Introduction

The Global and Domestic Politics of Health Policy in Emerging Nations

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Abstract In recent years, several emerging nations with burgeoning economies and in transition to democracy have pursued health policy innovations. As these nations have integrated into the world economy through bilateral trade and diplomacy, they have also become increasingly exposed to international pressures and norms and focused on more effective, equitable health care systems. There are several lessons learned from the case studies of Brazil, Ghana, India, China, Vietnam, and Thailand in this special issue on the global and domestic politics of health policy in emerging nations. For the countries examined, although sensitive to international preferences, domestic governments preferred to implement policy on their own and at their own pace. During the policy-making and implementation process, international and domestic actors played different roles in health policy making vis-à-vis other reform actors—at times the state played an intermediary role. In several countries, civil society also played a central role in designing and implementing policy at all levels of government. International institutions also have a number of mechanisms and strategies in their tool box to influence a country's domestic health governance, and they use them, particularly in the context of an uncertain state or internal discordance within the state.

Keywords emerging nations, global health, health policy, BRICS, international institutions

In recent years, several emerging nations exhibiting burgeoning economies and transitions to democracy have pursued health policy innovations. Brazil, Russia, India, China, and South Africa, known as the BRICS, as well as Thailand, Vietnam, Singapore, Mexico, and Peru, have realized that developing sustainable, equitable economic systems requires sound

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investments in health care and other social welfare policies (Gómez 2014; Haggard and Kaufman 2008). Moreover, as these nations have integrated into the world economy through bilateral trade and diplomacy, they have become increasingly exposed to international pressures and norms advocating for more effective, equitable health care systems (Ruger and Ng 2010).

This special issue examines how several of these emerging nations have pursued health policy innovations within an increasingly globalized context. These articles study the countries of Brazil, Ghana, India, China, Vietnam, and Thailand in order to analyze and explain the complex intersection of international and domestic political, economic, and social processes shaping health policy making and implementation.

In the spring of 2013 we released a call for papers focused on the following key questions. First, what have been the international and domestic linkages related to health policy making in the emerging nations, and how have these linkages evolved over the years? What are the respective roles of international and domestic institutions in the policy-making process in these countries? For example, do international institutions, such as the World Health Organization (WHO), the World Bank, and the Global Fund to Fight AIDS, Tuberculosis and Malaria, employ conditionality or other coercive measures to influence health policy, and what are the implications? By addressing these questions, we sought to better understand what roles international versus domestic institutions play in health policy making, the type of relationship that international and domestic institutions have, and to what extent developing nations have become autonomous and effective in implementing policy.

Second, given the growing importance of domestic actors, including national governments and civil society, we were interested in understanding how civil society organizations (CSOs), nongovernmental organizations (NGOs), and social health movements create and shape health policy. What is the nature of the linkages between international institutions, international NGOs (e.g., Médecins Sans Frontières), and domestic institutions, including national governments, and how does it influence health policy? And has civil society worked closely with national governments or the international community—or perhaps both?

Third, we were also interested in how the role of national governments and health policy has evolved over time and what lessons these changes provide for global health governance and domestic health policy. Who, if anyone, is monitoring domestic health policy and holding national governments to account? Given that NGOs and social health movements, as well as democratization processes, are emerging in these nations, one

might expect to find wide variation in civil societal strategies and influence over time. What role, if any, have democratizing processes played in shaping domestic health policy in these emerging nations?

Respective Roles of International and Domestic Actors

The articles in this special issue suggest that for the countries examined, although sensitive to international preferences, domestic governments preferred to implement policy on their own and at their own pace. Health policies initially influenced by international organizations were eventually taken over by national governments and civil societal actors. The case studies in this special issue demonstrate that at least for these emerging nations, they have become increasingly independent of international influence and are striving to find their own policy solutions to health care challenges.

The following articles also revealed that during the policy-making and implementation process, international and domestic actors played different roles throughout the policy-making process. Stakeholders at the international level, such as international donors, had interests in providing funding and technical support to ensure that health policies were implemented effectively. Alternatively, at the domestic level, public health bureaucrats took center stage in implementing and sustaining policy reforms. As seen in Thailand's efforts to establish a universal health care system, Joseph Harris argues that health bureaucrats established their own networks of support within and outside the state, mainly to legitimatize and deepen their reform efforts. In China, Ghana, and Vietnam, health bureaucrats also led the policy-implementation process. And as Eduardo J. Gómez explains, in Brazil, in response to the burgeoning obesity epidemic, the bureaucrats mainly responsible for implementing policy were located at the municipal level, in turn suggesting that the locus of policy innovation, at least in Brazil, occurs at the local rather than the national level.

