THE PROSPECT FOR HEALTH CARE RIGHTS IN CHINA

by

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ABSTRACT

The 2009 reform of China’s health care system attempts to lower the burden of medical costs and provide universal access to health care. This thesis focuses on a particular access and equity gap within the health care system that faced by internal migrants, and explores the potential value of a legally enforceable and justiciable right to health care in the Chinese context to address such gaps. Despite recent advances in the health care reform, lack of a framework of health care rights could be a limiting factor to current health care initiatives which are falling short of their promises of universality in some way. In the long run, establishment of such framework could be a direction that deserves further research.
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Chapter 1

Introduction

As a party of the International Covenant on Economic, Social and Cultural Rights ("ICESCR"), China has committed itself to ensure equal access to health services, especially for the vulnerable or the marginalized.\footnote{UN Committee on Economic, Social and Cultural Rights, \textit{General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12)}, E/C.12/2000/4 (2000) at para.43 [\textit{General Comment No. 14}].} While China has ratified the ICESCR, it would only have legal force in China when it is domesticated.\footnote{Li’an Xia, “The Justiciability of Economic and Social Rights: From the Perspective of the Right to Health” (2008) 2 Law and Social Development 76, at 84 [translated by author].} Unfortunately, it is generally accepted that no right to health or health care exists under China’s Constitution. The establishment of a legal mechanism regarding the right to health care is still in progress, and the legal framework to address health inequity problems remains limited in scope.

The Chinese health care system has been subjected to various attempts at reform over the past three decades. The most recent attempt, passed by the State Council in 2009, is the new Health Care Reform Plan ("the new Plan"), which aims at lowering the burden of medical costs and providing universal access to health care. According to recent figures published by the Ministry of Health, about 1.295 billion rural and urban residents (95% of China’s total...
population) have joined the health care schemes.\(^3\) These figures represent a dramatic improvement compared to 44.8% urban residents and 79.4% rural residents that were uninsured before the new Plan.\(^4\) Therefore, the new Plan marks the first time in modern history that reforms have led to the majority of China’s population being covered by health care schemes.

Despite these successes, there remain issues with respect to providing accessible and equitable health care to marginalized and vulnerable groups in China. In particular, the health status of internal migrants, who comprise about 154.5 million people or about 10% of China’s total population,\(^5\) is particularly poor. More than 60% of internal migrants are concentrated in jobs with very low monthly salaries, such as within the construction and manufacturing industries.\(^6\) Due to their low incomes, most internal migrants cannot afford private health care insurance.

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\(^5\) Kam Wing Chan, “China, Internal Migration” in Immanuel Ness & Peter Bellwood, eds., The Encyclopedia of Global Migration (Blackwell Publishing) [Forthcoming].

Besides China, many developing countries also face health inequity problems. Some of these countries have established health rights and resulting jurisprudence, which represents both the desire of governments and courts’ attempts to respond to these systemic inequities in health care. In particular, a trend of enforcing a constitutional right to health or health care has emerged in developing countries (e.g., Brazil, Columbia, India and South Africa) to address such equity concerns. Brazil and Columbia have each experienced an increasing number of lawsuits based on the right to health since 1990s. The increase in enforcing constitutional health rights has also impacted some resource-constrained countries, such as India and South Africa. A fairly sizable number of studies have investigated the phenomenon of health rights jurisprudence in these countries, which would lay the groundwork and provide reference for the discussion of the prospect for health care rights in China. Inspired by health rights jurisprudence in other developing countries, I will explore whether we would expect to see improvement from the perspective of internal migrants’ access to health care if there was a justiciable framework of health care rights. In other words, I will examine the potential role of a legally enforceable and justiciable right to health care in the Chinese context.

The thesis consists of five chapters in addition to this introduction and a conclusion. Chapter two describes the emerging trend of enforcing a constitutional right to health or health care
in developing countries. Chapter three provides an introduction to China’s institutional and legal context so as to better understand the possibilities and impediments to the use of health care rights as a means to address existing access and equity gaps within the current health care system. Chapter four focuses on a particular access and equity gap in China’s current health care system that faced by internal migrants. In chapter five, I propose a hypothetical framework of health care rights in the Chinese context. This framework will include a discussion of the justification for a right to health care, access to justice, standards of judicial review and other issues. In order to further explore the potential value of establishing a framework of health care rights in China, in chapter six, I will conduct a hypothetical test of the internal migrant case. Through this comparative analysis, it will be argued that, despite China’s recent advances in health care reform, China has not fully met its international obligation, and that the lack of a legally enforceable and justiciable right to health care could be a limiting factor to current health care initiatives which are falling short of their promises of universality in some way.
Chapter 2

The Benefits of A Constitutional Right to Health Care

Human rights have become increasingly important in the area of health care. The legal foundation for health care rights has both international and national dimensions. Not only international legal instruments (e.g., the Universal Declaration of Human Rights, the ICESCR) but also regional and national legal documents (e.g., the European Social Charter, the African Charter on Human and People’s Rights) make reference to the right to health care. A review conducted in 2002 of 187 countries found that 165 countries had written constitutions and of these, 73 countries’ constitutions made reference to a right to health care, and 29 countries’ constitutions prescribed free health care for at least some population subgroups.

One can also see an emerging trend of enforcing a constitutional right to health care in developing countries to meet equity concerns. Brazil and Columbia have each experienced an increasing number of lawsuits based on the right to health since 1990s.

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8 Ibid.
In Brazil, before the adoption of the 1988 Constitution, the government had no explicit constitutional obligation to carry out health actions or provide universal health care services. A majority of Brazilians had to depend on private providers through out-of-pocket payment or through limited insurance schemes for the employed. Consequently, poor people or the unemployed had little or no access to health care services. In general, adoption of the 1988 Constitution not only indicates a legal milestone in the country’s democratic transition, but also signifies the movement towards institutionalizing human rights. According to article 5, “the rights and guarantees expressed in this Constitution do not exclude others deriving from … the international treaties in which … Brazil is a party.”

With respect to the right to health, article 196 of the Constitution stipulates that “health is the right of everyone and a duty of the State; it is to be guaranteed as far as possible…by universal and equal access to treatment and services for its promotion, protection and recovery.” Indeed, social rights, such as health rights, are fundamental rights and are justiciable in the Brazilian context.

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10 Ibid.
11 Ibid.
14 Piovesan, supra note 12 at 183.
15 Ibid.
Columbia also faces serious social inequalities, including within the health field. In 1991, this country adopted a progressive Constitution, and a Constitutional Court was established. According to article 93 of the new Constitution, international human rights treaties ratified by Columbia take precedence over domestic law. The main legal mechanism to protect constitutional rights is called a *tutela* (protection writ), which is a vital instrument to ensure respect for human rights. The Constitution does not explicitly use the term “right to health,” but this expression has been adopted by the Constitutional Court and scholars to refer to the content of article 49, which states

> “Public health … are public services for which the state is responsible. All individuals are guaranteed access to services that promote, protect, and rehabilitate public health.

It is the responsibility of the state to organize, direct, and regulate the delivery of health services … to the population in accordance with the principles of efficiency, universality, and cooperation, and to establish policies for the provision of health services by private entities and to exercise supervision and control over them. In the area of public health, the state will establish the jurisdiction of the nation, territorial entities, and individuals, and determine the shares of their responsibilities within the

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limits and under the conditions determined by law. Public health services will be organized in a decentralized manner, in accordance with levels of responsibility and with the participation of the community.

