Regional Intergovernmental Organizations as Catalysts for Transnational Policy Diffusion: The Case of UNASUR Health

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Regional Intergovernmental Organisations as Catalysts for Transnational Policy Diffusion: The Case of UNASUR Health*

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Abstract

Why do member states of regional intergovernmental organisations (RIOs) voluntarily adapt their policies and institutions to norms and procedures implemented in other member states? I tackle this puzzle by investigating the domestic effects of health cooperation among South American states within the Union of South American Nations (UNASUR). The article shows how the establishment of a regional sector-based institution like the Health Council of UNASUR triggered the diffusion of similar policies by reducing transaction costs and increasing information exchanges among member states' health bureaucracies. I argue that RIOs such as UNASUR catalyse transnational diffusion not by enforcing binding regional norms (as in the case of the EU), but by bridging member states' shared functional needs and asymmetric capacities in specific policy areas. Through the case of UNASUR Health, the article contributes to the study of the logics of transnational diffusion *within* RIOs in the absence of authority delegation to supranational institutions.

Introduction

This article analyses the domestic effects of regional health cooperation among South American states in the framework of the Union of South American Nations (UNASUR)[1], addressing the following interrelated puzzles: (i) why do member states of regional intergovernmental organisations (RIOs) voluntarily adapt their policies and institutions to practices, norms, and procedures implemented in other member states? (ii) What is the role of regional institutions in this process? The article sheds light on the transnational policy diffusion effects triggered by the creation of the Health Council of UNASUR (hereafter UNASUR Health), investigating the causal mechanism behind member states' adoption of similar policies and institutional arrangements in the field of health. I argue that sector-based regional institutions like UNASUR Health catalyse transnational diffusion by enabling the interaction of member states' shared functional needs and asymmetric capacities in specific policy areas. They do that by reducing transaction costs and increasing information

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[1] UNASUR is a regional intergovernmental organisation that brings together all South American states in a process of multi-purpose cooperation structured into 12 sectoral ministerial councils. The councils deal with a wide range of policy areas, including defence, health, transport infrastructure, and electoral assistance. All the resolutions adopted by the sectoral councils must be approved by the political organs of UNASUR (first by the Council of Foreign Affairs Ministers and then by the Council of Heads of State), which are the organisation's only bodies endowed with decision-making authority.

exchanges among state experts and practitioners, which catalyses inter-bureaucratic learning processes that lead to diffusion. Transnational diffusion is conceptualised here as a horizontal process of voluntary internalisation of new policy instruments and institutional arrangements triggered by the establishment of regional institutions. As discussed in the next section, this process differs from the much more studied Europeanisation process inasmuch as no hierarchical (i.e. top-down) transfer of norms from the supranational level takes place. In the cases under analysis, transnational diffusion occurs among states following a non-hierarchical horizontal pattern that has non-uniform effects on member states.

Through the case of UNASUR Health, the article contributes to the study of transnational diffusion *within* RIOs, exploring how regional institutions that are not endowed with the authority to formulate and enforce binding norms can stimulate member states' voluntary convergence towards similar policies and institutional designs. Such an analysis belongs to the comparative regionalism literature (Acharya and Johnston, 2007; De Lombaerde et al., 2010; Börzel and Risse, 2016a; Closa and Casini, 2016; Fioramonti and Mattheis, 2016) inasmuch as it bridges the gap between mainstream political science and the study of regionalism as a global phenomenon. Comparative regionalism has advanced a great deal in the analysis of the reasons underlying the emergence and design of regional organisations across the globe (Lenz and Marks, 2016), yet it has struggled to grasp the effects of regional institutions, particularly those located outside Europe[2] (Börzel and Risse, 2016b). The article addresses this gap in the research agenda by providing a theory-guided and empirically rich analysis of the diffusion effects that took place within a RIO in South America. In doing so, this article aims to feed the dialogue between EU studies and comparative regionalism, whose potential for theory development can help us better understand the logics and effects of regionalism across different world regions (De Lombaerde et al., 2010; Söderbaum and Sbragia, 2010; Warleigh-Lack and Rosamond, 2010).

The article is organised as follows. The first section discusses why the diffusion processes under analysis differ from those addressed by the literature on transnational policy diffusion and the Europeanisation scholarship, introducing a theoretical framework that allows grasping how regional sector-based institutions catalyse diffusion effects by facilitating inter-bureaucratic learning. Part two discusses research design and methodological issues. The third section presents the findings of four cases of transnational diffusion stimulated by the creation of UNASUR Health. The fourth section provides a cross-case interpretation of the logics of policy diffusion within UNASUR Health. The conclusions summarise the article's contribution to the study of how regional institutions affect member states' domestic policies in the absence of authority delegation to supranational bodies.

1. Grasping the role of regional sector-based institutions as catalysts for transnational policy diffusion

Two bodies of literature have dealt with the diffusion of policies and institutions among states: the literature on transnational policy diffusion and the Europeanisation scholarship.

[2] Two notable exceptions are Pevehouse's work on the domestic impact of regional organisations on member states' democratic transition/consolidation (Pevhouse, 2002, 2005) and Börzel and van Hüllen's edited volume on governance transfer by regional organisations (Börzel and van Hüllen, 2015).

The former focuses on the identification of the mechanisms driving the adoption of policies displayed or promoted by other states and international organisations. The latter applies the insights on diffusion mechanisms to the case of the European Union (EU), analysing the effects of EU institutions on member states' domestic policies. Both literatures struggle to explain diffusion effects *within* RIOs like UNASUR, inasmuch as they fail to grasp how regional sector-based institutions can catalyse the diffusion of similar policies among member states despite not being endowed with the authority to formulate and enforce binding norms. To fill this gap, this article builds a theoretical framework that combines insights on policy learning from the diffusion literature with the scholarship on the transaction-costs-reducing and information-enhancing effects of international institutions. In doing so, the article connects two bodies of literature that help us better understand the interconnection between the domestic and the regional levels in the absence of authority delegation to supranational institutions.

