Global health in foreign policy—and foreign policy in health? Evidence from the BRICS

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Accepted 19 July 2013

Amidst the growing literature on global health, much has been written recently about the Brazil, Russia, India, China, South Africa (BRICS) countries and their involvement and potential impact in global health, particularly in relation to development assistance. Rather less has been said about countries’ motivations for involvement in global health negotiations, and there is a notable absence of evidence when their motivations are speculated on. This article uses an existing framework linking engagement in global health to foreign policy to explore differing levels of engagement by BRICS countries in the global health arena, with a particular focus on access to medicines. It concludes that countries’ differing and complex motivations reinforce the need for realistic, pragmatic approaches to global health debates and their analysis. It also underlines that these analyses should be informed by analysis from other areas of foreign policy.

Keywords BRICS, emerging economies, antiretroviral, access to medicines, TRIPS, global health diplomacy

KEY MESSAGES

• Investigating why countries engage in global health negotiations is not straightforward, but is potentially enlightening.
• We use a framework linking foreign policy and global health to better understand the motivations for countries’ behaviour, in this case in debates about access to antiretrovirals.
• Countries’ differing and complex motivations reinforce the need for realistic, pragmatic approaches to global health debates and their analysis.

Introduction

In September 2006, Foreign Ministers from seven countries met to explore how foreign policy could contribute to tackling important health issues and how a health dimension could benefit foreign policy. The resulting Oslo declaration (Amorim et al. 2007) provided a major stimulus to an emerging concept of ‘global health diplomacy’. This envisages a bi-directional set of relationships whereby foreign policy is used to achieve health goals, and health policy is used to achieve foreign policy goals (Fidler and Drager 2006; Kickbusch and Erk 2009; Feldbaum and Michaud 2010; Feldbaum et al. 2010; Fidler 2010; Mogedal and Alveberg 2010). Thus, health advocates argue that foreign policy offers a means to achieve better health for all, improved international relations and the promotion of health as a human right and a global public good (Kickbusch and Berger 2011). Equally, there are committed proponents of the idea that health can be a respectable aim for ministries of foreign affairs (Katz and Singer 2007; HM Government 2008; Mogedal and Alveberg 2010; Vidyasagar 2010).

On the other hand, relationships between health and foreign policy are complex, given the many ministries and domestic agencies, potentially with competing agendas, vying to be heard in international negotiations (McKee 2007) and the diverse approaches to global health taken by different countries.
(Stuckler and McKee 2008). Several commentators have tried to introduce structure to analysis of this area, particularly when considering issues of global health governance (Hill 2011; Kickbusch et al. 2013). One framework invoked five metaphors as motivations for global health action: global health as foreign policy, as security, as charity, as investment and as public health (Stuckler and McKee 2008). Lee (2009) identified four main discourses on global health governance: ‘biomedicine, economism, human rights and security’ (Hill 2011), with Kay and Williams, in the same book (Kay and Williams 2009) arguing that neoliberalism is also important, transcending the other four. A more recent analysis (Kickbusch 2011) draws on the identification by the United Nations Secretary General of core goals of foreign policy as ‘achieving security, creating economic wealth, supporting development in low income countries, and protecting human dignity’ (UN Secretary General 2009), as well as the UK’s framework for global health (HM Government 2011). She identifies three global agendas that link health to foreign policy (Kickbusch 2011). These are security, covering fear of global pandemics, bioterrorism, humanitarian conflicts and natural disasters; economic, covering the impact of health on development, the impact of disease outbreaks (such as Severe Acute Respiratory Syndrome (SARS)) on global markets and the global market in health goods and services; and social justice, with health as a social value and human right, linked to the United Nations Millennium Development Goals, access to medicines and primary health care, and calls on high-income countries to invest in global health initiatives.

Whichever classification is used, they all agree that there are different rationales for engaging in global health activities, with health and foreign policy usually co-existing but to different extents. Thus, some commentators (Aginam 2010; Feldbaum and Michaud 2010; Labonte and Gagnon 2010) note how some stances that are portrayed by the participants as being primarily social justice are at least influenced by, if not dominated by traditional goals and interests of foreign policy, such as economic self interest. Likewise there has been some examination of whether discussions of ‘global health security’ are really about global health, or rather about national security fears, particularly of industrialized countries (McInnes and Lee 2006; Aldis 2008; Rushton 2011).