The law will determine the limits within which basic care for all the people will be free of charge and mandatory…”

The increase in enforcing constitutional health rights has also impacted some resource-constrained countries, such as India and South Africa. These two countries face deep and systemic health inequity problems. Although India does not have a specific constitutional right to health, the Supreme Court has recognized the right to health as an integral component of the right to life. In South Africa, a critical objective of the 1996 Constitution is to facilitate the transformation of South African society from the apartheid system to a constitutional democracy. The entrenchment of socio-economic rights could provide constitutional support for redistributive state measures to ensure equal access to social services. Article 27 of the South African Constitution explicitly recognizes the right to access health care:

21 Ibid. at 77.
“Health care, food, water and social security:

(1) Everyone has the right to have access to-

(a) health care services, including reproductive health care;

(b) sufficient food and water; and

(c) social security, including, if they are unable to support themselves and their dependants, appropriate social assistance.

(2) The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realization of each of these rights.

(3) No one may be refused emergency medical treatment.”

It should be noted that “progressive realization” is also part of the South African Constitution. Even though there is an explicit constitutional right to access health care, this right is subject to the clause that allows for the fact of limited resources on the part of the state. In other words, the right to access health care is not free-standing, and it has to be calibrated against existing resources.

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Taken together, some developing countries have included in their written constitutions health care rights to respond to equity problems or access gaps. The establishment of health rights and resulting jurisprudence represents both the desire of governments and courts’ attempts to respond to these systemic inequities in health care. In order to facilitate the deployment of a rights-based approach in the area of health care to address equity and access gaps in the Chinese context, inclusion of a constitutional right to health care could be a starting place.
Chapter 3

Institutional and Legal Context

In order to understand the possibilities and impediments to the use of health care rights as a means to address existing access and equity gaps within the Chinese health care system, one has to first understand something about the specific legal regime that exists within China. China follows the civil law tradition, and as such a court decision normally does not stand as a precedent for subsequent decisions. Since the People’s Republic of China was founded in 1949, there have been four separate constitutions promulgated in 1954, 1975, 1978 and 1982. The 1982 Constitution, which has been revised four times so far, contains four chapters: General Principles, the Fundamental Rights and Duties of Citizens, the Structure of the State and the National Flag/the National Anthem/the National Emblem/the Capital. Article 2 of this Constitution declares that China is a socialist state where all power belongs to the people.23

Under the constitutional governance framework, which is modeled on the Soviet system, the National People's Congress (NPC) and the local People's Congresses are the organs

through which the people exercise state power.24 The NPC, as the highest organ of state power, has power “to amend the Constitution” and “to supervise the enforcement of the Constitution.”25 The Standing Committee of the National People's Congress, the working body of NCP, is empowered “to interpret the Constitution and supervise its enforcement.”26 If interpretation of questions concerns specific application of laws and decrees in court trials, such interpretation shall be provided by the Supreme People's Court.27 The Supreme People's Court is the highest judicial organ, which “is responsible to the National People's Congress and its Standing Committee,” and local people's courts are responsible to local People’s Congresses.28

China’s judicial system consists of the Supreme People's Court, the local people's courts, military courts and other special people's courts. Unlike many other countries where the majority of court members are not selected and cannot be removed by the people or their representatives directly,29 in China, the President of the Supreme People's Court is elected and can be removed by the National People's Congress.30 The Vice-presidents, members of

24 Ibid.
25 Ibid. article 57&62.
26 Ibid. article 67.
28 Constitution of China, supra note 23 article 127&128.
the judicial committee, chief judges and associate chief judges of divisions and judges at the Supreme People’s Court “shall be appointed or removed by the Standing Committee of the National People's Congress upon recommendation of the President of the Supreme People's Court.”

Similarly, the Presidents of the local people's courts “shall be elected or removed by the local People's Congresses.” As for other court members, they “shall be appointed or removed by the Standing Committees of the People's Congresses at the corresponding levels upon recommendation of the Presidents of those courts.”

Thus one can see that the notion of separation of powers, which is fundamental in common law systems, is not present in China.

As a legal document, China's Constitution has often been viewed as a political document which “serves as a vehicle for the enunciation of the government’s current political philosophy.” As a matter of fact, neither the Constitution nor the other domestic laws prescribe how to enforce the Constitution through the court system. In practice, the Constitution is normally regarded as non-justiciable, which makes the concept of

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31 Ibid.
32 Ibid.
33 Ibid.
35 Ibid. at 217.
enforcement of health care rights very difficult. Indeed, even if one finds a health care right, one then has to face the question of enforcement.

Apart from the question of enforcement, with respect to the issue of the existence of a “right” to health care, it is generally accepted that no such right exists under China’s Constitution. Nevertheless, as I will discuss further below, there are general provisions (e.g., article 21, 42 & 45) that concern the development of medical and health services by the state to protect people’s health, enhancement of occupational safety and health and development of social insurance. These general provisions could be used – if courts were empowered to interpret them – to ground a right to health care:

“Article 21: The state develops medical and health services, promotes modern medicine and traditional Chinese medicine, encourages and supports the setting up of various medical and health facilities …for the protection of the people's health.

Article 42: …the state creates conditions for employment, enhances occupational safety and health, improves working conditions …

Article 45: Citizens … have the right to material assistance from the state and society

when they are ... ill or disabled. The state develops social insurance, social relief and medical and health services that are required for citizens to enjoy this right.”

Notably, through the fourth Amendment to the Constitution which was passed at the Second Session of the Tenth National People's Congress in 2004, a vital article – article 33(3) – was added into the Constitution. This article declares that “the state respects and protects human rights.” The inclusion of a human rights article in the Constitution is likely to have an important impact on the constitutional system of fundamental rights. This article also has the potential of broadening and enriching the content of fundamental rights enshrined in Chapter 2 of the Constitution.\(^{38}\) In general, the current constitutional system identifies a right to vote and stand for election,\(^{39}\) right to criticize and make suggestions to any state organ,\(^{40}\) right to make to relevant state organs complaints and charges against violation of law or dereliction of duty by any state organ,\(^{41}\) right to work,\(^{42}\) right to rest for working people,\(^{43}\) right to material assistance,\(^{44}\) right to receive education,\(^{45}\) and right to equality\(^{46}\) if the word “right” is used. In addition, freedom of speech/ the press/ assembly/ association/ procession/
demonstration, freedom of religious belief, freedom of person, freedom of correspondence, freedom to engage in scientific research, literacy and artistic creation and other cultural pursuits, and freedom of marriage are also enumerated in Chapter 2 of the Constitution.

There are still debates with respect to whether article 33(3) should be construed similarly to the Ninth Amendment of the United States Constitution which prescribes that “the enumeration in the Constitution, of certain rights, shall not be construed to deny or disparage others retained by the people.” In order to highlight the value of human rights and preserve the openness of the current fundamental rights system in the Chinese context, certain rights (e.g., right to life, right to health) are supposed to be deduced from this article. In my opinion, article 33(3) has the potential of being interpreted as an inclusive clause that contains the connotation of health care rights due to its vague wording.

Apart from the Constitution, health care rights could be grounded in other domestic laws, but

47 Ibid. article 35.
48 Ibid. article 36.
49 Ibid. article 37.
50 Ibid. article 40.
51 Ibid. article 47.
52 Ibid. article 49.
53 Han, supra note 38 at 4.
54 The Constitution of the United States of America, 1787, amendment IX, online: Legal Information Institute <http://www.law.cornell.edu/constitution/>.
55 Han, supra note 38 at 4; Libin Xie, “Protection of the Right to Freedom” (2011) 1 Journal of Comparative Law 35, at 37 [translated by author].
it does not seem that other Chinese laws (e.g., the General Principles of Civil Law, the Criminal Law, the Tort Law and related judicial interpretation) provide a basis for a right to health care as they mainly focus on personal injury, medical negligence/malpractice, and production and sale of fake medicine.

