

Confronting Health Inequalities in the BRICS: Political Institutions, Foreign Policy Aspirations and State-civil Societal Relationships

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Abstract

The BRICS (Brazil, Russia, India, China and South Africa) have emerged as potentially robust economies with considerable international influence. Nevertheless, essentially all of these nations have fallen short of simultaneously developing strong economies and health care systems, contributing to the emergence of health care inequalities, such as inadequate access to medicine, health care treatment and out-of-pocket spending. This is puzzling considering that most of these nations' economies burgeoned during the 1990s and early-2000s, thus potentially providing additional revenue for health care spending, while constitutional guarantees of universal access to health care and the presence of democratic electoral institutions in most nations should have incentivized governments to successfully address these inequality issues. Nevertheless, with the exception of South Africa, this study finds that waning political commitment to health care spending, increased foreign aid commitments and tenuous state-civil societal relationships accounted for these ongoing inequality challenges.

Policy Implications

- Ensuring that all health care inequality issues are addressed prior to creating and implementation health insurance programs in the BRICS.
- Ensure that governments are fully committed to introducing regulatory institutions that avoid inequality issues, such as out-of-pocket and catastrophic expenses.
- Ensure that governments are not distracted by foreign policy goals in providing foreign aid in health, at the expense of over looking ongoing domestic health care needs.
- Ensure that civil society is fully integrated in the health care policy making process, especially on policy interventions that avoid inequality issues.

Introduction

Scholars interested in understanding the successful developmental prospects of emerging economies have recently emphasized the importance of simultaneously investing in health care and other social welfare programs (Haggard and Kaufman, 2008; Sen, 1999). Several have emphasized the importance of democratic institutions, electoral accountability, centralized public health institutions, and strong state-civil societal relationships as necessary conditions for developing equitable and effective health care systems amidst transitions to democracy and economic reform (Boone and Batsell, 2001; Gauri and Khaleghian, 2002; McGuire, 2010; Nathanson, 1996). However, some of the most dynamic emerging economies have failed to achieve these objectives, notwithstanding the presence of these institutional and civil societal preconditions.

A good example is the BRICS (Brazil, Russia, India, China and South Africa). During the 1990s and early-2000s, these nations saw the emergence of stable economic growth rates, rising per capita income alongside increased health

care inequalities. This article primarily concerns itself with three types of inequalities: universal access to medicine; out-of-pocket (OOP) expenditures among the poor; and geographic urban versus rural differences in the quality of health care infrastructure, e.g., beds and equipment and human resources: doctors and nurses.

In a context of growth and development, why did these inequalities emerge? This article claims that these outcomes were attributed to a lack of government commitment to increasing government spending for health care, a byproduct of political apathy and conflicting viewpoints within government. Within the BRICS, South Africa was the only nation to see an increased government commitment to reducing inequalities in access to medicine and reduced OOP, resulting from years of policy neglect, the transition to democracy and the overwhelming burden of disease. Yet another challenge, as seen in Russia and China, were political leaders being distracted by their efforts to become leaders in providing foreign aid in health, dovetailing with preexisting ambitions to become geopolitical powers (Hurrell, 2006); and yet, these ambitions led Russia and

China to overlook domestic health care needs. This assertion comports with a growing consensus in the literature suggesting that increasing foreign aid in health at the expense of neglecting funding for domestic health programs, ensuring adequate health insurance and infrastructure leads to the presence of inequitable health care systems (Brezhneva and Ukhova, 2013; Clark, 2013; Huang, 2014); public opinion polls conducted by Russian and Chinese scholars underscore politicians' and society's discontent with this kind of biased allocation in health care spending, for the aforementioned reasons (Brezhneva and Ukhova, 2013; Huang, 2014). Finally, in essentially all of these nations, save for South Africa, the government's reluctance to adequately incorporate the views of civil society created few incentives to address health care inequality issues. This article therefore contributes to our understanding of the international and domestic political institutional and policy challenges of addressing health care inequalities within the BRICS group, rather than seeking to establish lessons for other nations and the global health policy literature.

But why focus on the BRICS, especially if we consider their recently different political and economic trajectories? First, this was done in order to provide yet another reason for why and how these nations eventually diverged onto different developmental trajectories, while highlighting ongoing health care challenges that if not addressed could continue to hamper economic performance. Second, the BRICS were selected because they share unique institutional challenges not seen in other emerging economies: that is, large geographic territories; a high degree of federalism and decentralization, which occurred at a fast pace, posing challenges for local governments lacking adequate resources. Governments of other emerging economies, such as the MINTs (Mexico, Indonesia, Nigeria and Turkey), do not have as large of a geographic territory to govern, have a higher degree of centralization in the financing of health care services, and are thus expected to have a stronger government response to health care inequalities (Gómez, 2015a). And finally, the author focused on the BRICS to raise the question if these nations are in a position to provide health care policy recommendations to developing nations, such as through their BRICS Development Bank; findings from this article suggests otherwise.