1.1 Transnational policy diffusion and Europeanisation: identifying the gap

The literature on transnational policy diffusion investigates how are decisions in one nation-state influenced by practices, norms, and policies displayed or promoted by other states and international organisations (Simmons et al., 2006; Gilardi, 2012). Transnational policy diffusion is conceptualised as a process triggered by growing international interdependence that leads to the spread of specific policies across states and world regions through a variety of diffusion mechanisms. The emerging consensus is that diffusion mechanisms can be grouped into four categories: coercion, competition, learning, and emulation. Coercion refers to those situation in which international organizations and powerful countries pressure states to adopt a given policy, promoting top-down diffusion through positive (providing conditioned access to resources) and negative (sanctions) incentives. Competition means that actors influence one another in their policy decisions in the effort to attract or retain resources. Learning implies that other actors' experiences supply information on the likely consequences of a policy that decision-makers use to evaluate the benefits of a given reform. Emulation is the process whereby policies diffuse because of their normative appeal (Simmons et al., 2006; Gilardi, 2012).

This body of literature provides valuable analytical tools for identifying transnational diffusion mechanisms –both vertical (incentives) and horizontal (competition, learning, and emulation among states) ones– yet it says little about how international institutions affect policy diffusion *among* member states[3]. The literature acknowledges that the existence of international networks facilitates horizontal exchanges among actors, boosting diffusion through communication and information-sharing (Simmons and Elkins, 2004; Elkins, 2009). However, it falls short of addressing how the participation of state bureaucracies in formal international institutions triggers the activation of horizontal diffusion mechanisms that lead to policy and institutional convergence among member states.

The literature on Europeanisation sought to address this gap, providing key insights to

[3] The diffusion literature predominantly focuses on how centralised and independent international institutions (e.g. the International Monetary Fund and the EU) promote vertical *coercive* policy diffusion through conditionality requirements (Schimmelfenning and Sedelmeier, 2004; Simmons et al., 2006).

understand how policy diffusion works within regional institutions. Europeanisation scholars analysed the mechanisms through which the EU induces changes in the domestic policies of member states as well as of accession candidates. The focus was initially placed on vertical diffusion mechanisms such as legal imposition, positive and negative incentives (i.e. conditionality), and persuasion exerted by EU institutions (Featherstone and Radaelli, 2003; Schimmelfenning and Sedelmeier, 2005). The literature gradually addressed also indirect mechanisms like lesson-drawing and normative emulation, which explain member states' (and would-be member states') voluntary adaptation to EU norms, moving beyond legal hierarchy and conditionality (Börzel and Risse, 2012a; Moumoutzis and Zartaloudis, 2016). Europeanisation can thus be understood as a special case of transnational diffusion, which investigates why and how EU member states adapt their policies and institutions in response to EU rules and norms (Börzel and Risse, 2012b).

The Europeanisation literature provides a useful bridge between transnational diffusion and the study of regional institutions' effects. However, Europeanisation scholars place the focus on domestic changes caused by regional norms that are transferred from a supranational centre to member states' national level. Consequently, this literature cannot easily travel to parts of the world where regional institutions are not endowed with the authority to formulate norms and enforce member states' compliance with them. Differently from what happens in the EU, in the case of UNASUR there is no hierarchical diffusion of legally superior norms from the regional to the national level. Nevertheless, transnational diffusion effects have taken place among member states, which begs the questions of why and how does policy diffusion occur *within* RIOs like UNASUR[4].

I argue that regional institutions play a key role in the diffusion processes under investigation, yet their effects differ from those analysed by Europeanisation. In order to understand the logics of non-hierarchical diffusion within RIOs, we must incorporate insights on the transaction-costs reducing and information-enhancing effects of international institutions. These allow grasping how regional sector-based institutions like UNASUR Health bridge member states' shared functional needs and asymmetric capacities by intensifying information exchanges among state experts in a specific policy area, catalysing diffusion effects through inter-bureaucratic learning.