As discussed above, the relatively settled practice of non-justiciability of constitutional provisions within China would be a major barrier to enforce health care rights. However, in the past few decades, the conventional idea of the Constitution “as static and unchanging” has been challenged by some scholars, lawyers, activists and judges.\textsuperscript{56} For instance, a prominent legal scholar from Beijing University, Wang Lei, explicitly proposed that the Constitution, as a source of law, should be invoked by courts in adjudicating certain cases.\textsuperscript{57} It is worth noting that even those who advocate acknowledging the ability of courts to draw on the constitutional rights provision do not question the overall structure of the state, and believe the court should only adjudicate rights-related disputes in certain context without usurping the constitutional authority of the National People's Congress.\textsuperscript{58} In practice, there have been some important cases in different areas that indicate the attempts to invoke constitutional rights as a legal basis to file claims to the courts. In the following, I will discuss two vital cases that contain important constitutional implications. The Qi Yuling case

\textsuperscript{56} Kellogg, \textit{supra} note 34 at 218.


\textsuperscript{58} \textit{Ibid.} at 212-213; Kellogg, \textit{supra} note 34 at 222.
represents a milestone in China’s legal construction when the notion of the justiciability of the Constitution was tested.

3.1 The Qi Yuling Case

Qi Yuling (the plaintiff) and Chen Xiaoqi (the defendant) took the same Entrance Examination of Institutions for Higher Education in 1990. Chen failed the exam, and Qi passed. After learning this result, Chen’s father colluded with some local officials to arrange for his daughter Chen to continue higher education by taking Qi’s place through assuming Qi’s name. On the other hand, Qi was notified that she failed the exam. Eventually, Chen received and finished higher education in the college and worked at a local bank after graduation, while Qi lived in poverty as a peasant. After about eight years, Qi discovered the truth. Later, Qi launched a legal action against Chen, Chen’s father and related local authorities for infringing Qi’s right of name and right to receive education. Shandong Higher People’s Court (the provincial court) heard the case on appeal. Since the claim concerned the constitutional right to receive education under article 46 of the Constitution, this provincial court sought guidance from the Supreme People’s Court before giving a judgment.

The written reply from the Supreme People’s Court was simple, which stated that

“defendants Chen et al. infringed Qi’s constitutional right to receive education by means of

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violating her right of name and caused concrete damages. Therefore, defendants shall bear corresponding civil responsibilities.” After receiving this reply, the provincial court continued to hear this case and eventually ruled that “defendants Chen et al.…infringed Qi’s right of name and her constitutional right to receive education per se.” This judicial interpretation has aroused heated debates since this is the first time that the Supreme People’s Court admitted the direct reference to a constitutional right as the legal basis and that a local court adjudicated a case on the basis of a constitutional right.

Chinese scholars often regarded this case as “the first light” and an important first step towards achieving the justiciability of the Constitution. Nevertheless, many scholars do not endorse the idea that the Constitution could be invoked without any restrictions. Instead, the justiciability of the Constitution should be achieved under certain circumstances, such as exhausting appropriate reliefs as a prerequisite.

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61 Unfortunately, this judicial interpretation was abolished in 2008 through the Decision of the Supreme People’s Court on Abolishing Relevant Judicial Interpretations (the Seventh Batch) Promulgated before the end of 2007. As for the reason of abolishment, this Decision only stated that this judicial interpretation “has stopped applying.”

62 Luhua Zhao, “Judicial Independence under China’s Contemporary Constitutional System” (2011) 8 Legal System and Society 139, at 139 [translated by author].

3.2 The Zhang Xianzhu Case

In 2003, Zhang Xianzhu, a university graduate, took the civil service exam offered by the Wuhu City Personnel Bureau in Anhui province. Zhang passed both the written and the oral examinations with the highest grade among 30 applicants, and he entered the process of physical examination conducted by the People’s Liberation Army No.86 Hospital. Through this physical examination, it was discovered that he was a carrier of hepatitis B. Due to his hepatitis B status, he was denied a position in the local bureaucracy for which he applied. In November 2003, Zhang filed a claim to Xinwu District People’s Court in Wuhu City against the local Personnel Bureau after his attempt to apply for administrative reconsideration failed.

In this case, Zhang’s lawyer Zhou Wei was an influential constitutional lawyer and professor. Zhou’s involvement in this case was very important for drawing much attention from the media, and the attention that his participation garnered also contributed to promoting a response from the government. A key issue in this case raised by Zhou was the use of the Physical Examination Regulation for National Civil Service of Anhui Province, which listed various circumstances/test results that could lead to ineligibility of an individual from holding a position in public/government services.

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64 Kellogg, supra note 34 at 237.
Zhou’s first constitutional argument was that the Physical Examination Regulation for National Civil Service of Anhui Province violated Zhang’s right to equality under article 33 of the Constitution.65 Specifically, he argued that excluding a group of people on the basis of hepatitis B status under this provincial Physical Examination Regulation fell short of “rationality, appropriateness and necessity,” and such exclusion was also irrelevant to “national, public and social interests.”66 Therefore, this provincial regulation violated the constitutional principle of equality before the law.67 This argument is crucial in that it attempts to render article 33 justiciable through proposing a rational-basis test by which the governmental regulation could be scrutinized.68

Zhou also argued that the Physical Examination Regulation did not have legal basis.69 Zhang was performing his political right to participate in state affairs by entering the civil service exam. According to article 2 (3) of the Constitution, “the people administer state affairs and manage economic, cultural and social affairs … in accordance with the law.”70 Article 8 (5) of the Legislation Law also prescribes that matters concerning deprivation of an

65 Article 33 of the Constitution of China:
“…All citizens of the People's Republic of China are equal before the law.

67 Ibid., at 338.
68 Kellogg, supra note 34 at 240.
69 Zhou, supra note 66 at 338.
70 Constitution of China, supra note 23 article 2 (3).
individual’s political rights have to and only can be legislated by law.\textsuperscript{71} The provincial Physical Examination Regulation was an administrative regulation which fell outside the category of law, so it undercut the authority of the National People’s Congress to legislate on matters pertaining to individuals’ political rights. Further, this Regulation also infringed Zhang’s constitutional right to work under article 42 of the Constitution and his personal dignity protected under article 38 of the Constitution.\textsuperscript{72}

In 2004, the court issued its adjudication which did not rule on the constitutional arguments raised by Zhou. Instead, the court ruled that the conclusion reached by the People’s Liberation Army No.86 Hospital that Zhang failed the medical examination did not adhere to the Physical Examination Regulation.\textsuperscript{73} Hence, the local Personnel Bureau’s decision to remove Zhang from the recruitment process lacked factual basis, and this decision should be revoked.\textsuperscript{74} Nevertheless, it is worth noting that the court did mention in its decision that the plaintiff and his lawyers had claimed that “the Physical Examination Regulation infringed the plaintiff’s constitutional right to equality, political right to participate in public services, right to privacy and right to work.”\textsuperscript{75} The court’s approach was regarded as “appropriate,” and the court’s note of the plaintiff’s constitutional rights claims “could be interpreted as a