We aim to contribute to these debates by examining one group of emerging economies that, arguably, have much at stake both in international relations and health. The ‘BRIC’ group (Brazil, Russia, India, China) (O’Neill 2001), recently ‘joined’ by South Africa in analysis in the literature (Bliss 2010), is a relatively well-researched group of countries, now taking on a distinct identity as a formal grouping. This coalition is manifest in, for example, joint statements such as that issued just before the 63rd World Health Assembly (Ministers of Health of Brazil China India Russian Federation and South Africa 2010), and in formal structures, with meetings of heads of states and health ministers (BRICS Health Ministers 2011; Xinhua 2011; BRICS Information Centre 2013). Given the broad scope of global health, it was necessary to select one area for study. Access to medicines, and specifically antiretrovirals (ARVs), was chosen pragmatically as it is an area where all the countries can be considered to have some stake and where at least some comparable data are available, which is not the case for many other topics.

Using the framework developed by Kickbusch (2011), we have sought to explore the relative importance of different motivations to determine each country’s stance in the global health arena. In doing so, this article both contributes to a more systematic understanding of the links between foreign policy motivation and engagement by the BRICS in the specific area of access to medicines and examines an analytical framework that could be applied to other areas of global health engagement.

Methods
Case selection
The BRICS are a pertinent grouping for analysis of global health diplomacy, yet they have differing political structures, seen by some as being a crucial variable to control in comparative analysis (e.g. Nassmacher 2008), they vary in population size and they are making varying progress in economic growth and social development. Yet while politically, culturally and demographically very diverse, these countries share some key health challenges: large populations (from a regional and/or global perspective) and a high burden of disease. Indeed in terms of disease burden, all suffer from the potentially financially catastrophic ‘double burden’ profile of high incidence of infectious disease, including HIV, and chronic disease (Tables 1 and 2). They are also examples of ambitious, middle-income countries trying to make their mark on the global scene.

By comparing a small group of countries with differing historical, institutional and policy characteristics it is possible to make what Skocpol and Somers (1980) refer to as a contrast of contexts, where the goal is to highlight and learn from unique features of historical case studies.

Analytical challenges
There are significant methodological difficulties involved in the study of global health engagement, including a lack of metrics or benchmarks for measuring or comparing tactics, activity, aggression, impact or success of negotiations. The academic literature on global health negotiations, while growing rapidly, remains limited. Sovereignty issues and the natural desire of governments to maintain discretion in negotiations will mean motivations will always be difficult to untangle. Even some basic data that would inform research are missing. Thus, the most recent publicly available report on compliance with the International Health Regulations (IHRs), a key measure of engagement with health security, lacks data from Brazil, India and Russia (World Health Organisation 2012). Moreover, negotiations take place in many different global (such as the World Trade Organization (WTO), World Health Organization (WHO) and trade-related aspects of intellectual property rights (TRIPS) Council) and regional (such as Association of Southeast Asian Nations, Mercado Común del Sur - Southern Common Market and European Union) fora, differing in economic and political power (Organisation for Economic Cooperation and Development (OECD), G8, G20, G77), and of varying levels of transparency. Publicly available records for most relevant fora (e.g. the World Health Assembly (WHA) and
other UN bodies) do not attribute contributions to particular countries and are not easily interrogated for other measures that might be proposed, such as ‘number of resolutions proposed’. We therefore supplemented analyses of objective, quantitative data with information from a literature review, including of grey literature (including news articles, comments, books, websites, etc.), and advice from key informants, chosen on the basis of their expertise in this area, whether as academic observers, civil society protagonists or employees of the ministries of health or foreign affairs.

Framework analysis

We have taken Kickbusch’s categorization of links between global health and foreign policy (security, economy and social justice) as our framework of analysis (Kickbusch 2011). We begin by looking at each country’s overall level of engagement in this area, as reflected in existing literature. We then look for evidence that activity is rooted in each of these three agendas in turn, focusing on access to ARVs, triangulating quantitative and qualitative sources. For each of the three dimensions, we selected key indicators (wherever possible directly related to access to medicines) and supplemented this with literature reviews and discussions with key informants. Indicators were:

(a) For social justice, potential interest in access to ARVs from a health perspective, using incidence/prevalence of HIV/AIDS and ARVs coverage [from WHO and the Joint United Nations Programme on HIV/AIDS (UNAIDS) databases and publications].