Methodology

This study conducted a qualitative comparative case study design. This methodological approach helps to highlight the unique causal mechanisms, contexts and policy outcomes between nations (George and Bennet, 2004). With respect to the BRICS, these nations exhibited differences in their cultural, political, socio-economic characteristics and thus differences in the domestic and international factors leading to health care inequalities.

Indeed, the BRICS are considerably different with respect to their political and economic challenges. Brazil's democratic presidential system has seen political instability due to allegations of corruption, contributing to an economic

recession (*The Economist*, 2016). In contrast, while Russia's democratic presidential system has avoided political instability due to the presence of a strong president, Russia has joined Brazil in seeing an economic recession due to a decline in world oil prices (Oxenstierna, 2016). Despite ongoing corruption with the bureaucracy, social intolerance and unrest, India's parliamentary democracy has also been politically stable and has seen general improvements in economic growth (Narayanan, 2015).

Though not democratic, China's political system has a more centralized governance structure under the State Council, contributing to political stability while facilitating the policy making process (Goodman, 2015). In contrast to Brazil and Russia, China's economy has continued to grow despite a recent slowdown due to rising inflation and a decreased demand for China exports (Marans, 2015). Finally, South Africa has seen political stability in its presidential parliamentary democracy, though recent social unrest and competing political parties may challenge this stability going forward (Smith, 2014). Similar to Brazil and Russia, South Africa's economic growth has recently decreased because of waning fiscal revenues and high social welfare spending (BBC, 2014).

The BRICS also differed with respect to the influence of the international community on the emergence and impact of health care market reforms. In Russia and India, the World Bank's International Financial Corporation (IFC) and the Bill & Melinda Gates Foundation (in India) had an early and profound effect on introducing private hospitals and insurance companies, gradually contributing to a rise in inequalities in access to medication and treatment (Hunter and Murray, 2015; Marquez, 2008). Conversely, in Brazil, China and South Africa, the international community did not influence the emergence of a private health care sector, though the latter subsequently emerged due to inefficiencies stemming from the public sector. In Brazil and South Africa, there existed preexisting government commitments to providing health care for the poor (Collins et al. 2000; Econex, 2013), thwarting the international community's ability to pressure the state into adopting market reforms. Eventually, due to a decline in public sector financing, limited access to medicine and low quality treatment, a thriving private health care industry emerged in Brazil and South Africa, contributing to inequalities, though to a lesser extent in South Africa due to a stronger government response to these challenges – discussed shortly. In China, eventually a free market for health care emerged during the 1980s with the government's decision to decentralize health care responsibilities to the provinces and the government's indirect willingness to allow for the introduction of a private health insurance industry and for poorly funded public hospitals to sell medication (Yip and Hsiao, 2015).

Finally, the BRICS was compared in this study to evaluate the efficacy of theoretical frameworks underscoring the conditions under which nations implement effective health care systems and minimize inequalities. Through this comparative analysis the goal was to show the limitations of these theories while highlighting alternative causal factors differentiating the BRICS. The author used primary and

secondary qualitative data, such as articles, books and policy reports, to support empirical claims.

Politics, state capacity and health care inequalities

Researchers have recently concerned themselves with understanding developing nations' ability to create equitable and effective health care systems amidst economic reform. Arguments have been put forth underscoring the conditions under which governments achieve these outcomes. Some claim that the presence of democratic institutions, with constitutions guaranteeing health care as a human right and electoral accountability, heightened through the media's presence, induces politicians to introduce equitable and effective health care systems (Bor, 2007; Sen, 1999). Others claim that nations with strong bureaucratic and technical capacity can succeed in strengthening health care systems (Nathanson, 1996; Skocpol and Amenta, 1986). Strong state capacity has been emphasized to explain variation in nations' ability to overcome health care inequalities, such as children and women's mortality (McGuire, 2010). Others agree and emphasize that state capacity is more important than electoral accountability in providing medical treatment (Gauri and Khaleghian, 2002).

Alternatively, others maintain that civic mobilization and pressures are important for motivating governments to overcome health care inequalities and eradicate disease. NGOs provide governments with the information needed to create legislation and interventions that are effective in providing health care services (Boone and Batsell, 2001); to achieve this, governments seek to establish strong partnerships with NGOs (Boone and Batsell, 2001). Others emphasize the importance of creating representative institutions, such as legislative committees, that formally represent and incorporate the interests of civil society (Immergut, 1993). Effective prevention policies in response to diseases have often relied on this kind of civic institutional representation and incorporation into the policy making process (Boone and Batsell, 2001).