\textsuperscript{71} Legislation Law of the People’s Republic of China, 2000, article 8 (5).
\textsuperscript{72} Zhou, supra note 66 at 338-339.
\textsuperscript{73} Zhang Xianzhu v. Personnel Bureau of Wuhu City, [2003].
\textsuperscript{74} Ibid.
\textsuperscript{75} Ibid.
tacit embrace of the idea that constitutional rights should be justiciable.”\textsuperscript{76}

This was the first hepatitis B discrimination case ever brought to the Chinese court. Although the court did not rely on the constitutional claims to rule, this case, to some extent, is regarded as “one of China’s first successful constitutional litigation cases.”\textsuperscript{77} Following this case, a series of hepatitis B discrimination claims against various defendants (e.g., public university, governmental department, private sector) were filed.\textsuperscript{78} Although many of these cases ended up being withdrawn, being dismissed or losing in courts, these legal actions often brought positive results, such as changes of legislation or reconsideration of administrative decisions.\textsuperscript{79} Particularly, new National Standards of Medical Examinations for Civil Servants (Pilot Scheme) was issued in 2005, which explicitly prescribed that “… For carriers of hepatitis B, as long as they have been tested to eliminate the possibility of active hepatitis, they meet the required standard in the medical examination.”\textsuperscript{80}

Overall, the cases discussed above imply the persistent efforts of lawyers, activists and scholars to advocate the justiciability of the Constitution. No matter how the results of these

\textsuperscript{76} Kellogg, \textit{supra} note 34 at 241.
\textsuperscript{77} \textit{Ibid.} at 242.
\textsuperscript{78} Jinrong Huang, “A Burgeoning Legal Movement: Comments on the Practice of Public Interest Law in China”, \textit{China’s Institute of Law}, online: Iolaw.org.cn < http://www.iolaw.org.cn/showArticle.asp?id=1891>.\textsuperscript{79} \textit{Ibid.}
\textsuperscript{80} Ministry of Personnel & Ministry of Health, \textit{National Standards of Medical Examinations for Civil Servants(Pilot Scheme)}, 2005.
cases in courts turned out, they contain important constitutional implications.

At this point, I would like to shift the attention to health care. No one can deny the significance of access to health care, especially access to primary and preventive health care services. Besides the constitutional right to receive education, the connotation of right to health care also has obvious relevance to the right to subsistence which is accepted as the first moral entitlement in China’s human rights discourse. However, people may still think that it is not practical to include a constitutional health care right in China. As discussed above, some developing countries have tried to deploy the leverage of health care rights to address health inequity.

Considering the emerging phenomenon of invoking a constitutional right in litigation, I put forward an assumption that China’s Constitution is justiciable so as to better examine the feasibility of a hypothetical framework of health care rights in the Chinese context. In other words, if China had an enforceable right to health care in its Constitution, would this improve equity/access for a vulnerable population like internal migrants? If so, then perhaps that is a direction that deserves further research, even if it will be a long way to go.

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Chapter 4

A Case Study: Internal Migrants

4.1 Status Quo of Internal Migrants

As the urbanization process increases, an increasing number of rural-to-urban migrant workers look for job opportunities in cities. In China, this group is referred to as internal migrants, the majority of whom are unskilled or low-skilled workers. A recent figure shows that there are about 154.5 million internal migrants, which accounts for about 10% of China’s total population.82

Internal migrants often face health risks as a result of their employment, living conditions and mobile status.83 Their jobs are low-paid and often involve high risks of occupational injury and illness.84 According to figures published by the National Bureau of Statistics, more than 60% of internal migrants are concentrated in jobs with very low monthly salaries, such as within the construction and manufacturing industries.85 Due to their low incomes, most internal migrants cannot afford private health care insurances. In the past few years,

82 Chan, supra note 5.
84 Supra note 6.
85 Ibid.
more women and families have migrated and eventually settled down in cities.\textsuperscript{86}

According to the new Health Care Reform Plan, China’s health coverage programs include:

(1) Urban Resident Basic Medical Insurance; (2) Urban Employee Basic Medical Insurance;
(3) New Rural Cooperative Medical Scheme; and (4) Medical Assistance. Among these programs, the Urban Employee Basic Medical Insurance (UEBMI) and the New Rural Cooperative Medical Scheme (NRCMS) are closely connected with internal migrants. In addition, the Migrant Workers Catastrophic Medical Insurance (MWCMI), as a supplementary insurance program, is also presumably available for internal migrants. However, under the new Plan, the central government only requires that those migrants who have signed labor contracts and established stable labor relationship with urban employers should be covered by the UEBMI.\textsuperscript{87} As for other migrant workers, the new Plan equivocally mentions that they could be covered by rural or urban insurance and no specific plans have been provided for to cover their health care needs.

4.2 Access and Equity Gaps in China’s Current Health Care System

As a result of China’s household registration system which is also known as the Hukou


system, there is an institutional separation between rural and urban health care systems.\(^88\)

The Hukou system requires that people in different places of residence register with their local authorities. Urban residents have urban household registration, while rural residents have rural household registration. Generally speaking, it is very difficult to change one’s rural registration into urban registration. From an administrative management perspective, the existence of the household registration system, to some extent, contributes to administrative convenience. At present, this system mainly works as an entitlement distribution mechanism.\(^89\) Many urban benefits, such as health resources, are only available for urban residents.\(^90\) This bifurcated system was based on the assumption that people did not move between rural and urban areas.\(^91\) Consequently, internal migrants’ in-between status leaves them without access to health care in cities.\(^92\) In a word, the cause of inequity in health care largely rests with the Hukou system which is still far from dead despite the advent of the universal health insurance plan.\(^93\)

On the other hand, it should be noted that the average time spent by internal “migrants” in cities is: about 40% of them stay in a city for 1 to 4 years, and about 36% of them stay for

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\(^88\) Xiang, *supra* note 83.
\(^89\) Chan, *supra* note 5.
\(^90\) *Ibid*.
\(^92\) *Ibid*.
more than 5 years in a city.\textsuperscript{94} During this period of stay, they make contribution to economic development of their host cities as those registered urban residents do. Unfortunately, when it comes to the allocation of health resources, local governments seem less willing to expand health resources to this group.\textsuperscript{95}

For urban residents who are not qualified for the UEBMI, they can join the Urban Resident Basic Medical Insurance (URBMI) instead. However, for internal migrants, if they cannot join the urban employee insurance in cities, the urban resident insurance is also unavailable for them because they don’t hold urban Hukou/household registration. Internal migrants’ children are often left without health care insurance in cities. That is to say, even if internal migrants and their families live in cities, they cannot enjoy the same level of health care benefits as urban residents to a varying degree.

Besides the access gap, three health coverage programs (UEBMI, URBMI and MWCMI) that are presumably available for internal migrants also indicate equity gaps. In the following, I will discuss these programs in detail, and highlight the access and equity gaps in health care faced by internal migrants.

\textsuperscript{95} Ibid.
4.2.1 Urban Employee Basic Medical Insurance

Following the State Council’s decision, the UEBMI was put in place in 1998. Employer participation is supposed to be mandatory. The minimum premium contribution is set at 8% of total wages, shared between employers and employees at 6% and 2% respectively. Due to different local conditions, benefit packages may vary between cities, but both inpatient and outpatient services are covered. In general, this insurance covers most of outpatient services, not just the catastrophic ones. The purpose of establishing this insurance is to provide basic medical insurance for all formally employed urban employees. Compared with the rural medical scheme which will be discussed later, the urban employee insurance provides better benefits (e.g., higher reimbursement rate). [Table 1]

By and large, migrants employed by registered enterprises can be covered by this medical scheme. Unfortunately, many of them work in informal sectors or small private businesses. These sectors or private businesses are often reluctant to sign labor contracts or pay insurance fees for migrant workers. Under this circumstance, if migrants still want to enjoy medical insurance, a more feasible way is probably to join the New Rural Cooperative

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97 Ibid.
Medical Scheme.