(b) For economic interests, data on trade in medicines (from a grey literature search and WTO data on the value of imports and exports) as well as analysis of WTO dispute data and TRIPS council reports.

(c) For the ‘security’ element, domestic compliance with immunization and the IHRs.

Results

Degree of engagement in global health negotiations

Previous studies indicate a broad consensus that Brazil and India are most engaged in the global debate on access to medicines (Teixeira 2003; Nunn et al. 2009; Gómez 2011, 2012). India was a key partner in the early negotiations in 2001 and then in 2003, Brazil, India and South Africa signed the Brasilia Declaration (Armijo 2007), working together to secure flexibilities in the implementation of TRIPS to ensure access (Rolland 2007; Yu 2008). India is also the primary global provider of cheap ARVs (Greene 2007). The visibility of Brazil and India on debates around access to medicines and vaccines at the WHO and the WTO is well-described in the literature (Nunn et al. 2009; Bliss 2010; Dukkipati 2010). This is rather different for the other three countries. South Africa’s legal battle against the pharmaceutical companies was a critical milestone, but literature on South Africa’s involvement is more limited and commentators have noted a lack of institutional maturity and capacity (Cooke 2010). In contrast, the diplomatic activities of China and Russia do not figure in the literature on access to medicines.

All five countries have committed to ‘support and undertake inclusive global public health cooperation projects, including through South-South triangular cooperation’ (GHSL 2012). In terms of channelling support through newer global health initiatives, all five are contributors to the Global Fund against AIDS, TB and Malaria, albeit so far at fairly token levels (Bliss 2010; Sridhar and Gómez 2011; GHSL 2012). Looking more broadly at global engagement in health agendas, only two of the
BRICS countries have signed up to the Oslo declaration (Brazil and South Africa). All five countries have foreign assistance programmes, but on very different scales, with China’s by far the greatest, estimated at US$3.9 billion in 2010, followed by Brazil (estimates vary between US$400 million and US$1.2 billion), India (US$680 million), Russia (US$472 million) and South Africa (US$147 million) (GHSI 2012). All five countries have ratified the Framework Convention on Tobacco Control, led by India (February 2005) and followed by South Africa (July 2005), Brazil (February 2006), China (January 2006) and finally Russia (September 2008). However, Brazil stands out as a pioneer in tobacco control and in terms of its active involvement in the negotiations leading up to the treaty (Sebrie et al. 2010). This brief review is taken as the context for the analysis and discussion that follow.

Social justice

We begin by considering the potential ‘social justice’ angle. The five countries differ on two key measures, burden of disease and drug coverage of those infected. Table 2 provides key indicators on the former.

Judged on HIV prevalence, access to ARVs should be of greatest interest to South Africa, followed by Russia, Brazil and India, and then China. However, data on ARVs coverage (Figure 1) provides a different picture. These figures can be considered as an indicator of the actual priority that each country places on access to medicines. Brazil is clearly in the lead, followed by South Africa, China, India and then Russia.

To gain insight into the extent to which these figures are different because of different motivations, rather than for other reasons (e.g. economic development, capacity), we used our supplementary evidence gathering from the literature and key informants about the extent to which each country’s domestic and international positioning of health and access to medicines is rooted, or appears to be rooted, in human rights or justice arguments.

The Brazilian government’s strategies at the international level read across most easily to a social justice lens (Buss et al. 2011). Its 1988 constitution enshrines universal access to health care as a human right (Galvao 2005; Gómez 2011, 2012; Flynn 2013). The origins of this commitment are believed to lie in the ‘sanitarista’ movement comprised of medical elites, health professionals, politicians and intellectuals, and by ‘grass roots’ activities by civil society, gradually cultivating a political commitment to providing universal health care from within the relevant Ministries (Weyland 1995; Galvao 2004, 2005). Since 1996, all HIV-positive individuals have had the legal right to free and full access to ARVs medication (Teixeira 2003).

A ‘right to health’ in India is extrapolated from the constitutional right to life, rather than being explicit (Grover and Citro 2011). India’s 1983 National health policy called for universal access to health care by 2000, but it has not been achieved. Out-of-pocket expenditures are among the highest in the world and there is poor coverage in rural areas (Kumar et al. 2011). However, a Supreme Court ruling in December 2010 directed the government to provide second-line ARVs therapy to all AIDS patients in the country, rejecting the arguments of financial constraints (Times of India 2010).