However, most of these institutional and civil societal conditions for strengthening health care systems and reducing inequalities were present in the BRICS; and yet, these outcomes never emerged. Instead, findings from case studies in this article suggest that even amidst economic reform and growth, most governments still could not credibly commit to overcoming health care inequalities. Differences in government commitment to establishing equitable health care systems, and, in some instances, aspirations for global leadership in foreign aid, when combined with the government's tenuous relationship with civil society appears to have created obstacles to overcoming inequalities.

Brazil

Despite the transition to democracy and constitutional commitments to providing universal health care, the quality and effectiveness of health care in Brazil has waned in recent

years (Khazan, 2014); moreover, this occurred amidst strong economic growth rates by the late-1990s up through 2010. Brazil has a mixed public/private health care system, where universal health care is provided through the *Sistema Único de Saúde* (SUS, Unified Health System), decentralized and managed mainly by state governments (Collins et al. 2000). A private health care system is also present, where businesses and individuals purchase insurance at premiums set by the government. Despite the fact that most individuals partake of SUS services and because SUS has often failed to ensure adequate health care, most individuals have purchased private insurance. SUS' main challenges have been due to limited funding, poor administration and human resources, corruption and a lack of accountability (Khazan, 2014).

A particular challenge that has emerged is access to medicine and high OOP expenses. Notwithstanding the fact that the 1988 democratic constitution guarantees that all citizens have the right to obtain essential medicines free of charge, inequality in access to medicine persists. A study conducted by Bertoldi et al. (2013) found that 40 per cent of the generics provided by the public sector were not available, which in turn has led to approximately 25.5 per cent of the poor spending out of pocket for medications (Bertoldi et al., 2013). Moreover, approximately 9 per cent of the poor spend out of pocket for health care services, with medications representing the largest expense: approximately 31.5 per cent of monthly health expenses, while 2 per cent of monthly family income were spent on medications (Bertoldi et al. 2011).

In response, in 2004 the government created the *Farmácia Popular do Brasil* (Brazil Popular Pharmacies Program). Managed by state and municipal governments, these pharmacies provide drugs that are difficult to find and at an affordable price (Bertoldi et al. 2011); approximately 90 per cent of the costs for drugs at these pharmacies are provided by the government (Bertoldi et al. 2011). Nevertheless, Bertoldi et al. (2013) found that only certain types of medications are covered through this program, such as anti-hypertensive, diabetic and contraceptive medication.

Additionally, hospitals with the best infrastructure, technology and staff are located in more affluent urban areas, such as São Paulo and Rio de Janeiro (La Forgia and Couttolenc, 2008). The converse holds for poorer rural areas, where it is difficult to incentivize doctors and nurses to work. Despite the presence of a federal program, known as the *Programma Família de Saúde* (FHS, Family Health Program), which provides monetary incentives for medical staff to make family visits and provide primary care in rural areas (Kepp, 2008), FHS teams can only cover so much territory. Consequently, even though the poor are covered by SUS, if they are located in rural areas their ability to access quality health care is limited.

These inequality challenges appear to be attributed to the government's unwillingness to increasing health care spending; moreover, this problem has unmasked conflicting policy priorities. Under the Luiz Inácio Lula da Silva administration, his focus was on funding anti-poverty programs, such as

Bolsa Familia (Tavares de Almeida, 2005). Despite Lula's commitment to improved health care for all, congressional spending for the Ministry of Health (MoH) flat-lined during his presidency (Gómez, 2012). Anti-poverty spending and *Bolsa Familia's* direct cash transfer schemes for the poor seemed to provide greater electoral benefits when compared to health care.

With respect to foreign policy, the Lula and current Dilma Rousseff administrations have continued to provide bilateral assistance, such as helping African nations respond to HIV/AIDS (Gómez, 2015b). Nevertheless, this assistance has never distracted the government from maintaining its focus on domestic health care policy (Gómez, 2015b). In large part this is due to the government's historic effort to work closely with the international community rather than striving to become a global leader in health care financing (Gómez, 2015b). As Table 1 illustrates, this policy tradition is reflected in the comparatively lower level of funding Brazil provides to international health agencies.

What is puzzling about Brazil is that health care inequalities persist despite a relatively strong partnership between the government and civil society. Ever since the creation of the 1988 democratic constitution and the introduction of SUS, national and subnational institutions were created to ensure civil societal representation in health policy making. At the national level, the State-Civil Society National Health Council was created, as well as the State and Municipal Health Councils (CONASS and CONASEMS, respectively). These commissions' responsibility were to incorporate the views of civil society when formulating policy (Collins et al., 2000).