In several countries, civil society also played a central role in designing and implementing policy, at all levels of government. In India, for example, women's groups at the village level helped increase awareness about health care. In Vietnam, activists and NGOs at the local level proved instrumental in determining the implementation of HIV/AIDS policy, while NGOs in Thailand helped legitimize the introduction of universal health care legislation by working closely with federal officials.

International institutions have a number of mechanisms and strategies in their toolbox to influence a country's domestic health governance. In the China case study, the challenges of an opaque and exclusive authoritarian

structure are illuminated. Despite these difficulties, international institutions shaped China's health policy process by financing health projects conditionally, fostering civil society groups, identifying new health problems, promoting policy innovations, and facilitating norm internalization and learning. The China case study highlights the effect of selective and strategic mechanism choice in influencing government policy-maker preferences and the timing and content of government agendas and action. The significance of positive or negative externalities related to China's state behavior suggests that effective cooperation between international institutions and China's domestic policy making depends on the degree to which China's state behavior has an effect globally.

In contrast, the Vietnam case study illustrates the important role of global institutions in the context of an uncertain state or internal discordance within the state. In parallel, the role of the state was demonstrated when the sexual rights movement focused on employment rights with involvement of multiple global and domestic stakeholders and sectors. In Vietnam, CSOs also provided input in influencing negotiations between the state and the donor community, resulting in a continual process of incremental change.

The Politics of Health Policy Reform

Vested political and civil societal interests were found to be influential at various governmental levels and at different stages of the agenda-setting process. Governing boards within multilateral heath agencies, such as WHO and the World Bank, were important for helping draw attention and funding to health care issues in China, Vietnam, Thailand, and, to a certain extent, Brazil. As policies were adopted and implemented, however, federal health officials in Thailand, China, Vietnam, and Ghana played important roles in using funding to expand programs and to work with local governments and civil society.

In other countries, however, influential stakeholders were found in civil society. As the work of Candace H. Feldman and colleagues in this series explains, Indian women's groups at the village level, through their own initiative, exerted influence through mobilization and participation.

Another theme that emerged from the articles in this special issue was the intermediary role that the state played, vis-à-vis other reform actors, in health policy making. State actors initially paid heed to external policy recommendations but eventually appeared not always to take such recommendations seriously. This finding suggests that emerging nations are

becoming more confident in their abilities to implement policy while cherishing their sovereign ability to do so.

Nevertheless, not all emerging nations acted as independently. As Yanzhong Huang explains, China's national government was willing to work with the World Bank and WHO to implement national tobacco control policies while paying more attention to ongoing diseases, such as HIV/AIDS.

The Importance of Networks

The case study of Thailand's universal coverage policy demonstrates the important role of networks of bureaucrats who are able to marshal resources for reform. In this case study a network of doctors, along with members of civil society, international organizations, and a political party, mobilized. The political party was effective with its focus on the broader goal of universal coverage as opposed to the maneuvering of private interests and regulatory capture for the maximization of private interests (e.g., corporate profits). Accessibility to resources, as evidenced by the high rank of the civil servants in the network, was important to the adoption of Thailand's universal health care policy by a political party. This case study also suggests that the impact of this network of doctors extended globally and that Thailand is an important locus of lessons learned for other developing countries, especially on the role of networks of civil servants.

Government Platforms and Timing

The shift to a national health insurance scheme from a cash-and-carry system in Ghana illustrates the importance of change in both government and government platforms. Employing John W. Kingdon's multiple streams framework of agenda setting, the Ghana case study demonstrates how a policy window was created when the three streams of problem, policy, and politics converged. In Ghana, identification of the social and economic problems of a cash-and-carry system, the incorporation of district health insurance plans into the overall national health insurance strategy, despite divisions about health financing, and strong political support from the government all merged to enable health policy reform. Moreover, the strength of the government's ability to pass legislation was solidified by a parliamentary majority. Additional policy entrepreneurs

were helpful in addressing some of the politics related to an opposition party that, while opposing the government's platform, was unable to block reform.

And in Vietnam, the importance of timing for policy intervention is illustrated by the ways that dissension within government agencies may have provided an opportunity for a drive for change by CSOs. The timing and confluence of historical social and political factors creating opportunities for health policy change requires further study.