Since the end of apartheid, South Africa also has a right to health care written in its Constitution. It has not, however, pursued health as central to economic and development policy (McIntyre et al. 2007). In 2004, largely as a result of civil society pressure (Nattrass 2007), the policy of universal access to ARV treatment was introduced (Department of Health 2003). This has resulted in increased ARV coverage, which together with HIV prevention seems to have had a positive impact (UNAIDS 2010). As in Brazil, the activities of civil society and academia (Schneider 2002; Kickbusch et al. 2007) have been critical, not least in the eventual turnaround on ARV access in South Africa (Galvao 2004, 2005; Friedman and Mottiar 2005).

The Chinese government also has a long history of providing universal health care. However, Mao Zedong’s (1949–76) commitment was not based on democracy and human rights but rather on socialist principles and a need to expedite economic development (Hesketh et al. 2008). However, the public health system was weak and did not guarantee essential medicines to all. It was not until Hu Jintao’s Presidency (2002–12), with increasing attention being paid to human development, and arguably the emergence of SARS and the AIDS epidemic (see below) that the national government began to invest in its public health infrastructure and treatment policies (Huang 2006).

The expansion of health care in Russia began in the late 19th century, in reforms that accompanied the liberation of the serfs. It continued during the Soviet period and the ability of the USSR to provide universal health care, in marked contrast to its superpower rival the USA, was a matter of national prestige. This was especially apparent in 1978, when it hosted a major international conference on primary health care in Alma-Ata, capital of the Soviet Republic of Kazakhstan. However, there was always a gap between the rhetoric and the reality, with health care being funded on what was termed the residual principle, receiving what was left after other demands were met. The post-Soviet period was characterized by a rejection of socialist principles and only since the mid-2000s has significant attention been given to strengthening the health system. Unlike the other countries, the HIV/AIDS epidemic has largely remained concentrated among marginalized populations, such

![Figure 1](https://academic.oup.com/heapol/article-abstract/29/6/763/575614/1000x1000)
as drug users and sex workers, and much of the response has been by civil society organizations.

In summary, to the extent that each country has prioritized health system development and a response to HIV/AIDS in particular, the motivations seem to have varied, with only Brazil, and to a somewhat lesser extent South Africa, demonstrating a clear underpinning of domestic policy by principles of social justice, principles that Brazil also promotes in international fora.

**Economic engagement**

From an economic perspective, what matters is the cost of health care (particularly pharmaceuticals) to the government and the potential economic gains from trade. These are not necessarily two sides of the same coin: in some cases the gains are not just from decreasing domestic costs, and increasing domestic gains via increased productivity, but also about harnessing a share of global trade. Domestic commitments to equity, as in Brazil and South Africa, necessarily increase the burden on resources. Thus, there is a linkage between social justice and economic concerns.

Most of the data available to support this part of the analysis include all pharmaceuticals, rather than specifically ARVs. Expenditure on pharmaceuticals is important for each of the countries. Table 3 sets out key financial data on spending for this purpose. Table 3 sets out key financial data on spending for this purpose.

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<tbody>
<tr>
<td>Brazil</td>
<td>943</td>
<td>9.0</td>
<td>25.1</td>
<td>12.6 (2009)</td>
</tr>
<tr>
<td>China</td>
<td>309</td>
<td>4.6</td>
<td>42.5</td>
<td>80$^b$–103$^b$ (2009)</td>
</tr>
<tr>
<td>India</td>
<td>132</td>
<td>4.2</td>
<td>40.9</td>
<td>10.76 (2008)$^b$</td>
</tr>
<tr>
<td>Russian Federation</td>
<td>1038</td>
<td>5.4</td>
<td>20.3</td>
<td>11.6$^b$–14.6$^b$ (2009)</td>
</tr>
<tr>
<td>South Africa</td>
<td>862</td>
<td>8.5</td>
<td>23.3</td>
<td>2.68 (2009)$^b$</td>
</tr>
<tr>
<td>Weighted average of OECD for comparison (2009)</td>
<td>3910</td>
<td>10.4$^b$</td>
<td>17.1$^b$</td>
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</tbody>
</table>

*a*Includes private and public expenditure, courtesy of WHO (http://www.who.int/nha/country/en/#B). 
Sources:


*Note:* GDP = Gross Domestic Product.
(€1.4 billion) in 2008. That said, commentators are optimistic about South Africa’s ability to maintain exports at a similar percentage of GDP to other emerging markets (Deloitte 2010). Russia’s pharmaceutical industry has struggled in recent decades: according to one report ‘production of substances contracted 20 times since 1992…The Russian pharmaceutical industry is practically not present on the international markets’ (Malyshева 2011).