Nevertheless, it seems that the presence of these commissions has not motivated the government to increase health care spending, while ensuring that such spending targets the aforementioned inequality challenges. Consequently, in recent years civil society has engaged in several rounds of protest, claiming that the state has waned in its commitment to providing adequate health care (Gupta and Crellin, 2013).

Table 1. BRICS' financial contributions to the Global Fund and GAVI

	Global Fund Contributions (up through 2012, \$US millions)	Global Fund funding received (\$US millions)	GAVI Contributions (\$US millions)	GAVI funding received (\$US millions)
Russia	297.0	372.0	24.0	0.0
Brazil	0.0	39.1	0.0	0.0
India	10.0	1,019.9	0.0	94.0
China	25.0	763.3	0.0	38.7
South Africa	10.3	350.6	0.0	0.0

Source: Sridhar et al. (2013).

Russia

Russia has also been affected by a myriad of health care challenges. And this occurred despite the fact that the government had, until recently, modestly high economic growth rates. Inequalities in access to medicine stand out as a reoccurring problem. Despite Article 41 of the constitution stating that all citizens have the right to medicine and that all medications are free of charge (Popovich et al. 2011), there is often a shortage of medication, especially in poorer areas, while inadequate state insurance coverage is provided. Patients are eligible for state assistance discounts, but on average this only covers approximately 11 per cent of the population needing medication (Marquez and Bonch-Osmolovskiy, 2010; Popovich et al. 2011). In a survey conducted in Russia about the overall quality of the health care system, roughly 20 per cent of those polled stated that they were refused medication (Popovich et al. 2011). This context has led to an increase in OOP and catastrophic expenses, especially among the poor (Perlman and Balabanova, 2011; Popovich et al. 2011). Popovich et al. (2011) claims that OOP expenditures rose by a factor of 7.5 since 2000. Moreover, prices for medication increased, translating to a 1 per cent loss of total household expenditures, which disproportionately affected the poor (Marquez and Bonch-Osmolovskiy, 2010; Popovich et al. 2011).

Furthermore, highly trained doctors, nurses, and staff are primarily located in affluent urban centers, such as Moscow and St. Petersburg, while there are few medical staff in poorer rural areas. There were approximately 49.6 doctors per 10,000 throughout Russia, while there were only 12.1 per 10,000 in rural areas (Popovich et al. 2011). Furthermore, despite having one of the highest numbers of health care workers per capita in the world (Zakirova et al. 2012), the government's distribution of medical doctors is often seen as inefficient (Davydov and Shepin, 2010).

What is more, the number of hospital beds in the urban areas was 118.3 per 10,000 beds versus 45.1 beds per 10,000 for rural residents (Popovich et al. 2011). Consequently, individuals seeking quality health care have had to travel to other regional jurisdictions; however, they must often pay out of pocket to be treated, as they are out of regional jurisdiction and consequently not authorized regional discounts (Rozenfeld, 1995).

But why did the government not address these inequalities? First, it seems that there is little presidential commitment to improving the health care system (Kucheryavenko, 2014). The Vladimir Putin administration has mainly focused on strengthening the economy and increasing spending for military defense. In 2013, Putin announced a further reduction in health care spending in order to increase military spending (Petrenko, 2013). This focus on building a strong defense and economy dovetails with Putin's unrelenting priority to strengthen the government and its international influence.

Yet another challenge has been Russia's efforts to become a global leader in health care financing, which Putin views as a means to bolster Russia's international significance

(Gómez, 2015b). As Table 1 illustrates, Russia has led the BRICS group in providing funding for international health agencies, such as the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria (Global Fund) and GAVI (Global Alliance for Vaccines and Immunizations) (Sridhar et al. 2013). Nevertheless, some have questioned Putin's focus on providing international support, especially as there are ongoing domestic health care needs (Brezhneva and Ukhova, 2013; Clark, 2013).

Also problematic is the MoH's unwillingness to fully integrate civil society's views into the policy making process. Little evidence suggests that the MoH is proactively trying to work with civil societal groups to obtain information about how to ensure equitable access to health care (Lokshina, 2012). This mainly stems from the government's lack of trust in NGOs, which are often perceived as being associated with Western donors (Lokshina, 2012). Further complicating matters is civil society's lack of experience in mobilizing and lobbying the government for better access to health care.

India

India has seen a relatively stable economic growth rate amidst several health care challenges. The nation's persistent health care inequalities across a broad spectrum of issues and its effects on individual welfare, aspiration and productivity has led scholars to question India's long-term economic growth potential (Dréze and Sen, 2013).