4.2.2 New Rural Cooperative Medical Scheme

In 2002, the Central Committee of the Communist Party of China and the State Council released a “Decision on Further Strengthening Rural Health Work.” Following this decision, the NRCMS was established in 2003. This new scheme is a voluntary program for rural residents, which operates at the county level and focuses on inpatient services and catastrophic outpatient services. That is, regular outpatient services are not covered. Local governments are free to choose the benefit package, and administrative arrangements of this scheme are based on local conditions as long as such arrangements follow two policy guidelines: voluntary enrollment and coverage of catastrophic illnesses. Although premiums are paid by each household (one household is considered as an enrolment unit), they are heavily subsidized by governments. According to recent figures published by the Ministry of Health, about 836 million rural residents had joined this medical scheme and the enrollment rate of total rural residents was about 96% until 2010. In theory, this medical scheme can cover all internal migrants.

In 2012, Director-General of the Ministry of Health Yang Qing declared that reimbursement rates for inpatient spending will be increased to 75% within county level. Following the Ministry of Health’s guideline, local governments adopt corresponding plans to improve reimbursement rates for inpatient spending.

It is hard to obtain an accurate average reimbursement rate nationwide. In general, reimbursement rates are much lower if the medical expenditure is spent in a hospital outside the county. However, the majority of internal migrants look for job opportunities outside their counties. They mainly concentrate in big cities (e.g., Beijing, Shenzhen and Shanghai) where healthcare cost is often much higher than that in the rural areas. For those migrants who suffer from catastrophic illnesses, even if they have joined the rural medical scheme, it is still difficult for them to afford medical services in health facilities of their destination cities because of the low reimbursement levels of the NRCMS. [Table 2]

Besides the low reimbursement rates, another problem is the procedure of reimbursement. Since this medical scheme is managed at county level, migrant workers need to physically return to their counties to obtain part of the reimbursement. Some provinces have moved towards immediate reimbursement if migrants receive medical services in designated

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103 “Pilot Project to Realize Inter-provincial Immediate Reimbursement in Health Care” Sohu (28 February 2012), online: Sohu < http://health.sohu.com/20120228/n336097793.shtml >.
medical institutions within the provinces. However, for those migrants who move across provinces, such as moving from inlands to coastal areas, they still need to travel back and forth, which would be costly and time-consuming.

This rural medical scheme, on one hand, can be used as a back-up for those internal migrants who cannot join the Urban Employee Basic Medical Insurance and provides an alternative for them to go back to rural areas to receive medical treatment when they suffer from catastrophic illnesses. On the other hand, the existence of two health care regimes (rural and urban) *per se* indicates systemic inequity between rural and urban residents. In particular, the burden of the access and equity gaps in health care brought on by this traditional bifurcated system is a heavy one for internal migrants.

### 4.2.3 Migrant Workers Catastrophic Medical Insurance

In 2006, the State Council issued a document entitled, “Several Opinions on Resolving the Problem of Migrant Workers,” which called for further efforts to ensure equal access to public services for migrants and required different cities to establish their own Catastrophic Medical Insurance for migrant workers. In response to the State Council’s initiative, the Ministry of Labor and Social Security later issued a document indicating plans for this initiative. Unfortunately, the content of both documents is vague and they both fail to

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Ibid.
provide practical guidance to local governments and thus in practice, establishment of this medical insurance falls entirely into local authorities.\textsuperscript{105} Due to uneven regional development in China, the actual implementation shows great disparities between different cities.\textsuperscript{106}

In general, the premium contribution is set at 2\% of total wages, which is paid by employers. The deductible is higher than that of urban employee insurance, and the reimbursement rate is lower. Since the government policy does not provide practical guidance to initiate this insurance as mentioned above, it is up to enterprises themselves to decide whether to join this insurance or not. Because employer participation is voluntary, many enterprises have not joined this insurance scheme.\textsuperscript{107} This year, Chongqing Municipality revoked this insurance and incorporated it into the Urban Employee Medical Insurance. Compared with previous two insurance schemes, this one may simply work as a supplementary choice.

\textsuperscript{105} Wu Hu, “Migrant Workers Catastrophic Medical Insurance Study” (2008) 3 Study and Practice 130, at 135.
\textsuperscript{106} Ibid. at 134.
\textsuperscript{107} Ibid. at 131.
Chapter 5

A Hypothetical Framework of Health Care Rights

5.1 Justification for A Right to Health Care

5.1.1 Content of A Right to Health Care

In order to address the indeterminacy problem and realize the justiciability of the right to health care, it is necessary to define the content of this right. First of all, there is a distinction between the right to health and the right to health care. “The highest attainable standard of physical and mental health” articulated in article 12(1) of the ICESCR is not limited to the right to health care. In other words, the right to health is an inclusive right which includes “timely and appropriate health care.” In addition, health care can be regarded as an instrument to maintain health. In China, health care is often regarded as equivalent to medical care. So, we can understand the right to health care as a right to particular medical services in the Chinese context, and thus requiring the government to ensure equal access to these services. The emphasis is placed on equality of access, especially equal access to “primary and preventive health care benefiting a far larger part of the population.”

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108 General Comment No. 14, supra note 1 at para.4.
109 Ibid. at para.11.
111 General Comment No. 14, supra note 1 at para.19.
5.1.2 Feasibility of A Right to Health Care

In this section, I will analyze the feasibility of creating a right to health care from moral, political and legal perspectives.

5.1.2.1 Moral and Political Implications

Health care is a vital instrument for the exercise of other fundamental human rights.\(^{112}\)

Without such a vital instrument, it would be hard to achieve one’s social value. Following Rawls’ principle of redress, in order to achieve equality of all individuals and equality of opportunities, society should give greater attention to the less gifted and less privileged.\(^{113}\)

Those less gifted and less privileged have already been left behind at the beginning.

Therefore, when it comes to the allocation of health resources, especially primary and preventive health resources, access to these resources should be guaranteed to those most in need. Without the guarantee of equal access to health care, it would be unrealistic to realize genuine equality in society.

In the Chinese context, the right to subsistence has been established as the foremost human right.\(^{114}\) This right indicates that everyone has the right to maintain a basic normal life with

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\(^{112}\) Ibid. at para.1.


necessary material conditions. The right to subsistence not only contains the connotation of the right to life, but also implies the right to social security. Arguably, health care, especially “essential primary health care,” should form part of the social security program. Hence, the government has an obligation to ensure the satisfaction of these health care services.

The notion of creating a right to health care is also consistent with the ideology of constructing a “Harmonious Society,” a concept promoted by the Chinese government for about a decade, which reflects that the focus of governmental policy has transformed from economic growth to social justice and harmony. Particularly, an essential way to achieve the goal of Harmonious Society is to redistribute social resources so as to fulfill subsistence needs of every social member. Actually, the ideology underlying the vision of Harmonious Society is, to some extent, consistent with Rawls’ principle of redress. Taken together, the creation of a right to health care has both moral and political grounds in China.