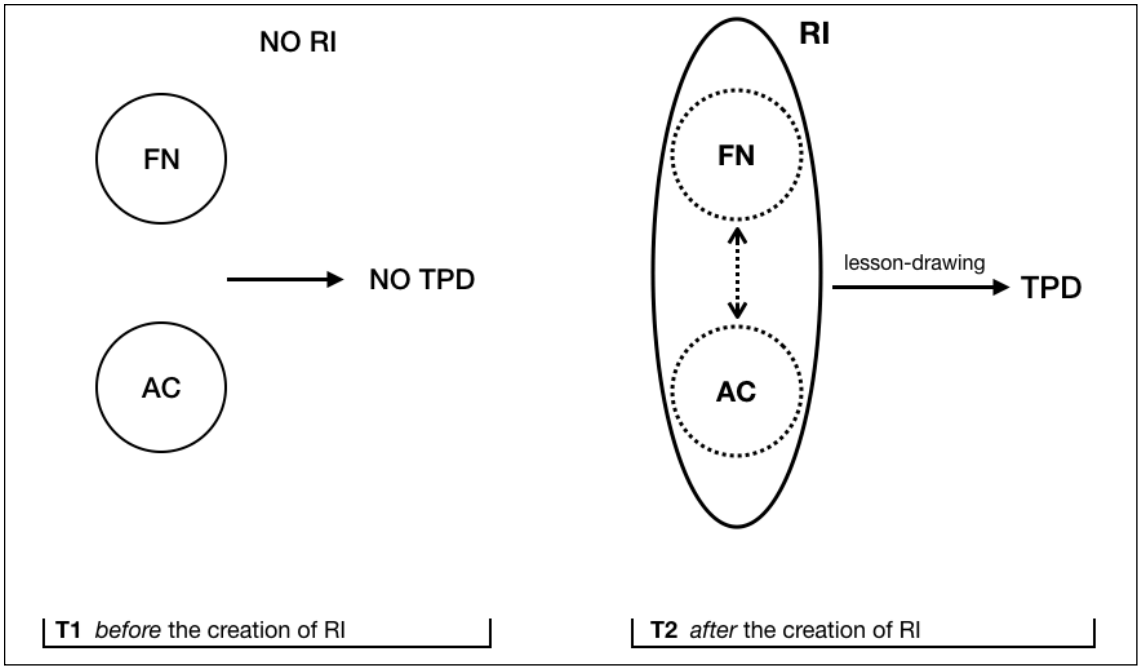
1.2 The theoretical framework

I argue that the transnational diffusion effects under analysis are the result of the interaction of the following causal factors: the (i) shared functional needs (FN) and (ii) asymmetric capacities (AC) of states in the public health sector, and (iii) regional sector-based institutions (RI). Firstly, states face similar challenges in the area of public health, which means that policy tools and institutional arrangements implemented in one state can provide effective solutions to domestic challenges in another state. Differently from sectors like trade and energy, where states can adopt alternative models, in the public health sector states move towards a shared set of best practices that are the result of scientific research. Secondly, states are endowed with asymmetric capacities in the field of public health. This implies that

[4] As pointed out by Risse (2016), we know little about transnational policy diffusion *within* regional organisations located outside Europe. Two exceptions are Acharya's work on ASEAN (Acharya, 2004) and Duina's work on NAFTA (Duina, 2015).

resourceful states can provide lessons and assistance to those states that lack adequate capacities. Differently from other sectors, the transfer of knowledge in the health sector has limited material and political costs for providers. High levels of interdependence among neighbouring states' health systems reduce the risk of competition and make interstate cooperation desirable because mutually beneficial for dealing with inherently transnational threats like epidemic outburst.

Figure 1: The theoretical framework



Source: Author's own elaboration

Transnational policy diffusion effects (TPD) are the result of the positive interplay of FN and AC, which is triggered by the creation of a regional sector-based institution. FN and AC were there before the creation of RI yet did not produce diffusion effects (T1 in Figure 1), being necessary but insufficient conditions for TPD. The core hypothesis of the causal mechanism is that the establishment of RI transforms the relationship between member states' FN and AC, leading to the emergence of a new conjunctural causal configuration that results in TPD (T2 in Figure 1). RI does that by reducing transaction costs and intensifying information exchanges among member states' sectoral bureaucracies (see Keohane, 1984; Abbott and Snidal, 1998; Martin and Simmons, 1998; Botcheva and Martin, 2001). The establishment of RI enables state officials with a common expertise in a specific area of public health to gather and exchange information with high frequency in technical settings insulated from direct political pressure, creating conditions conducive to inter-bureaucratic learning[5]. Within RI member states' health experts share policy-relevant knowledge about the

[5] Constructivist scholars (see Checkel, 1999, 2005) addressed the diffusion-boosting effects of technical international institutions by arguing that they facilitate "social learning" among experts: a diffusion mechanism whereby agents develop new interests and identities through frequent interactions within insulated technical settings. Whereas the theoretical framework developed here argues that the sector-based design of RI triggers a "simple" type of learning, whereby state experts acquire new information that alters their policy choices and strategies in a specific issue area.

needs and capacities of the respective health systems, which makes them aware of opportunities for drawing lessons from other member states' successful experiences that were not exploited in T1.

In doing so, RI acts as a bridge between member states' needs and capacities in a specific policy area, catalysing the voluntary internalisation of policy and institutional innovations through the horizontal diffusion mechanism of lesson-drawing: a goal-oriented type of learning driven by functional needs, whereby policy makers draw lessons from the experiences of others to improve the performance of their domestic policies (Rose, 1991; Dolowitz and Marsh, 2000). Differently from social learning, lesson-drawing does not imply a change in the basic interests and identities of actors, but rather the adoption of new policy instruments prompted by the informative value of particular experiences conducted by others (Meseguer, 2005). Likewise, differently from emulation, lesson-drawing is a purposive act driven by instrumental considerations regarding the functional value of a given policy rather than by the normative appeal of it (Gilardi, 2012).

2. Research design, methodology, and data

This article investigates a set of domestic changes introduced by South American states in the public health sector as a result of TPD effects triggered by UNASUR Health. I adopt a qualitative comparative research methodology that identifies the causal mechanism underlying TPD within UNASUR Health and provides empirical evidence for it through four case studies. Case selection responds to a strategy based on the analysis of a set of positive cases in which we observe TPD, which serves the heuristic purpose of identifying the causal pathway to the effects under investigation (Collier et al., 2004). Such a selection strategy is part of a 'before-after' research design, whereby single cases are divided into two sub-cases that are separated by change in one variable (George and Bennett, 2005, p. 166). In the cases presented in section three, the dividing factor is the establishment of UNASUR Health (RI), which activates a new causal configuration that leads to TPD (see Figure 1). The domestic changes analysed are the result of the voluntary adoption of policy instruments implemented by other member states. TPD follows a non-hierarchical horizontal pattern that is determined by the contingent interaction of member states' FN and AC, rather than by the top-down diffusion of regional norms from a legally superior supranational centre. As discussed in the next section, non-hierarchical TPD effects can either take place at the bilateral level or be the result of lesson-drawing from multiple sources.