Access to medicines poses a particular challenge. This may be attributed to the lack of federal legislation guaranteeing the universal provision of medication. In this context, most of the population has had to pay out-of-pocket (OOP) for medicine and other health care services (Balarajan et al., 2011). OOP expenditures rose to approximately 80 per cent of the population (Prinja et al. 2012), with most of this spending targeted at fee-for-service private providers and hospital user fees (La Forgia and Nagpal, 2012). Rising drug costs have disproportionately affected the poor (La Forgia and Nagpal, 2012), compounded by a decline in the number of medications subject to price control (La Forgia and Nagpal, 2012 Selvaraj, 2010).

Furthermore, hospitals with the best technology and the greatest number of beds are mainly only located in affluent urban centers (Balarajan et al. 2011). With the rising growth of private health care providers, there are also a disproportionately higher number of better quality private hospitals in urban centers (Balarajan et al. 2011); these challenges are further complicated by the long distance that rural residents must overcome to obtain better quality care (Balarajan et al. 2011). Additionally, most of the best qualified doctors and nurses are located in urban centers, while a large percentage of health care workers in rural areas lack formal training and are unqualified for medical care (Balarajan et al. 2011).

But why have these inequalities persisted? This is because in recent years, prime ministers and the parliament have not placed improving access to health care high on the national policy agenda (Drez and Sen, 2013; Gómez, 2015a). Rejuvenating the economy, introducing free markets

(especially for the health care industry), and improving technology have instead been the government's priorities (Drez and Sen, 2013). Additionally, the low level of media coverage for health care has created few incentives for parliamentarians to focus on strengthening the health care system (Drez and Sen, 2013).

While in recent years the government has proclaimed its commitment to investing in health care, budgetary evidence suggests otherwise. India recently allocated approximately 1.2 per cent of its GDP to health care spending; only nine other nations in the world have had a lower ratio (Drez and Sen, 2013, p. 148). At the per capita level (in purchasing power parity to 2005 international dollar rates), the government spends approximately \$39 per person, compared to \$203 in China and \$483 in Brazil (Drez and Sen, 2013, p. 149).

In contrast to Russia, however, providing foreign aid does not appear to account for why the government has not responded to health care inequalities. While India has contributed funding to multilateral health agencies (see Table 1), these contributions are substantially less than the other BRICS nations (Sridhar et al. 2013). Moreover, no evidence suggests that India is trying to use its foreign aid as a means to increasing its international influence (Gómez, 2015b); instead, it continues to work in multilateral partnership with other nations (Gómez, 2015b).

Finally, yet another challenge problematizing the government's focus on overcoming health care inequalities is its weak partnership with civil society. There are no national, state and/or municipal health committees, or any other types of institutional venues, that can incorporate society's policy suggestions, while government officials have not tried to establish a close partnership with NGOs (Koenig and Nilsson, 2015). The Ministry of Health's relationship with NGOs can at best be characterized as tenuous, exhibiting lack of trust and cooperation (Koenig and Nilsson, 2015). Much of this stems from the high level of corruption, mainly by way of the registration of fake NGOs seeking to obtain funding from the government and donors, and general government suspicion of NGO activities and their ties with donors (Mashru, 2014). There is also no long history of social health movements and NGOs working closely with health officials.

China

China has also confronted health care inequalities amidst economic growth. Despite the constitution stating that all citizens have the right to health care, which includes access to medication, in reality this has never been achieved (Wang and Li, 2011). Over time, equal access to medications decreased (Sussmuth-Dyckerhoff and Wang, 2010). While the government has created an essential drugs list, which is distributed by hospitals, the list only covers approximately 300 medications (Sussmuth-Dyckerhoff and Wang, 2010).

The challenge of accessing medication also seems to be influenced by fiscal decentralization and inadequate health insurance coverage. Because the provision of health care services has become increasingly decentralized (Hipgrave

et al., 2012), hospitals bear the brunt of funding most medications. Yet, in a context where the central government has not provided sufficient financial assistance and as hospital costs increase (Sussmuth-Dyckerhoff and Wang, 2010), hospitals have been forced to increase drug prices, while engaging in other corrupt practices, such as prescribing unnecessary medications and lab tests (Su, 2007). In 2011, public hospitals earned approximately 60 per cent of their revenue from the sale of prescription drugs (PBS, 2011). Hospitals therefore have financial disincentives to make drugs more affordable and accessible to all.