116 Ibid.
117 General Comment No. 14, supra note 1 at para.43.
118 Ibid.
5.1.2.2 Legal Implications

As discussed above, an increasing number of countries, especially developing countries, have attempted to employ the leverage of a constitutional right to health care to close equity and access gaps in health care.

At the international level, a series of international legal instruments, such as the Universal Declaration of Human Rights\(^{120}\) and the ICESCR\(^{121}\), provide grounds for the right to health care. China has ratified both treaties. In terms of the legal force of international human rights treaties in China, unlike Columbia, such treaties would only have force if and when domesticated by specific adoption into domestic laws.\(^{122}\) Unfortunately, the establishment of a legal mechanism regarding the right to health care is still in progress, and a legal framework to address health inequity problems remains limited in scope.

Having said this, although it could be difficult to obtain authority over health policy without an explicit legal right, the fact that China is a party of the ICESCR may be “a sufficient basis to ground judicial authority.”\(^{123}\) Indeed, according to article 2 (1) of the ICESCR, China is obligated to take steps to realize the rights that are recognized in the Covenant, “including

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\(^{122}\) Xia, supra note 2 at 84.

particularly the adoption of legislative measures.”124 Therefore, recognizing the right to health care through legislation (e.g., constitutional amendment) would contribute to the fulfillment of China’s international obligation.

5.2 Access to Justice and Other Issues

As a reminder to the reader, I am assuming for the purpose of discussing that the barrier of non-justiciability of constitutional rights could be overcome (a big assumption admittedly). Apart from this issue of non-justiciability, another significant barrier to realization of health care rights concerns access to justice. Can internal migrants (and other poor and vulnerable groups) who often cannot afford health care get into a courtroom to make a claim? In some countries, health claims are mainly brought by NGOs, human rights groups or other organizations on behalf of the poor. In some other countries, cases are overwhelmingly brought by individuals seeking specific remedies to address their own health concerns.125

In the following, I will use Columbia and South Africa as examples to analyze concerns about access to justice and other issues if health rights litigation was realized in China.

The health rights jurisprudence in Columbia is among the most progressive in the world.126

Through a legal mechanism called tutela (protection writ), any Colombian citizen can launch

124 ICESCR, supra note 121.
125 Siri Gloppen, “Litigating Health Rights: Framing the Analysis” in Yamin & Gloppen, supra note 9, 17 at 31.
a legal action when their constitutional rights are violated. This unfettered access has greatly spurred the health rights litigation brought by individuals. Tutela was established in the 1991 Constitution as an action to provide immediate protection of one’s fundamental constitutional rights, when one fears any of these “may be violated by the action or omission of any public authority.” The process of a tutela action is fast. Once a tutela has been filed, the judge must rule on it within 10 days.

Compared with other suits (e.g., popular actions and class actions), a tutela action is much more widely used in the health area. According to figures published by the Human Rights Ombuds Office, 674,612 tutelas concerning health rights were submitted from 1999 to 2008. On one hand, the use of tutelas enhances individuals’ access to justice, and tutelas provide a relatively efficient legal mechanism to hear and resolve individual health claims. Due to the dysfunctional health system, the availability of tutelas to some extent works as a vital “escape valve” to address individuals’ health concerns. On the other hand, tutelas are granted on a first-come, first-served and case-by-case basis. The better-off with greater access to justice would benefit more from tutelas than the worse-off. Simply relying on the use of tutelas may be insufficient to benefit a larger part of the society, as almost

128 The Constitution of Columbia, supra note 18 article 86.
129 Ibid.
130 Yamin, Parra-Vera & Gianella, supra note 126 at 108.
131 Ibid. at 113.
132 Ibid. at 114.
two-thirds of the population lives below the poverty line. The widespread use of tutelas may also have the potential of abusing limited judicial resources, and the effect of individual remedies could be limited to address systemic problems.

As a matter of fact, the limitation of using tutelas was confirmed through a landmark case T-760/08, which represents a turning point of the health rights jurisprudence in Columbia. In this judgment, the Court declared that it was necessary to adopt a structural approach to the health system’s failings because “the organs of government responsible for . . . the regulation of the health system have not adopted decisions that guarantee the right to health without having to seek recourse through the tutela.”

In general, before the landmark case T-760/08, health rights jurisprudence in Columbia covered three circumstances: (1) “when not providing care to the ill person would threaten his/her right to life”; (2) “when the case involved a person or group of people in especially vulnerable circumstances” (e.g., the disabled, children and the elderly); and (3) when the case concerned “the right to receive the health care defined in the national

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133 Judgment T-760/2008, Colombian Constitutional Court, cited in Yamin, Parra-Vera & Gianella, ibid. at 117.
insurance scheme (POS)."\textsuperscript{136} After T-760/08, the court differentiated two dimensions of the health rights jurisprudence: immediately enforceable or subject to progressive realization. Simply speaking, the benefits or services contained within the POS\textsuperscript{137} were enforceable immediately.\textsuperscript{138} As for progressive realization, the state can delay implementing a specific obligation for the fact of limited resources.\textsuperscript{139}

Unlike Columbia where health rights litigation is often brought by individuals to a \textit{tutela}, in South Africa, public interest litigation is much more popular.\textsuperscript{140} This litigation on health rights has been facilitated by a generous standing provision and in theory, direct access to the Constitutional Court is possible.\textsuperscript{141} According to section 167(6) of the Constitution, a person is allowed to bring a matter directly to the Constitutional Court if the matter is in the interests of justice and with leave of the court.\textsuperscript{142} But in practice, most constitutional cases reach the Constitutional Court only on appeal as the constitutional jurisdiction has been expanded to the High Court.\textsuperscript{143} The high cost of litigation and the professional knowledge

\begin{itemize}
  \item \textsuperscript{136} \textit{Judgment T-261/2007}, Colombian Constitutional Court, \textit{ibid.}
  \item \textsuperscript{137} Under a national insurance scheme (POS), there is a two-tier system of benefits: (1) the contributory regime (POS-C) for those formally employed or earning more than twice the minimum wage; (2) the subsidized regime (POS-S). \textit{See} Yamin, Parra-Vera & Gianella, \textit{supra} note 126 at 109.
  \item \textsuperscript{138} Yamin & Parra-Vera, \textit{supra} note 134 at 442.
  \item \textsuperscript{139} \textit{Ibid.}
  \item \textsuperscript{140} Carole Cooper, “Health Rights Litigation: Cautious Constitutionalism” in Yamin & Gloppen, \textit{supra} note 9, 190 at 193.
  \item \textsuperscript{141} \textit{Ibid.} at 193-194.
  \item \textsuperscript{142} \textit{Constitution of South Africa, supra} note 22.
  \item \textsuperscript{143} Cooper, \textit{supra} note 140 at 193.
\end{itemize}
needed to file a claim also hinders individuals to bring cases to the court.\textsuperscript{144} Indeed, the reason why the popularity of health rights litigation in South Africa has not increased as sharply as that in Columbia is probably due to the expense and difficulty in accessing the justice system and lack of a mechanism equivalent to a \textit{tutela}.\textsuperscript{145}

Generally speaking, health rights cases fall into three categories in South Africa: (1) challenges to health policies or laws that hinder access to health care; (2) challenges to practices that are detrimental to health needs of the poor and the vulnerable; and (3) challenges to the government’s failure to implement health policies or laws which undermine health rights.\textsuperscript{146}

Would situating an unfettered or generous standing provision in the Chinese context contribute to improving equity/access to health care for a vulnerable population like internal migrants?