Figure 2 shows that the BRICS countries currently have very different involvement in the global trade in pharmaceuticals: India is the only net exporter. The pattern alters when adjusted for GDP (Figure 3), with trade in pharmaceuticals in dose form relatively more important in India (export), Russia and South Africa (import), than in Brazil and China.

Where economic interests are at play, therefore, the data suggest that India, as an exporter, and Russia and South Africa as importers, would be most motivated to engage in the global agenda on access to medicines. As the WTO is the main multilateral body for trade interests, it ought to be possible to gain insights from annual reports of the TRIPS council (which do attribute contributions) and of WTO disputes. TRIPS council reports indicate that over the past decade or so, since 2001, access to medicines has frequently appeared on the agenda, and there have been a wide range of contributors, but these are often broad coalitions from across middle- and lower-income countries, rather than fixed groupings such as the BRICS. With the TRIPS agreement and Doha declaration, activity seems somewhat to have lessened and narrowed, with India and Brazil remaining active.

Table 4 illustrates the total number of WTO disputes each country has engaged in, and the much smaller number of disputes that have involved pharmaceutical products. Russia, as an observer to WTO during this period and still in negotiation about its accession, is absent as it could not have participated. Arguably the only disputes which seem to encapsulate Brazil and India’s now well-formed position on access to medicines are the most recent, about the seizure of generic drugs in transit through the European Union (DS408 and 409). Even taking into account how the rigidity of WTO rules on disputes, and the TRIPS provisions themselves, limit the means available to governments that are unhappy with the status quo, as well as the general under-representation of developing countries in disputes (Abbott 2007; Alavi 2007), dispute activity at the WTO has been remarkably modest. However, this may in part reflect longer grace periods to introduce provisions on pharmaceuticals in the countries concerned. Likewise, despite their prominent part in the negotiations of the Doha declaration, each has made use of the compulsory licensing provisions in TRIPS only once, Brazil in 2007, for Merck’s Efavirenz (International Centre for Trade and Sustainable Development 2007), and India in 2012 for Bayer’s Sorafenib (Burki 2012). India and Brazil seem to balance carefully the use of ‘soft’ vs ‘hard’ mechanisms. In several cases, best documented for Brazil (Nunn et al. 2007), the threat of compulsory licensing seems to have been enough to force price changes. In turn, the risks to other areas of trade of forcing a WTO dispute may be part of the explanation why, despite the WHO’s unsuitability as a forum for discussion of trade in health issues (Lee et al. 2009), these frequently figure in its debates.

Security

It is difficult to quantify either the drivers or the reality of engagement in global health negotiations in this area on grounds of security. Although HIV/AIDS has been identified as a global health risk, not least in a UN Security Council resolution and in the Oslo declaration (Aldis 2008; Rushton 2011), and Russia has identified it as a threat to national security (Sjöstedt 2008), this has not been the dominant rhetoric on access to ARVs.

As with using domestic policies to provide context about social justice, corroboratory evidence for the security dimension can be gained from activities on other aspects of health security. Compliance with the IHRs might be relevant, although these data are only available for two of the five countries, China and South Africa, as noted earlier. Another indirect measure of the priority that a country gives to communicable disease (as a key element of health security) is the immunization rate with diphtheria, pertussis and tetanus. Three of the countries (China 99%, Russia 98% and Brazil 97%) have achieved rates over 95%, whereas South Africa (78%) and India (74%) lag behind. Russia stands out as having prioritized communicable disease, as the only BRICS country to contribute to the Global Alliance for
Discussion

While the existing literature on global health diplomacy acknowledges the tension between foreign policy and health interests, it leaves room for a more rigorous appraisal, in particular scrutiny of the claims made for global health diplomacy (Buss and Ferreira 2010; Kickbusch and Berger 2011). We have taken a group of countries, albeit with very different political contexts, that face significant health challenges and therefore arguably all have comparable interest in the potential health gains of successful global health diplomacy. Yet they display very different diplomatic behaviours. We used Kickbusch’s framework as a starting point to explore possible reasons for this divergence.