In response to these challenges, in 2009 the government issued an essential medicines list (EML), which included approximately 307 medications to be covered (Barber and Yao, 2010). The following year, the government stated its commitment to ensuring that all essential medicines are reimbursable (Barber and Yao, 2010), a central aspect of the Health Care Reform Implementation Act of 2009–2011 (Wang and Li, 2011). Nevertheless, only 38 per cent of public primary health care facilities adopted this mandate (Wang and Li, 2011), reflecting ongoing hospital efforts to profit from drug sales.

Estimates in 2010 nevertheless suggest that health insurance coverage is increasing in urban and rural areas, mainly through the introduction of health insurance programs for the poor, such as the Urban Resident Basic Medical Insurance (URBMI) and the New Rural Cooperative Medical System (NRCMS) (Sussmuth-Dyckerhoff and Wang, 2010). Through these voluntary insurance programs, approximately 90 per cent of the population now has health coverage (Eggleton, 2012). Nevertheless, because much of the funding for these programs depend on central and local government taxation (Weiyuan, 2010), and because smaller cities cannot raise sufficient revenue to cover costs, a large percentage of the poor still end up paying for medication and other health care services: approximately 40 per cent of all individual health care costs are paid through individual premiums or as OOP expenses (Eggleton, 2012; Sussmuth-Dyckerhoff and Wang, 2010).

OOP expenditures across all income levels have in fact increased in recent years (Li et al. 2013, 2014; Liu et al. 2014). However, the poor have borne most of the costs compared to the more affluent classes (Long et al. 2013; Yip et al. 2012). Complicating matters even more is the fact that despite increased government spending for health insurance programs for the poor, such as NCMS in rural areas and URBMI in urban areas, the poor continue to pay high co-pay premiums for services not covered through these programs (Yang, 2013).

The best hospitals and infrastructure, such as beds and x-ray machines, are also predominantly found in wealthier urban areas (Sussmuth-Dyckerhoff and Wang, 2010). To help overcome this geographic disparity, between 2003 to 2007, through the Rural Health Services Construction and Development Program, the State Council invested US\$ 2 billion for health infrastructure and equipment for rural areas (Barber and Yao, 2010). And between 2000 and 2008, there was a 23 per cent increase in the number of public hospitals

established (Barber and Yao, 2010). Nevertheless, having more publically funded hospitals, even in rural areas, will not guarantee their proper functioning. Because the majority of hospitals are publically owned (Eggleton, 2012), their ability to improve in total quality management increases only when provinces have the fiscal capacity to do so.

Further complicating matters is the fact that China's best doctors and nurses mainly reside in urban centers (Eggleton, 2012). Going forward, the central and provincial governments will need to allocate more funding for training medical personnel in rural areas, especially general practitioners (GPs), as the current medical curriculum offered in medical schools allows for early specialization in a particular medical area rather than general practice (Eggleton, 2012). The State Council's creation of the Directions on the Establishment of the General Practitioner System in July 2011, which mandates improved GP quality in training and service provision by 2020, is a positive step in this direction (Eggleton, 2012).

But why have these health care inequalities emerged? This can be attributed to the government's delayed commitment in placing health care onto the national policy agenda (Hipgrave, 2011). The State Council's emphasis on strengthening the economy, lack of adequate media attention to health care problems, and the absence of electoral accountability and pressures failed to incentivize the government to address the aforementioned inequality issues (Gómez, 2015a).

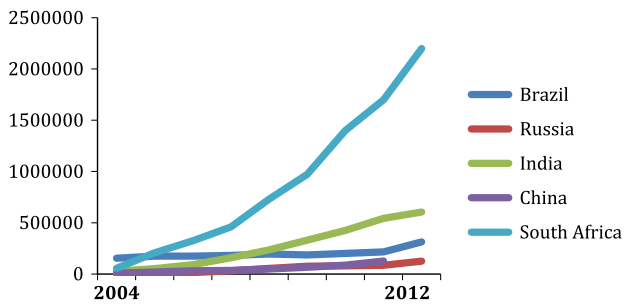
Yet another reason stems from the government's geopolitical aspirations. The State Council has viewed providing foreign aid in health as a means to increasing the government's international presence and influence (Huang, 2014). For example, funding to help several African nations respond to HIV/AIDS has been used to help win the hearts and minds of African citizens and governments, with the goal of facilitating China's ability to acquire access to lucrative markets, such as oil (Huang, 2014). What is interesting to note is that China's foreign assistance has been increasing while there is still an ongoing need for domestic health care spending (Huang, 2014). This seems to suggest that as in Russia, the government has been more focused on bolstering its international influence rather than ensuring that health care inequalities are effectively addressed.