The first concern rests with the cost of litigation in China. After all, despite an unfettered/generous standing provision, if the cost of litigation was too high, the vulnerable would still have difficulty bringing a lawsuit to the court. According to article 107 of the

\textsuperscript{144} \textit{Ibid.}
\textsuperscript{145} \textit{Ibid.} at 194.
\textsuperscript{146} \textit{Ibid.}
Civil Procedure Law of China, parties who have difficulty paying litigation expenses can petition the court to postpone, reduce or wave the payment.\textsuperscript{147} Actually, quite a few cities have adopted related regulations to reduce or remove litigation fees for internal migrants when their cases concern delayed payment of salaries by employers.\textsuperscript{148} There are also an emerging number of NGOs in China that often represent the poor or the marginalized to bring lawsuits before the courts. Hence, the cost of litigation may not be a significant barrier to filing a claim to the court.

Besides concern about the cost of litigation, another potential barrier may be the technical knowledge that required for filing a claim. If a tutela-like protection writ was introduced in China, it would eliminate the requirement of professional knowledge. The knowledge required to make a Columbian tutela petition is basic, since the tutela petition only needs to include the basic facts that are necessary for the judge to address the case, and there is also no formal written process.\textsuperscript{149} Furthermore, the procedure to invoke a tutela is simple. An individual may file a complaint to any judge that has jurisdiction over the dispute.\textsuperscript{150}

On the positive side, a constitutional mechanism like the tutelas is an effective way to enhance access to justice and empower the vulnerable with legal instrument. In the case of

\textsuperscript{148} It is a relatively frequent phenomenon in some areas that employers delay or don’t pay salaries to internal migrants.
\textsuperscript{149} Delaney, supra note 127 at 54.
\textsuperscript{150} Ibid.
lacking access to health care or facing inequity in health care services, instead of solely relying on responses from political branches, *tutelas* offer alternatives to address health care concerns. On the negative side, the convenient access to *tutelas* may send a wrong message to the public that leads to dependency on judicial remedies rather than focusing more on the reform and improvement of the health care system itself. It is also hard to envision the potential litigation wave that may occur with the introduction of *tutelas* in the Chinese context. Indeed, a wave of litigation through *tutelas* may cause significant resource pressures on the health care system and it may be difficult for the system to cope.

Unlike Columbia, China has a larger population and broader territory. Although China’s current health care system contains equity and access gaps, there is no denying the fact that the majority of the population has been covered by various health care schemes through the adoption of the new Health Care Reform Plan since 2009. According to recent figures published by the Ministry of Health, about 1.295 billion rural and urban residents (95% of China’s total population) have joined the health care schemes.\(^{151}\) Compared with previous health care reforms, the new Plan marks the first time in modern history that reforms have led to the majority of China’s population being covered by health care schemes. Without designing a more feasible and appropriate alternative health care system, seeking improvements and thus enhancing equity in health care for a vulnerable population like

\(^{151}\) Wen, *supra* note 3.
internal migrants within the current health care schemes is probably the way to go. Claiming a complete revocation of the current system is not idealistic in the short run. Under this social context, it may be necessary to define the categories of health claims that are enforceable so as to strike a balance between judicial intervention and rational priority setting by political branches.

Determining the categories of cases that are enforceable can be achieved through legislative or judicial interpretation. In China, the Standing Committee of the National People's Congress has power to interpret the Constitution and other laws.¹⁵² The Supreme People’s Court supervises the administration of justice by the local People’s Courts and by the special People’s Courts.¹⁵³ One main duty of the Supreme People’s Court is to draft and adopt judicial interpretation which has legal force and provides very vital guidance on judicial activities.

Drawing experience from Columbia, health rights jurisprudence could be divided into two dimensions: immediately enforceable or subject to progressive realization. Benefits or services contained within the medical insurance schemes are supposed to be enforceable immediately. The right to health care also could be enforceable immediately when the case involves a person or group of people in especially vulnerable circumstances (e.g., internal

¹⁵² Constitution of China, supra note 23 article 67.
¹⁵³ Ibid. article 127.
migrants) and their health care status would threaten their rights to subsistence.

Defining these two circumstances as enforceable immediately has some potential advantages. Firstly, the court does not create new entitlements or propose content for existing medical insurance schemes. Instead, it follows what has been prescribed in prior insurance schemes and only prompts the political branches to actually enforce the benefits enunciated in the schemes. Hence, concerns about overdue judicial intervention in political branches’ health plans and rational priority setting could be eliminated. Secondly, enjoyment of health care (especially primary health care), as a vital aspect of ensuring the right to subsistence, has moral and political implications in the Chinese context as abovementioned. Therefore, the court judgment that calls for immediate enforcement of the right to health care contributes to protecting individuals’ right to subsistence.

If a case concerns a challenge to health policies or laws, a dialogic approach could be adopted to promote progressive realization. In China, the legislative process is often organized in a way that excludes the participation of internal migrants.154 Internal migrants did not have representation in the National People’s Congress until 2008, despite the large number of this group. Therefore, they might not be consulted and thus be excluded from

discussion in public affairs, even though they are directly affected by the norm at stake.\textsuperscript{155} Currently, there are only three members representing internal migrants in the National People’s Congress which has about 3000 representatives. It is said that representation for internal migrants will be increased in the 12\textsuperscript{th} National People’s Congress in 2013.\textsuperscript{156} In fact, no matter whether the percentage of representation will be increased or not, what is worth emphasizing is the idea of bringing voices into the public forum or creating opportunities for open discussion.

Shifting attention to two developing countries, when it comes to the enforcement of health rights, judges in South Africa might properly intervene simply with the purpose of ensuring respect for the deliberative process.\textsuperscript{157} In Argentina, the court may call a public meeting so as to promote a public discussion concerning appropriate solution to a rights violation.\textsuperscript{158} Adopting a dialogic approach can restrain the court’s role in enforcing positive rights and thus eliminate the concern that judges are not well equipped to scrutinize resource allocation decisions or interfere with budgetary issues. Case studies of various countries also indicate that the courts are much more engaged and effective when they “act in dialogue with

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\textsuperscript{155} Ibid.  \\
\textsuperscript{156} Representation will Increase in the 12\textsuperscript{th} Session of the National People’s Congress, Xinhuanet (8 March 2012) online: Xinhuanet < http://news.xinhuanet.com/politics/2012lh/2012-03/08/c_111624335.htm>.  \\
\textsuperscript{157} Gargarella, supra note 29 at 238.  \\
\textsuperscript{158} Ibid. at 242-243. 
\end{flushleft}
political, bureaucratic, and civil society actors.” As for how to employ such dialogic approach in the Chinese context, it is better to leave it to the courts to decide, though South African and Argentinian approaches could provide references to a varying degree. In fact, even if the court itself does not initiate a public forum for discussion, once a case has been filed in the court, litigation could infuse the language of rights into policy discussion and courts serve as another forum for debate.

5.3 Standards of Judicial Review

In health rights jurisprudence, there are two leading standards of judicial review: reasonableness and the minimum core. I will place these two standards into close examination and discuss which standard would be more appropriate in the Chinese context.

5.3.1 Reasonableness Review

In South Africa, the jurisprudence of socio-economic rights has been established in the court system, which concerns health, housing, social security or education. Generally, socio-economic rights have played the strongest role in health cases. A standard of

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160 Ibid. at 304.


162 Ibid.
judicial review, reasonableness test, was established in health rights jurisprudence through two cases: the *Grootboom* case\(^ {163}\) and the *Treatment Action Campaign* case\(^ {164}\). This standard was first established in *Grootboom*, which concerns the constitutional right to housing, and later applied in *Treatment Action Campaign (TAC)* case.