There is the clearest evidence for Brazil, followed by South Africa, demonstrating strong commitment to social justice. Brazil’s normative and policy commitments do seem to have motivated health officials to ensure that other nations enjoy the same rights, shaping Brazil’s foreign policy strategies in relation to access to ARVs and other medications (Russo and Shankland 2008; Bischoff 2009; Youla 2009) and to assert regional leadership (Burges 2006), including in health, through its major role in the newly created Union of South-American Nations (Almeida et al. 2010). Meanwhile, several commentators have noted (Sidiropoulos 2008; Bischoff 2009; Youla 2009) the apparent contradictions between post-apartheid South Africa’s image of a model democratic state, and the reality of its foreign policy. Mbeki’s aims of protecting domestic interests by focusing on security and wealth creation were endangered by his failure to stand up to Mugabe (Herbst 2005) and the HIV scandal, despite his ability in other areas to build a reputation as an international player, key regional partner and driver of the ‘African renaissance’ (Sidiropoulos 2008; Cooke 2010). Of course, ‘social justice’ might mean very different things to different countries so while our analysis assumed it required a connection to human rights, some of the countries examined are more likely to recognize arguments relating to ‘mutual benefit’ and ‘non-intervention’—core, for example, to China’s engagement in technical medical assistance since the 1960s, particularly in Africa (Freeman and Boynton 2010) and more broadly in Asian participation in global health (Fidler 2010). South Africa’s diplomatic activities also reflect the principles of state

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**Table 4: WTO dispute cases by country**

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<thead>
<tr>
<th>Country</th>
<th>As complainant</th>
<th>As respondent</th>
<th>As third party</th>
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<tbody>
<tr>
<td>Brazil</td>
<td>25 (1—DS409, concerning seizure of generic drugs in transit)</td>
<td>14 (1—DS199, concerning patent protection/compulsory licensing)</td>
<td>67 (1—DS114, concerning Canada’s stockpiling provisions with respect to certain patented pharmaceuticals from European Communities)</td>
</tr>
<tr>
<td>China</td>
<td>8</td>
<td>26</td>
<td>89</td>
</tr>
<tr>
<td>India</td>
<td>20 (3—DS168, concerning anti-dumping duties in South Africa; DS233, concerning market access in Argentina; DS408, concerning seizure of generic drugs in transit)</td>
<td>21 (1—DS50, concerning the filing of patent applications in India)</td>
<td>74 (2—DS199, DS114)</td>
</tr>
<tr>
<td>South Africa</td>
<td>0</td>
<td>3 (1—DS168)</td>
<td>2</td>
</tr>
</tbody>
</table>

The number of dispute cases in which each country has been involved in the period up to December 2012. Figures in brackets relate to numbers of cases specifically concerning pharmaceutical trade, and their respective dispute codes.

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Vaccines and Immunisation Alliance’s Advanced Market Commitment (GHSM 2012). Both Russia and China, as the BRICS members on the UN Security Council, can be observed to be particularly interested in the outcome of any WHO debates relating to global health security (e.g. smallpox, in the case of Russia). It is also clear that the SARS episode had a critical impact on China’s approach to global health overall: perceiving itself as a new global power (Hurrell 2006), since the 1990s China has become much more sensitive to international criticisms, reaching a turning point when other nations identified China’s weak public health system as a key factor in the emergence of SARS. These criticisms instigated an immediate investment in public health policy and infrastructure, as well as prevention and treatment programmes for HIV/AIDS (Huang 2006; Zunyou and Sullivan 2006; Kaufman 2009; Chan et al. 2010).

SARS illustrates the links between economic and security concerns. This seems to hold also for HIV/AIDS, as seen by Western commentators (Rushton 2011), and its potential for economic and other impacts.
sovereignty, non-interventionism and resistance to western ideals, which are inevitably seen as associated with racism (Lipton 2009; Youla 2009). South Africa faces significant tensions in its desire to create the right reputation with the right audience, balancing donor and African interests.

Economic interests (key to all countries’ foreign policies) are important for global health diplomacy but are not, at least using readily identifiable metrics, sufficient to explain its complexities. Differing motivations are suggested by the fora in which debates take place, including at the WTO (rather than WHO), in the context of the TRIPS agreement, and the Doha declaration in 2001 (Smith et al. 2009). If trade in pharmaceuticals is a critical issue for a government, it should pursue that agenda aggressively at the body responsible for improving trade, the WTO. Yet interestingly, although Brazil, China and India are all active in the WTO, for example, in terms of involvement in disputes, pharmaceutical issues have not been high on their agenda in this forum.