Finally, the government's ongoing lack of commitment to working closely with civil society also seems to account for the government's unwillingness to address health care inequalities. Two challenges stand out. First, the absence of a historic social health movement and, consequently, civil society's inexperience in collectively responding to health care and lobbying the government for policy reform (Yang Da-huang, 2004); and second, the ministry of health's apathy towards incorporating civil societal views into the policy-making processes (Yuk-ping Lo, 2014). Because of this, there are no federal committees where civil society can express their opposition to the health care system.

South Africa

By the early-2000s, South Africa also confronted several health care inequalities amidst economic growth. Like Brazil,

Figure 1. Number of individuals on ARV therapy in the BRICS (2004–12).



Source: UNAIDS (2013).

China and Russia, South Africa's constitution states that: 'Everyone has the right to have access to health care services' (The Constitution of the Republic of South Africa, 1996, p. 11). When compared to these other nations, however, it seems that South Africa's government has fared better in ensuring that individuals have access to medicines.

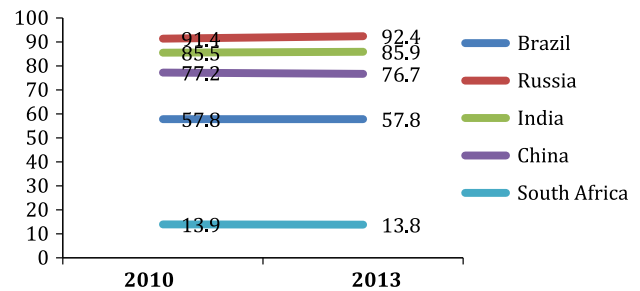
As early as 1996, the Department of Health (DoH) created the standard treatment guidelines (STGs) and the essential drugs list (EDL). EDL lists were required for all public health clinics. Moreover, the STGs and EDLs were updated in 1998, while being supplemented with specific STG/EDLs for adult and pediatric hospitals in 2003 (Harrison, 2010). According to a commissioned report published by the Kaiser Family Foundation in 2010 (Harrison, 2010), approximately 97 per cent of all public health facilities dispensed all of the drugs on the EDL lists (Harrison, 2010); this was up from 59 per cent several years earlier (Harrison, 2010). Furthermore, most of the public health facilities in the provinces complied with the EDL list and had, on average, approximately 86 per cent of the drugs available for citizens (Harrison, 2010).

Recent government regulations have also helped to keep the price of drugs affordable for public health facilities. In 2005, the government imposed a 'single exit price' policy for all pharmaceutical companies, which requires manufacturers to publically declare drug prices once it leaves their complex (Harrison, 2010). This has helped to reduce the price of essential medicines by approximately 20 per cent (Harrison, 2010). Increased market competition for the sale of generic medication may also be contributing to this price reduction (Harrison, 2010).

Increased access to specific types of medications, such as antiretroviral medication (ARV) for HIV/AIDS, has also been achieved. As Figure 1 illustrates, South Africa led the BRICS in the percentage of HIV positive individuals having access to ARV (Mooney and McIntyre, 2008). This success mainly stems from years of government neglect in recognizing the cause of and the appropriate procedure for treating AIDS.

The South African government has also done a good job of keeping OOP expenditures at a minimum. As Figure 2 illustrates, when compared to the other BRICS, OOP expenses have been much lower, decreasing from 13.9 per cent of private expenditures for health in 2010 to 13.8 per cent in 2013. While much of the poor have experienced

Figure 2. BRICS out-of-pocket (OOP) expenses (percentage of total private expenditures for health)



Source: WHO (2015).

OOP and catastrophic expenses, the impoverishing impact of these payments has been relatively small when compared to other neighboring countries (McIntyre et al. 2014).

Nevertheless, hospitals with the greatest number of beds, best technology and equipment are located in urban centers, not rural areas (Human, 2010). This difference in the quality of hospital infrastructure and technology has led to differences in the overall quality of health care provided, which is lower in poorer rural areas (Keeton, 2010). In this context, some of the poor have been forced to travel to cities to receive better care (Keeton, 2010).

Furthermore, the most talented doctors and nurses tend to work for private hospitals, often located in urban centers, in hospitals that can afford to pay higher salaries (Miller, 2009); the converse holds for the public sector, which includes servicing thousands of clinics in poorer rural areas (Miller, 2009). As of 2010, approximately 70 per cent of all doctors and nurses work for the private sector, with the remaining 30 per cent in the public sector, which mainly serves the poor (Keeton, 2010). There is also an ongoing need to invest in adequate health care administration, support staff, which some find has created disincentives for physicians to practice primary care (Harrison, 2010). Finally, despite the impressive progress to date in providing ARV medication for AIDS patients, there has been a recent decline in the number of public sector posts and nurses providing AIDS prevention and treatment services (Harrison, 2010). This, again, appears to be the case mainly in rural areas, where the bulk of the epidemic is located.