As regards the generalisation scope allowed by case selection, this is circumscribed to UNASUR Health. Having said that, I argue that UNASUR Health is representative of a broader universe: regional sector-based cooperation within UNASUR. UNASUR Health shares key institutional design features with the other eleven sectoral councils of UNASUR. Consequently, the theoretical framework developed here could be used for investigating TPD effects in other sectoral councils. Likewise, the framework could be employed for tracing similar TPD effects *within* RIOs with similar sector-based institutional designs located in different world regions (e.g. the African Union).

The method chosen for guiding within-case analysis is process tracing: a technique that identifies the intervening causal process between an independent variable (or variables) and

the outcome of the dependent variable in a particular context (George and Bennett, 2005, p. 206; Bennett and Checkel, 2015, p. 7). Process tracing was based on different sources of empirical information. I conducted 18 semi-structured interviews with decision-makers and top-level bureaucrats from the health ministries and public health agencies of Argentina, Brazil, Chile, Colombia, Guyana, Peru, and Uruguay, as well as with officials from the South American Institute of Health Governance and the Andean Health Organisation (Annex I lists the interviews). Official documents issued by national, regional, and multilateral institutions, together with specialised media coverage and secondary literature, provided additional sources of empirical information, which served the purpose of testing the reliability of the evidence gathered from primary sources. The adoption of such a triangulation strategy increases the credibility of findings (Tansey, 2007).

3. Tracing TPD among South American states in the public health sector: analysis and results

Regional cooperation among South American states in the public health sector has a long history, which dates back to the early 20th century (Petersen and Schulz, 2018). This is the consequence of the transnational nature of health threats, which put in danger people's lives across national borders, creating high levels of interdependence among nation-states (Lee, 2003). Collective action started at the hemispheric level with the creation of the Pan-American Health Organisation (PAHO) in 1902, and further developed at the sub-regional level in the framework of the Common Market of the South and the Andean Community. Health cooperation at the broader South American level started in the early 2000s, when South American states promoted the convergence of pre-existing cooperation initiatives into a regional health agenda[6]. Yet, it was the leadership initiative of the Brazilian government of Lula da Silva that led to the creation of a South American health council in the framework of the newly established UNASUR in December 2008. The creation of UNASUR represented the final institutional outcome of Brazil's regional leadership project, which –since the early 2000s– had promoted the creation of an autonomous South American cooperation platform for governing the region through sector-based cooperation in areas like transport infrastructure and energy (Palestini and Agostinis, 2018). UNASUR Health was one of the first sectoral councils to be created within UNASUR as a result of the interplay of Brazil's leadership capacities in the health sector and member states' shared interest in deepening regional health cooperation[7]

Most of the literature on contemporary South American regionalism has disregarded the analysis of the domestic effects of UNASUR's regional institutions, privileging structuralist interpretations of the emergence of UNASUR as the outcome of a post-hegemonic wave of regionalism[8]. As regards the case of UNASUR Health, insightful research has been conducted on the council's capacity to provide a platform for coordinating regional health diplomacy at the multilateral level (Riggirozzi, 2015). However, little work has been done on

[6] Author's interview with Sebastián Tobar; author's interview with Oscar Feo.

[7] Author's interview with Celso Amorim; author's interview with José Gomes Temporão.

[8] UNASUR would embody a transition of South American regionalism from a trade-centred to a multi-purpose cooperation agenda aimed at providing regional public goods in non-trade areas while increasing member states' autonomy from the US-led neoliberal agenda (Riggirozzi and Tussie, 2012).

how the establishment of UNASUR Health affected member states' domestic policies and institutions.

3.1 The institutional design of UNASUR Health

UNASUR Health is a sector-based regional body headed by the health ministers of the 12 member states. Like the other sectoral councils of UNASUR, UNASUR Health is an intergovernmental institution governed through consensual decision-making, in which member states pursue collective action without delegating any executive, legislative, or enforcing authority to supranational bodies. As a consequence, UNASUR Health does not have agency capacities to directly promote domestic changes in member states' health policies. It is rather a platform for inter-state cooperation and knowledge exchange in the field of public health, whose decision-making is formally subordinated to the approval of the political bodies that govern UNASUR. The membership scope is the first institutional innovation introduced by UNASUR Health. For the first time, all South American states have been brought together under a unified institutional umbrella, which allows cooperative interactions among actors that had barely cooperated before due to the sub-regional segmentation of health cooperation. This is the case of Guyana, which found in UNASUR Health the possibility to articulate bilateral cooperation initiatives with Southern cone states like Argentina[9]. Likewise, the health authorities of Andean countries like Colombia and Peru used UNASUR Health for intensifying knowledge exchanges with Brazil in areas in which cooperation had been absent[10].

As regards the institutional design, the council of health ministers is the main decision-making body of UNASUR Health, while cooperation activities are coordinated by a rotating pro-tempore presidency that is in charge of the member state holding the pro-tempore presidency of UNASUR. However, the engines of UNASUR Health are the *technical groups* and the *structuring networks*. The former are integrated by experts from national health ministries in charge of cooperation in five areas prioritised by member states: epidemiological surveillance, universal health systems, universal access to medicines, social determinants of health, and human resources. The latter are regional networks of national health institutes. The structuring networks were a Brazilian initiative based on a proposal of FIOCRUZ[11]. The idea was that the creation of horizontal networks among specialised health institutions would stimulate exchanges of best practices and facilitate the emergence of a regional thinking within member states' health bureaucracies[12]. Six networks have been established so far: the Network of National Institutes of Health, the Network of Technical Health Schools, the Network of Public Health Schools, the Network of National Cancer Institutes, the Network on Disaster Risk Management, and the Network of Health Ministries' International Cooperation Offices. In 2011, member states further expanded

[9] Author's interview with Shamdeo Persaud; author's interview with Tomás Pippo.