In contrast, there seems only limited evidence that security considerations play a role in access to medicines, although that is likely to be different in other global health debates, such as risks of bioterrorism.

India most visibly bridges all three of the dimensions. Global scrutiny of India’s delays in eradicating smallpox, a security threat, led to a major diplomatic, bureaucratic, technical and medical response (Bhattacharyya 2004), and India has long been visible in raising the non-communicable disease agenda at the WHA (World Health Organisation 1956; Yach et al. 2004), including mental health (K Desiraju, personal communication). However, India’s stake in the ARVs market is without parallel, and India’s reputation as a key player in industry, economics, etc. does seem more important to India’s government than its reputation in health (Dukkipati 2010).

Russia and China sit apart from the other BRICS both in their approach and likely motivations (despite the obvious economic drive). There may be a wariness to pursue such important agendas multilaterally. Key informants confirmed that China’s increasing interest in global health at a multilateral level is rooted in pressure from international organizations, other countries and domestic academia, rather than from within the government. The Chinese government does, however, take great pride in the election (and re-election) of Margaret Chan to the post of Director General of the WHO (Freeman and Boynton 2010).

The St Petersburg G8 summit in 2006 was the first to bring together the G8 health ministers, thought to have been because health was seen to be a ‘safe’ area, where Russia, as a newly admitted member and increasingly important donor could be sure of contributing (Panova 2005, 2007; Guebert 2012). However, the downside of wanting to portray a modern, developed image internationally has been neglect in areas of domestic health, such as HIV/AIDS, which were felt to be incompatible with that image (Wallander 2005). More recently, with leadership on non-communicable diseases, Russia has taken a brave step in allowing global focus on a key area of weakness in its domestic system, which it had avoided at G8 events (Kirton and Mannell 2007; Kulik 2011). Russia’s selective and strategic involvement in global health seems designed to ensure it maintains the image of an international power, with Putin pursuing pragmatic foreign policy goals while maximizing domestic economic stability (Macfarlane 2006).

There are several limitations to this article. The lack of detail in available data meant that we had to reconcile specific information about ARVs with evidence about other pharmaceutical products: however, for the purposes of this comparative analysis, as the evidence was always consistent between countries, this does not seem to be a critical limitation. Trying to understand motivations assumes that governments make evidence-based and proportionate decisions and enact them in a predictable way. International relations are complex and nuanced: global health diplomacy is just as difficult to untangle. Our literature review identified of course other motivations and moderating factors, not least political leadership and bureaucratic capacity and maturity (which may limit a government’s ability to engage, and constitute a vital cause of variation between these countries).

Despite these limitations, the analysis above suggests that when a framework approach is applied, using diverse sources of data, it may be possible to gain fresh insights into relative motivations. In this area, it seems that where two or more dimensions of foreign policy converge, as they arguably do for India and Brazil, activity is greatest. There may be particular prominence, as there is for Brazil, where reputation is staked on one of the dimensions. These findings are pertinent not only because the importance of this group of countries is likely to increase, given the official formation of a BRICS coalition, but also since foreign policy interests are crucial to all countries. Further investigation along these lines, outside the reach of this paper, could in turn begin to facilitate a more realistic assessment of their potential impact on global health outcomes.

While our analysis supports the validity of using a foreign policy framework to unpick countries’ motivations, we argue for a more sophisticated understanding of the factors at play. In particular, there are ‘soft power’ dimensions to global health debates that transcend all of the arguments, and it is pertinent to ask whether a country’s motivations for engagement match the image the country wants to portray. Unsurprisingly, none of the three dimensions we used are enough in their own right to explain all of a country’s behaviour.

Acknowledgements

The authors would like to thank all informants and others who took the time to comment on the initial draft: Keshav Desiraju, Prof. Mala Rao, Javid Chowdury, Prof. Lucy Chen, Alok Mukhopadhyay, Liu Pellong, Prof. K.K. Cheng, Prof. Jose Temporao, Dr Gustaaf Wolvaardt, Prof. Ian Couper, Luvuyo Ndimeni, Dr Kirill Danishhevskiy, Prof. Rod MacFarquhar and Prof. Dame Sally Davies. Thanks go also to the two anonymous reviewers who commented on the first submitted version.

Conflict of interest

None declared.
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