, R., Vasquez, J., et al. (2007). Prevention, control and elimination of neglected diseases in the Americas. *BMC Public Health*, Retrieved from [http://www.biomedcentral.com/1471-2458/7​/6/](http://www.biomedcentral.com/1471-2458/7/6/)

ISAGS. (2012). *Sistemas de Salud en Sudamerica*, Rio de Janeiro: ISAGS/UNASUR

Lewis, C. & Lloyd-Sherlock, P. (2009). Social policy and economic development in South America: an historical approach to social insurance. *Economy and Society,* 38 (1), 109-131

Malamud, A. (2005). Mercosur turns 15: Between rising rhetoric and declining achievement. *Cambridge Review of International Affairs*, 18(3),421-36

Malamud A. & Gardini, G.L. (2012). Has regionalism peaked: The Latin American quagmire and its lessons, *The International Spectator: Italian Journal of International Affairs*, 47 (1), 116-133

Mansfield. E. & Solingen, E. (2010). Regionalism. *Annual Review of Political Sciences*, 13(1), 145-63

Nunn, A., Da Fonseca, E. & Gruskin, S. (2009). Changing global essential medicines norms to improve access to AIDS treatment: Lessons from Brazil. *Global Public Health: An International Journal for Research, Policy and Practice*, 4 (2), 131-49

Oliveira, M., Zepeda Bermudez, J., Chavez, G. & Vazquez. G. (2004). Has the implementation of the TRIPs in Latin America and the Caribbean produced intellectual legislation that favours public health?. *Bulletin of World Health Organization*, 8 (11), 815-821

Ortiz, I. (2007). Social policy in national development strategies. *Policy Note*. New York: United Nations Department of Economic and Social Affairs

PAHO. (2010). UNASUR’s role in the vaccination against pandemic influenza. *Pan-American Health Organisation, Immunisation Newsletter*, 32 (4).

Panizza, F. (2009). *Contemporary Latin America: Development and democracy beyond the Washington Consensus*. London and New York: Zed

Phillips, N. (2003). Hemispheric integration and subregionalism in the Americas. *International Affairs*, 79 (2), 327-49

Riesco, M. (2010). Binding material for a young giant? Regional social policies in Latin America. In B. Deacon, M. Macovei, L. Van Langenhove and N. Yeates (eds) *World-regional social Policy and global governance: New research and policy agendas in Africa, Asia, Europe and Latin America.* London: Routledge, 108-39

Riggirozzi, P. (2012). Region, regionness and regionalism in Latin America: Towards a new synthesis. *New Political Economy*, 17 (4), 421-443

Riggirozzi, P. & Tussie, D. (Eds.). (2012). *The rise of post-hegemonic regionalism: The case of Latin America.* Netherlands: Springer

Saguier, M (2007). The hemispheric social alliance and the free trade area of the Americas process: the challenges and opportunities of transnational coalitions against Neoliberalism. *Globalizations,* 4 (2), 251-265

Sanahuja, J. A. (2012). Post-liberal regionalism in south america: The case of UNASUR. Robert Schuman Centre for Advance Studies, EUI Working Paper RSCAS 2012/05. .

Sanchez, D. (2007). Health integration processes: challenges for MERCOSUR in the health field, *Caderno Saúde Pública*, 23 (2), 155-63

Scharpf, F. (1996). Negative and positive integration in the political economy of European welfare states. In G. Marks et al., *Governance in the European Union.* London: Sage, 15-39

SELA (Sistema Economico Latinoamericano) (2010). Bulletin 150 on Regional integration inLatin America and the Caribbean. Retrieved from <http://www.sela.org/attach/258/EDOCS/SRed/2010/07/T023600004239-0-Boletin_150__MAYO_2010_Ingles__.pdf>

So, A. (2004). A fair deal for the future: Flexibilities under TRIPs. *Bulletin of the World Health Organization*, 82 (11), 811-90

Söderbaum, F. & Stålgren, P. (eds). (2010). *EU and the global South*, Boulder, CO: Lynne Reinner Publishers

Söderbaum, F., Stålgren, P. & van Langenhove. L. (2005). The EU as a global actor and the dynamics of interregionalism: a comparative analysis. *European Integration*, 27 (3), 365-380

te Velde, D., Page, S. & Morrissey, O. (2006). *Regional integration and poverty*, Aldershot: Ashgate

Threlfall, M. (2003). European social integration: harmonization, convergence and single social areas. *Journal of European Social Policy*, 13(2), 121-139.

Shankland, A. & Cornwall, A. (2007). Realising health rights in Brazil: The micropolitics of sustaining health system reform. In A. Bebbington and W. McCourt (eds) *Development success: Statecraft in the South*. London: Palgrave

Stubbs, P. (2003). International non-state actors and social development policy. *Global Social Policy* 3 (3), 319-348

UNASUR. (2009). *Constitutional treaty*. Retrieved from http://www.comunidadandina.org/unasur/tratado\_constitutivo.htm

UNASUR. (2009b). *Plan quinquenal, 2010-2015.* Retrieved from http://www.ins.gob.pe/repositorioaps/0/0/jer/rins\_documentosunasur/PQ%20UNASUR%20Salud.pdf

UNASUR. (2011). *Salud:* *Report of the Pro Tempore Secretariat.* Retrieved from http://isags-unasul.org/site/wp-content/uploads/2011/12/Informe-2011.pdf

UNASUR Centro de Estudios Estratégicos de Defensa (CEED). (2013). Action Plan 2013, Centre for Strategic Studies: UNASUR Defense Council. Retrieved from http://www.ceedcds.org.ar/English/09-Downloads/Eng-PA/ENG-Plan-de-Accion-2013.pdf

UNDP. (2011). *Regional integration and human development: a Pathway for Africa*. New York: UNDP

UNU/CRIS. (2008). Deepening the social dimensions of regional integration. Retrieved from <http://www.ilo.org/public/english/bureau/inst/publications/discussion/dp18808.pdf>

Yeates, N. (2002) Globalization and social policy: From global neoliberal hegemony to global political pluralism. *Global Social Policy*, 2(1), 69-91

Yeates, N. & Deacon, B. (2006). Globalism, regionalism and social policy: Framing the debate. *UNU-CRIS Occasional Papers*, (O-2006/6).

1. Cuzco Declaration. Available at www.comunidadandina.org/ingles/documentos/documents/cusco8-12-04.htm (28 March 2013). [↑](#footnote-ref-1)
2. ALBA gathers Venezuela, Honduras, Cuba, Nicaragua, Bolivia, Ecuador, Dominica, Antigua y Barbuda, San Vicente [↑](#footnote-ref-2)
3. UNASUR Constitutive Treaty. Available at <http://www.unasursg.org/uploads/0c/c7/0cc721468628d65c3c510a577e54519d/Tratado-constitutivo-english-version.pdf> (28 March 2013) [↑](#footnote-ref-3)
4. For information about ISAGS, see <http://isags-unasul.org/site/sobre/?lang=es> (2 April 2012) [↑](#footnote-ref-4)