[10] Author's interview with José Gomes Temporão; author's interview with Oscar Feo.

[11] The *Fundação Oswaldo Cruz* (FIOCRUZ) is a public agency of Brazil's health ministry that acts as a pharmaceutical laboratory, research hub, and training centre. FIOCRUZ developed the concept of 'structuring cooperation' in the 1990s, in opposition to north-south vertical cooperation promoted by the WHO and PAHO (author's interview with Henri Jouval).

[12] Author's interview with Felix Rosenberg.

UNASUR Health's institutional design by creating the South American Institute of Health Governance (ISAGS). ISAGS is an advisory body of the health council endowed with legal personality and headquartered in the city of Rio de Janeiro. The institute's objectives are to support domestic capacity-building, conduct policy-oriented research, and disseminate scientific information on regional and global health issues in support of inter-state cooperation. The creation of ISAGS was also an outcome of Brazil's regional leadership in the health sector[13].

I argue that the establishment of a regional sector-based institution with the characteristics of UNASUR Health (RI) carved out new spaces for cooperation among South American health authorities, activating the interplay of member states' FN and AC in areas in which cooperation had been weak or absent (see Figure 1). In particular, the establishment of the council's structuring networks facilitated the emergence of issue-specific constellations of state health experts and provided them with technical settings in which exchange knowledge through regularised interactions, which catalysed the TPD effects presented below. As discussed in section 4, the sector-based institutional design of UNASUR stimulated inter-bureaucratic learning processes that took place outside the scope of the organisation's intergovernmental hierarchy. In fact, the diffusion effects catalysed by UNASUR Health were the result of autonomous interactions of member states' health experts, which followed a non-hierarchical horizontal pattern that escaped from the control and validation of the political bodies of UNASUR.

3.2 Four cases of TPD among the member states of UNASUR Health

This section conducts a process tracing analysis of four cases of TPD catalysed by UNASUR Health. The case studies show how the creation of UNASUR Health's structuring networks bridged member states' functional needs and asymmetric capacities by facilitating the sharing of policy relevant knowledge and the articulation of bilateral cooperation initiatives among national health bureaucracies.

The cases of Colombia and Uruguay's cancer institutes within RINC-UNASUR

The Network of National Cancer Institutes (RINC) was created in July 2011 and brings together public and private cancer institutes selected by member states' health ministries. The network's objective is to promote the diffusion of best practices in the fight against cancer and the convergence towards a South American cancer control strategy. Before the creation of RINC, the cancer institutes of South American states participated in multilateral cooperation within the International Agency for Research on Cancer of the WHO. Yet, institutionalised cooperation at the bilateral and regional level was weak. The leading actor behind the creation of RINC was Brazil's National Cancer Institute (INCA), which exploited its capacities in the field of cancer control for launching a cooperation initiative that embodied Brazil's regional leadership in the health sector[14]. Brazil's proposal interacted

[13] The ISAGS proposal was developed by FIOCRUZ with the objective of generating a regional space for sharing knowledge, training officials, and establishing regional networks of health institutes (author's interview with José Gomes Temporão).

[14] Author's interview with José Gomes Temporão.

positively with the growing interest of the other member states in strengthening regional cooperation in the fight against cancer, which represents a shared challenge for South American health systems[15]. Member states established a set of operative groups within RINC dealing with uterine cancer, breast cancer, bio-banks, and cancer registries. Operative groups brought together specialists from member states' cancer institutes, creating opportunities for lesson-drawing in multiple areas of cancer control. Two cases are particularly representative of the TPD effects catalysed by RINC: those of Colombia and Uruguay's cancer institutes.

The case of Colombia's public bio-banking system

Bio-banks are a strategic tool in the fight against cancer. They allow recollecting samples of tissues, cells, and blood from patients where cancer is a possible diagnosis. Samples are stored to form bio-repositories to which researchers apply for clinical data that are used for identifying biomarkers of cancer and discovering new therapeutic agents. South American states' capacities in the bio-banking sector have traditionally been asymmetric: some states are endowed with resourceful public institutions (e.g., Brazil and Argentina), while others lack any bio-banking structure (e.g., Bolivia and Venezuela). Despite the existence of shared functional needs and asymmetric capacities, technical cooperation among South American states had been weak. The creation of RINC altered this pattern. The bio-bank group has been among the most dynamic of RINC's operative groups due to South American states' shared interest in promoting the standardisation of bio-bank systems through growing cooperation among national cancer institutes[16]. RINC stimulated the intensification of knowledge exchanges among member states, which catalysed learning processes that resulted in TPD. An emblematic case is that of Colombia's public bio-bank: *Banco Nacional de Tumores Terry Fox* (BNTTF).

Colombia's National Cancer Institute (NCI) launched BNTTF in October 2010. The decision was taken by domestic actors in response to the functional needs of Colombia's national cancer strategy, which sought to converge towards a networked system pivoted on a central public bio-bank capable of storing samples that can be accessed by national and international researchers. The establishment of RINC's bio-bank group had a tangible impact on the institutional development of BNTTF[17]. The participation of Colombian experts in the activities of the group provided them with the possibility to draw lessons from the experiences of other South American states in the running of public bio-banks. In particular, the exchanges of best practices prompted by the meetings organised in the framework of RINC enabled Colombian authorities to identify a strategic opportunity to strengthen their bio-banking system by increasing bilateral exchanges with Brazil's INCA, which runs the most advanced bio-bank in the region. Before the establishment of RINC, bilateral cooperation on bio-banking between Brazil and Colombia was absent. What RINC did was increasing information flows between the two cancer institutes, which triggered the interaction between the needs of Colombia's BNTTF and Brazil's capacity to provide

[15] South American states are experiencing an epidemiological transition due to development-related phenomena like urbanisation, pollution, growing domestic consumption, new food habits, and ageing of the population, which have increased the impact of cancer on the population (author's interview with Walter Zoss).