Political Participation and Health

The role of certain civil society groups in the political process, as illuminated through case studies in this series, is an important theme for the politics of health policy. In Vietnam and India, in particular, the role and opportunities presented by the existence of CSOs, whether formal or informal, are significant. In these studies, civil society interests in relation to women's health issues (women's groups), HIV, and sexuality were the focus. The role of women and groups with a particular heath interest, like HIV and AIDS, in the health policy process is important for both academic and policy considerations. In Vietnam, researchers analyzed how formal networks of people living with HIV extended beyond one or two sites to gain greater attention through the national media and other public events. In India, the focus was primarily on women's groups at the community level. Exploiting a cluster-randomized controlled trial of a community-based behavior change management intervention, the study in northern India sought to better understand the relationship between political participation and health with all its complexities at the village level. Women's political participation at the global, national, and subnational levels and its relationship to health are complicated. In a qualitative study of semi-structured, in-depth focus groups in both intervention and nonintervention villages, researchers presented locally relevant, culturally sensitive scenarios to each group about the motivations and limitations related to women's political participation and health. A community-based behavior change management intervention for neonatal care was contextualized within the family and home setting, which was situated in broader social contexts that include the community and the wider political, economic, and social environments. Employing a health capability framework helped illuminate how these local political economies affect health. Health capability is the ability to be healthy and includes both women's health

outcomes and health agency—women's abilities to achieve health goals that they value. To improve women's health agency, a better understanding of cultural norms surrounding autonomy, local infrastructure and health systems, and male and female perceptions of self-efficacy and political participation is required. Knowing the context within which individuals and groups live is important to understanding health. Within-gender differences also require further study.

In both India and Vietnam, changes in government policy have sought to enhance the establishment of CSOs and their interests, with varying success. In Vietnam, for example, a change in government policy, which sanctioned the establishment of CSOs, helped fuel the introduction of CSOs in the fight against HIV and AIDS. Moreover, international donors such as the Global Fund to Fight AIDS, Tuberculosis and Malaria and the US President's Emergency Plan for AIDS Relief (PEPFAR) involved CSOs in the national response to HIV and AIDS. The involvement of CSOs in the policy-making process helped in passing the 2006 Law on HIV/AIDS Prevention and Control. In India, however, women remain less politically active than men despite a law that reserves one-third of government seats for women. The reservations for women in Indian politics have not resulted in adequate representation of women's interests. The India study in this series demonstrates that reservations alone cannot capture true female leadership or political participation. Assessing women's ability to be healthy through the lens of health capability provides a more comprehensive picture of how women are faring rather than supposing that national statements about quotas and equal rights obtain actual rights for women.

On a more practical level, lessons from the Vietnam experience suggest that in India, women's groups could significantly benefit from efforts to involve and build capacity for civil society to be involved in both community-led and national responses to women's health issues. Women's groups would also benefit from coalitions with women's groups around the country to build a nationwide or regionwide network to include hundreds of women's groups from villages and cities across the country.

Conclusion: Emerging and Transitioning Countries' Roles in Global Health

Until recently, global health scholarship has paid inadequate attention to emerging and transitioning countries, particularly the so-called BRIC

nations (Ruger and Ng 2010). But as the case studies in this special issue have demonstrated, these countries are becoming increasingly independent and important players in their own countries and in the global health architecture. These countries are building their own health systems and helping developing countries address population health problems. The case studies may also provide models for effective health policy making for all countries, more and less developed alike, as well as lessons learned from the health and development process. Despite their transforming status, these emerging nations are poised to graduate from financial and technical assistance from the global health community and transition from recipient to donor in global development assistance for health. Providing financial and technical assistance to lower-income countries, both individually and collectively, emerging nations are in a position to take a significantly greater role in global health governance.

What is hard to say is whether greater independence for emerging nations from donor countries and institutions means more democratic domestic processes or more resources within countries and improved health. What can be said is that greater independence for emerging nations in the donor-recipient nexus creates opportunities for these countries to address issues of global health. For example, the existing international development architecture leaves gaps in health system development. International organizations working in more equal partnerships with emerging countries can help address these gaps by advocating for financial assistance and raising overall awareness. Employing "soft balancing" techniques by combining diplomatic, economic, and institutional mechanisms to challenge and offset the major powers, emerging nations, acting in blocs, could negotiate better terms for intellectual property regulations (e.g., within the World Trade Organization) and ultimately improve access to medicines for their and others' populations.

Moreover, acting in concert, emerging nations can potentially address asymmetries in power and influence at the core of the global health system. As a counterforce and counterbalance to more powerful countries, emerging and transitioning countries can advocate for greater representation in international institutions, possibly even reforming the United Nations system toward greater inclusion. Finally, employing their collective agency for health, emerging and transitioning countries can themselves act as a type of stakeholder, representing the interests and needs of their countries and advocating for greater consideration and accountability of these needs in global health.

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