But why has South Africa performed somewhat better in terms of improving access to medicines and limiting OOP spending? First, it seems that heightened inequities in health care, often racially motivated, during apartheid the government instigated a radical backlash in the opposite direction after the transition to democracy and ANC rule beginning in 1996. The proactive mobilization of civil society in pressuring for improved health care, coupled with a President, Nelson Mandela (himself a victim of tuberculosis), who was fully committed to health care and human rights, helped to place health reform onto the national policy agenda. This shifting political context also emerged amidst overwhelming international criticisms and pressures to address the AIDS epidemic (Lieberman, 2009).

Furthermore, with respect to foreign policy, it seems that President Theba Mbeki and the ANC were never focused on increasing the government's foreign aid assistance in the hopes of bolstering the government's international influence. As Table 1 illustrates, South Africa joined Brazil and India in providing the least amount of funding to the Global Fund and GAVI. Instead, South Africa's interest in global health has been focused more on multi-lateral cooperation and partnerships in helping neighboring African countries with the resources needed to improve their health care systems (Watt et al. 2013).

Finally, notwithstanding several decades of weak state-civil societal relationships under apartheid, when it comes to public health, this relationship appears to be strengthening. In the past two decades, a myriad of health NGOs, especially focused on diseases such as HIV/AIDS and TB, have emerged to form a closer partnership with the Department of Health for prevention and treatment programs (Williams et al., n.d.). NGOs are now perceived by health officials as key allies in policy making, helping provide information on health sector needs and a response to the ongoing HIV/AIDS and TB epidemics (Gómez and Harris, 2015).

Conclusion

Several lessons emerge from this comparative analysis of the BRICS. First, despite the presence of democratic institutions, representation, and constitutional commitments to health care as a human right, most of these nations have not adequately addressed ongoing health care inequalities in access to medicine, OOP expenditures, infrastructure and human resources. What seemed to be most important in accounting for these inequality challenges was the lack of political commitment to addressing health care needs (Brazil, Russia, India and China), weak state-civil societal relationships (China, India and Russia), and foreign policy aspirations to become global leaders in health care financing (Russia and China). South Africa's government was the only one to recognize and respond to the need to improve access to medication and reduce OOP; this renewed government commitment mainly stemmed from years of political neglect, the transition to democracy, and dire health care needs. Nevertheless, South Africa's government still has much to do in addressing geographic differences in infrastructure and human resources.

The case of South Africa therefore suggests that increased and sustained government commitment to reducing health care inequalities was the most important factor accounting for differences between the BRICS. This suggests that more work needs to go into explaining why the BRICS are so different in the historical institutional, international and domestic conditions motivating politicians to effectively address health care inequalities, while exploring why strong state-civil societal partnerships (as seen in Brazil and South Africa) do not play as an important role.

Considering the BRICS' recent challenges in responding to health care inequalities, are any of these governments perhaps considering alternative, more innovative approaches to

health care delivery? And have they changed their interests and expectations? Unfortunately, this does not appear to be the case. While political leaders in recent years have been vocally committed to improving their health care delivery systems and accomplishing universal access to health insurance, there continues to be a general lack of financial and political commitment to achieving these outcomes. Worsening economic recessions, especially in Brazil and Russia, and heightened national security concerns, as seen in Russia, appear to be distracting political leaders from increasing their expectations, interest and commitment to achieving these outcomes.

This article nevertheless had several limitations, highlighting the need for future research. Considering that all of the BRICS have decentralized forms of health care, where the state and municipal governments play an important role in funding and implementing public health and health insurance programs, this study did not consider the roles that governors and mayors play in prioritizing health care spending for medication coverage, infrastructure and human resources. Given the proximity of sub-national politicians to voters, governors and mayors may have greater incentives to achieve these outcomes when compared to national politicians.

Finally, the ongoing challenge of out-of-pocket expenses among those enrolled in government health insurance programs in several of the BRICS suggests that more research needs to go into comparing the willingness of federal health agencies to regulate hospital reimbursement procedures. An issue that this article did not address is how national and sub-national governments are ensuring that hospitals fully reimburse individuals for medication expenses, thus complying with national health insurance policies and procedures. To achieve this, federal health officials could, for example, closely monitor the actions of municipal hospitals, either by periodically visiting hospitals and evaluating performance, or by requiring local health officials to periodically monitor them. As seen with Brazil's response to HIV/AIDS, federal officials could also contract NGOs or even the private sector to monitor and report any discrepancies in reimbursement procedures back to the national government (Gómez, 2015b). Understanding if this is indeed feasible, and if other nations have achieved these kinds of procedures, will require more research and analysis.

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