[16] Author's interview with Gustavo Stefanoff.

[17] Author's interview with Antonio Huertas Salgado; author's interview with Gustavo Stefanoff.

bilateral technical assistance. Colombian experts travelled to Brazil for receiving capacity-building on issues like samples recollection and storing, drawing lessons from the technical and administrative procedures adopted by INCA, which were internalised into Colombia's bio-banking system. This ultimately led to institutional convergence between Brazil and Colombia's bio-banks[18].

The case of Uruguay's national strategy against uterine cancer

The second case of TPD catalysed by RINC is that of Uruguay's National Cancer Institute (INCA). Before the creation of RINC, Uruguay's cancer programme was handled by officials from the ministry of health. The fact that the majority of South American states were represented within RINC by experts from the respective cancer institutes pushed Uruguay's health authorities to strengthen the role of INCA in regional cooperation. The domestic institutional change underlying INCA's growing role at the regional level represents a first TPD effect catalysed by RINC[19]. The participation of experts from INCA in the activities of the uterine cancer group stimulated also a policy change in Uruguay's domestic strategy against one of the deadliest types of cancer in the region[20]. Before RINC, the national prevention strategy of Uruguay was pivoted on the Papanicolao screening test, which permits the detection of precancerous lesions and cancers in early stages. Bilateral exchanges of best practices against uterine cancer between Uruguay and neighbouring states were limited by the lack of a regional space for health authorities to meet and pursue cooperative endeavours[21].

The establishment of RINC changed this scenario, intensifying the flow of information among member states' cancer institutes. In particular, the uterine cancer group gave Argentina and Peru[22] the opportunity to promote an innovative multilevel approach against uterine cancer based on preventive vaccination and the improvement of quality tests for Pap screenings. The experts of Uruguay's INCA drew lessons from the successful experiences of Argentina and Peru, internalising the policy tools introduced by the two member states into Uruguay's cancer control strategy. Uruguay currently counts on a vaccination plan against papillomavirus (the main vector of uterine cancer), as well as on stronger screening capacities, which were implemented as a result of the diffusion of best practices within RINC[23]. The creation of RINC exposed Uruguayan experts to innovations adopted by other member states, bridging Uruguay's functional need to increase the effectiveness of its fight against uterine cancer and the capacities of Argentina and Peru in that field. This exchange resulted in the reform of Uruguay's strategy against uterine cancer, which converged towards a set of best practices implemented in other member states.

[18] Author's interview with Antonio Huertas Salgado; author's interview with Gustavo Stefanoff.

[19] Author's interview with Álvaro Luongo.

[20] Uterine cancer is a major public health problem in Latin America, where it causes 28.000 deads every year (70 per cent of which are concentrated in South America) (Ferlay et al., 2012).

[21] Author's interview with Álvaro Luongo.

[22] Argentina and Peru have the highest cumulative incidence of uterine cancer in South America, whereas Chile, Brazil, and Uruguay have the lowest incidence and mortality rates (Murillo et al., 2016).

[23] Author's interview with Alvaro Luongo.

The case of Uruguay's Public Health School Programme within RESP-UNASUR

The Network of Public Health Schools (RESP) was created in April 2011 and is integrated by public institutions dealing with the training of health officials in member states. The main objective of RESP is to articulate a regional capacity-building platform aimed at strengthening the training capacities of South American states in the field of public health. Like RINC, the creation of RESP was a Brazilian initiative, which was coordinated by FIOCRUZ's National Public Health School Sergio Arouca (ENSP/FIOCRUZ). The proposal resulted particularly attractive to those member states that did not have a public health programme (e.g. Paraguay and Uruguay), which saw in RESP a strategic platform for building up their domestic capacity to train health officials[24].

Before RESP, the interactions between Uruguay's health authorities and experts from public health schools of other South American states were limited. RESP bridged this gap, creating opportunities for Uruguay's health experts to draw lessons from the experiences of those neighbouring states that had successfully established domestic institutions in charge of training health practitioners[25]. Drawing upon the technical and administrative support of FIOCRUZ and ISAGS, a constellation of domestic actors –composed of officials from Uruguay's health ministry and academics from the Universidad de la República– emerged for designing Uruguay's first public health school programme. FIOCRUZ and ISAGS provided inputs on the issues of public health services and universal health coverage[26], yet the implementation of the project was carried out by Uruguay's health ministry with the financial support of PAHO[27]. Uruguay's Public Health Programme was inaugurated in August 2013 with a training module devoted to health services and universal health coverage, which took place between August and October 2013. A second training module was held between June and July 2014. The two trainings provided participants with in-depth analysis of the strengths and weaknesses of Uruguay's health system in comparison with neighbouring states[28].

RESP acted as a catalyst for TDP by facilitating the interaction between Uruguay's health authorities and experts on public health education from other South American states and regional bodies like ISAGS and PAHO. This allowed Uruguay to address a functional need of its health system (i.e. developing a public health school programme) by drawing lessons from actors endowed with supply-side capacities in the field of health training and education[29]. The result was the inauguration of a public health school programme that Uruguay lacked before the creation of RESP.

The case of Peru's master programme on public health within RINS-UNASUR

[24] Author's interview with Gilberto Rios.

[25] Author's interview with Andrés Coitiño.

[26] Author's interview with Fernando Tomasina.

[27] http://www.msp.gub.uy/sites/default/files/archivos_adjuntos/Acuerdo%20MSP-OPS.PDF.

[28] http://www.msp.gub.uy/institucional/ministerio-de-salud-pública/escuela-de-gobierno-en-salud-pública.

[29] Author's interview with Andrés Coitiño.

The Network of National Health Institutes (RINS) was created in March 2010 for promoting regional cooperation on health research and services. The network was built upon a proposal of FIOCRUZ, which envisioned it as a regional space for stimulating the emergence of domestic institutions capable of dealing with health challenges in a way that combines the traditional epidemiological focus with a public health vision that includes social and environmental determinants of health[30]. One of the axes of collective action within RINS is the promotion of horizontal bilateral agreements among national health institutes aimed at strengthening member states' human resources in the public health sector[31].

In 2011, Peru's National Health Institute (INS) carried out an internal mapping to identify strengths and weaknesses of the Institute. The mapping showed that Peru's health practitioners had a solid bio-medical training focused on diagnosing, classifying, and treating diseases, yet they lacked public health training. The establishment of RINS intensified information exchanges among national health institutes, exposing Peruvian health authorities to the training experiences of other South American states. This made Peruvian authorities aware of a strategic opportunity to exploit FIOCRUZ's unparalleled resources in health training for addressing a functional need of Peru's health system: developing domestic capacity to provide public health training to health practitioners[32]. As a result of growing bilateral exchanges, INS and ENSP/FIOCRUZ signed a cooperation agreement that included the organisation of a master programme on public health. The agreement represented the first institutionalised cooperation initiative between INS and FIOCRUZ.

The master programme was organised by FIOCRUZ and hosted by INS in Lima. The targeted audience were health practitioners with at least four years of work experience in the public health sector. The programme was structured in 12 modules, which started in March 2012 and lasted two years, involving 36 experts from FIOCRUZ, who gave classes, organised workshops, and provided thesis supervision. The programme was built upon the master in public health taught at FIOCRUZ[33]. Funding was provided by both countries. Overall, 26 health practitioners attended the course, defending theses dealing with nutrition, transmissible and non-transmissible diseases, health services, and medicine production[34].

The master programme generated an intense exchange of knowledge between FIOCRUZ and Peru's health officials, providing a twofold opportunity: FIOCRUZ could disseminate Brazil's integral and universalist approach to public health, while Peru received capacity-building by one of the most advanced public health schools in the region[35]. The main effect of bilateral cooperation was a change in the health training policy of Peru's INS, which moved from a purely bio-medical focus to an integral approach that includes public health concerns[36]. Such a domestic change was a TPD effect catalysed by RINS, which connected

[30] Author's interview with Felix Rosenberg.

[31] Author's interview with Felix Rosenberg.

[32] Author's interview with Maricela Curisinche; author's interview with Dora Blitchetin.

[33] http://www.ensp.fiocruz.br/portal-ensp/informe/site/materia/detalhe/35334.

[34] http://portal.fiocruz.br/pt-br/content/fiocruz-forma-mestres-em-saude-publica-no-peru.

[35] Author's interview with Felix Rosemberg.

[36] Author's interview with Dora Blitchetin; author interview with Claudia Ugarte.

Peru's functional needs with Brazil's supply-side capacities by providing a space for lesson-drawing and policy transfer in a specific policy area.

4. Interpreting TPD effects among UNASUR member states in the health sector

This section provides a cross-case analysis of the effects of UNASUR Health, shedding light on the causal mechanism underlying TPD in the public health sector. The article presented four cases in which the creation of a regional sector-based institution with the characteristics of UNASUR Health catalysed the voluntary internalisation of policies and institutional designs implemented in other member states. By carving out spaces for state health experts to interact and exchange information with high frequency, UNASUR Health (RI) provided a bridge between member states' functional needs (FN) and asymmetric capacities (AC) in multiple dimensions of public health, catalysing learning processes that resulted in TPD effects among South American health systems (see Figure 1).

Empirical evidence shows that the creation of the council's structuring networks intensified knowledge exchanges in specific policy areas, enabling less resourceful member states to draw lessons from the experiences of other member states in dealing with shared public health challenges. This happened in the cases of the reform of Uruguay's uterine cancer strategy and the launching of Uruguay's public health school programme. The existence of regional networks of experts in the fields of cancer control and health education gave Uruguay's authorities the possibility to learn from policy and institutional solutions adopted by neighbouring states, which were incorporated into the Uruguayan health system for strengthening its capacity to train health official and tackle the spread of uterine cancer. In two cases, lesson-drawing was supported by technical assistance provided by a resourceful member state. This happened in the cases of Colombia's bio-banking system and Peru's master programme in public health. In both cases, TPD followed a bilateral pattern whereby growing interactions prompted by the establishment of UNASUR Health allowed the health authorities of Colombia and Peru to intensify knowledge transfer with a member state endowed with higher capacities in the health sector like Brazil. The overall outcome of TPD was policy and institutional convergence among member states' health systems, which voluntarily adopted similar policies and institutional designs for dealing with shared public health challenges.

Differently from what happens in the case of the EU, the domestic changes experienced by UNASUR member states were not caused by top-down diffusion of regional norms promoted by a hierarchically superior supranational jurisdiction. They were the effects of horizontal processes of diffusion among member states' health bureaucracies triggered by the establishment of a regional sector-based institution. No vertical diffusion mechanisms (e.g. legal coercion or conditionality) were at play within UNASUR Health, which instead catalysed horizontal inter-bureaucratic learning that unfolded following a non-uniform pattern determined by issue-specific interplays of member states' FN and AC. The non-hierarchical nature of diffusion within UNASUR distinguishes it from the Europeanisation process and is the result of the organisation's intergovernmental institutional design, where member states do not delegate to supranational bodies the authority to formulate and enforce common norms and policies. Having said that, it is interesting to notice how non-hierarchical TPD within UNASUR Health was not the product of political mandates

emanating from the decision-making bodies that govern UNASUR (i.e. the Council of Heads of State and the Council of Foreign Affairs Ministers), but rather the outcome of inter-bureaucratic learning that took place autonomously at the sectoral level. In other words, transnational diffusion happened outside the main political avenues of regional decision-making and free from the shadow of the organisation's intergovernmental hierarchy (see Héritier and Lehmkul, 2008; Börzel, 2010). In contrast to the intergovernmental – interpresidential more specifically– logic that has traditionally characterised South American regionalism (Malamud, 2005), the case of UNASUR Health shows how autonomous inter-bureaucratic learning stimulated by sector-based institutions can drive regional governance processes in South America.

Conclusions

This article shed light on the logics of policy diffusion among UNASUR member states in the field of public health, combining insights from the literature on transnational policy diffusion and the scholarship on the effects of international institutions. The article identified a set of TPD effects catalysed by the creation of UNASUR Health, showing how the council's sector-based institutional design reduced transaction costs and intensified information exchanges among member states' health bureaucracies, providing a functional bridge between the shared needs and asymmetric capacities of South American health systems. UNASUR Health generated new opportunities for state experts and practitioners from national health ministries and agencies to draw lessons from the positive experiences of other member states, which –in some cases– actively supported policy diffusion through bilateral technical assistance.

The domestic changes analysed in this article are vivid examples of how RIOs can affect member states' domestic policy decisions even in the absence of authority delegation to supranational bodies. The establishment of a sector-based institution like UNASUR Health catalysed TPD effects that pushed member states to converge towards similar policies and institutions in the field of public health. Differently from the Europeanisation process, where hierarchically superior EU norms are transferred (directly and indirectly) to member states' domestic level (Börzel and Risse, 2012a), TPD within UNASUR Health followed a horizontal pattern based on the voluntary internalisation of policies implemented in other member states for dealing with specific health challenges. The TPD effects stimulated by UNASUR Health made South American public health systems more similar and potentially compatible. In the medium-term, this might facilitate deeper forms of regional coordination among member states in the health sector, as well as stimulate the gradual emergence of a shared model of public health governance in South America. Through the case of UNASUR Health, this article sought to uncover a regionalisation dynamic that has been overlooked so far by the comparative regionalism literature: *non-hierarchical* policy diffusion catalysed by regional sector-based institutions. In doing so, the article aimed to bridge the gap between the diffusion research agenda of EU studies and comparative regionalism's effort to explore the effects of regionalism across different world regions (Börzel and Risse, 2016b). I posit that the theoretical framework developed here could be fruitfully applied to RIOs located in different world regions for deepening our understanding of regional institutions' effects in contexts marked by limited delegation of authority to supranational bodies and low levels of

sovereignty and resource pooling among member states. We may realise that similar non-hierarchical TPD effects have been taking place within RIOs in Sub-Saharan Africa, Southeast Asia, and even in Europe.

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Annex I – List of Interviews*

Last Name	Name	Position	Country	Date of Interview	Place of Interview
Amorim	Celso	Minister of Foreign Affairs (2003-2010)	Brazil	7 April 2015	Rio de Janeiro
Blitchetin	Dora	Director of the Research and Technology Department of Instituto Nacional de Salud de Perú	Peru	5 May 2017	Lima
Coitiño	Andrés	Former National Coordinator at UNASUR Health	Uruguay	25 March 2015	Montevideo
Curisinche	Maricela	Technical Coordinator at Research and Technology Department of the Instituto Nacional de Salud	Peru	5 May 2017	Lima
Feo	Oscar	Executive Secretary of ORAS-CONHU (2006-2010)	Venezuela	14 June 2015	Skype
Gomes Temporão	José	Minister of Health (2007-2011) and Director of ISAGS (2011-2016)	Brazil	2 April 2015	Rio de Janeiro
Huertas Salgado	Antonio	Scientific Director, Banco Nacional de Tumores Terry Fox, Instituto Nacional de Cáncer	Colombia	28 March 2017	Bogotá
Jouval	Henri	Former Technical Coordinator of ISAGS	Brazil	30 March 2015	Rio de Janeiro
Luongo	Álvaro	Director of the National Cancer Institute	Uruguay	5 April 2017	Skype
Persaud	Shamdeo	Chief Medical Officer, Ministry of Public Health	Guyana	28 March 2015	Georgetown
Pippo	Tomás	Former Director of the Health Economy Department, Ministry of Health	Argentina	27 March 2015	Buenos Aires
Rios	Gilberto	Director of the International Relations Department, Ministry of Health	Uruguay	25 March 2015	Montevideo
Rosenberg	Felix	Former Technical Coordinator of RINS/UNASUR	Argentina	10 April 2015	Petropolis
Tobar	Sebastián	Former Director of the International Relations Department of Argentina's Ministry of Health	Argentina	17 March 2015	Buenos Aires
Stefanoff	Gustavo	Coordinator of the Bio-banks Operative Group of RINC/UNASUR	Brazil	7 April 2017	Skype
Tomasina	Fernando	Dean of the Health School of the Universidad de la República de Montevideo	Uruguay	24 March 2017	Skype
Ugarte	Claudia	Director of the Human Resources Department of the Ministry of Health	Peru	22 November 2017	Skype
Zoss	Walter	Executive Manager of RINC/UNASUR	Brazil	31 March 2015	Rio de Janeiro

* I applied positional criteria to sample interviewees. Non-probabilistic sampling is the most appropriate approach to elite interviewing in the context of a process tracing study since it includes the most important players that have participated in the events under investigation (Tansey, 2007). This sampling method allows collecting first-hand information from a complete set of relevant actors, which generates empirical evidence that is used for identifying the causal mechanism underlying the transnational policy diffusion effects analysed in the article.