The *Grootboom* case concerned Mrs. Grootboom and others—510 children and 390 adults—who were evicted from their informal homes on private land.\(^ {165}\) Before moving to private land, they lived in appalling conditions and many had been waiting for low-cost housing for many years.\(^ {166}\) The Constitutional Court held that the state’s housing program was not reasonable because it contained no provision “for people in desperate need.”\(^ {167}\)

The *TAC* case involved a challenge to the governmental program dealing with mother-to-child transmission of HIV. This program imposed restrictions on the availability of nevirapine in public health sectors.\(^ {168}\) There were two main issues in this case. Firstly, it was contended that these restrictions were unreasonable.\(^ {169}\) Secondly, it was questioned whether the state was obliged to implement an “effective, comprehensive and progressive” program.


\(^{165}\) *Grootboom*, *supra* note 163 at para. 4.

\(^{166}\) *Ibid.* at para. 3.


\(^{168}\) *TAC*, *supra* note 164 at para. 4.

\(^{169}\) *Ibid.*
The Constitutional Court declared that the state’s program to prevent mother-to-child transmission of HIV fell short of compliance with sections 27 (1) and (2) (right to have access to health care services).

In both cases, the court laid out criteria for assessing the reasonableness of the government’s programs:

“A reasonable programme …must clearly allocate responsibilities and tasks to the different spheres of government and ensure that the appropriate financial and human resources are available.”

“To determine whether the nationwide housing programme … is reasonable …, one must consider whether the absence of a component catering for those in desperate need is reasonable in the circumstances.”

“A programme that excludes a significant segment of society cannot be said to be reasonable.”

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170 Ibid. at para. 5.
171 Grootboom, supra note 163 at para. 39.
172 Ibid. at para. 63.
173 Ibid. at para. 43; TAC, supra note 164 at para. 68.
“For a public programme…to meet…requirement of reasonableness, its contents must be made known appropriately.”174

In particular, that a program must cater for those in urgent needs is regarded as coming closest to “a threshold requirement” for the reasonableness test.175

“To be reasonable, measures cannot leave out of account the degree and extent of the denial of the right they endeavour to realise. Those whose needs are the most urgent and whose ability to enjoy all rights therefore is most in peril, must not be ignored by the measures aimed at achieving realisation of the right. It may not be sufficient to meet the test of reasonableness to show that the measures are capable of achieving a statistical advance in the realisation of the right. Furthermore, the Constitution requires that everyone must be treated with care and concern. If the measures, though statistically successful, fail to respond to the needs of those most desperate, they may not pass the test.”176

174 TAC, ibid. at para. 123.
175 Liebenberg, supra note 20 at 85.
176 Grootboom, supra note 163 at para. 44; TAC, supra note 164 at para. 68.
5.3.2 The Minimum Core

The minimum core analysis is developed in international law, the notion of which is aimed at establishing a minimum legal content for the indeterminate claims of socio-economic rights. When it comes to health rights, article 12 of the ICESCR stipulates that everyone has the right “to the enjoyment of the highest attainable standard of physical and mental health.” Instead of viewing the right to the highest attainable standard of health as an individual entitlement, this article has sometimes been interpreted as an aspirational individual right. However, General Comment No. 14 indicates that states have core obligations “to ensure the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups.” The minimum core obligation was first incorporated into the interpretation of the ICESCR in General Comment No. 3, which proposes that state parties have core obligations to ensure the satisfaction of the “minimum essential levels” of the rights enunciated in the Covenant, including “essential primary health care.”

180 General Comment No. 14, supra note 1 at para.43.
The minimum core obligation analysis has been denied by the South African Constitutional Court which applies a reasonableness review; but in Columbia, the Court established that health care can be immediately enforced if the lack of medical service would threaten “a minimum essential level.” From this perspective, the Columbian Court’s jurisprudence on the right to health is by and large consistent with General Comment No.14.

Compared with the minimum core, the potential downside of the reasonableness standard rests with its indeterminacy. The minimum core may better serve the purpose of identifying specific priorities, urgency and the key population of the vulnerable. Situating both standards of judicial review in the Chinese context, the adoption of the minimum core analysis may better cater for the health care needs of internal migrants. By establishing a minimum essential level of health care, internal migrants’ access to primary health care can be better ensured. However, considering the justiciability of socio-economic rights is still controversial in China, adopting the reasonableness review may be more appropriate. In the first place, the standard of reasonableness appears to defer to the political branches greatly by subjecting them simply to a standard of rationality rather than creating new entitlements. Consequently, a degree of flexibility and discretion has been preserved for the judiciary. In the second place, this standard does not necessarily conflict with the

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182 Yamin, Parra-Vera & Gianella, supra note 126 at 118.
183 Ibid.
184 Belani, supra note 177 at 37.
minimum core. The South African Constitutional Court stated that minimum core was not a self-standing right, but was treated as being relevant to reasonableness.\(^\text{185}\) The reasonableness review also emphasizes the basic needs of the poor and the vulnerable as discussed above. Last but not least, the reasonableness test may have a degree of domestic legitimacy. In *Zhang Xianzhu* Case, Zhou Wei, a prominent constitutional lawyer, attempted to advocate the use of a rational-basis test to scrutinize the governmental regulation. Rational basis refers to the most deferential level of scrutiny. Reasonableness review is a higher standard than rational-basis review. Nevertheless, if the realization of a rational-basis test comes true in health rights jurisprudence in the Chinese context, the adoption of a reasonableness test may be achieved gradually. After all, this is the case in South Africa.

Before formally applying a test of reasonableness in *Grootboom*, the South African Constitutional Court deployed a standard of rationality in the *Soobramoney* case, which was the first major Constitutional Court case concerning the enforceability of socio-economic rights, by stating that “a court will be slow to interfere with rational decisions taken in good faith by the political organs and medical authorities whose responsibility it is to deal with such matters.”\(^\text{186}\)

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\(^\text{185}\) TAC, *supra* note 164 at para. 34.

To explore the potential value of establishing a framework of health care rights in China, I will use the reasonableness test to analyze the internal migrant case. Assuming that internal migrants were able to bring a constitutional claim to health care rights to the court, would they succeed?

First of all, I will examine Migrant Workers Catastrophic Medical Insurance. According to the standard of reasonableness, “a reasonable programme …must clearly allocate responsibilities and tasks to the different spheres of government.” Under this insurance scheme, the central government fails to provide practical guidance on local governments, and these two-tier governments also do not co-operate with one another in carrying out this medical insurance. Indeed, the actual operation of this insurance scheme indicates great disparity between different cities. For example, category of the insured is equivocal. The governmental document issued by the Ministry of Labor and Social Security only mentions the possibility of establishing an independent catastrophic medical insurance scheme for migrant workers in areas where migrant workers gather, without defining which category of migrant workers can be insured. Currently, there are three general groups of internal migrants: one, those who have signed labor contracts and have established stable relationship
with urban employers; two, seasonal migrants who work temporarily in cities; three, those who often change jobs between different places. In theory, the first group is supposed to be insured under Urban Employee Basic Medical Insurance. As for the other two groups, cities have different regulations pertaining to participation in local insurance schemes for migrant workers. Taken together, the standard of reasonableness would probably not be met.

Based on the court judgments in South Africa, statistical advance is insufficient to prove that a particular program is reasonable. Everyone, especially those desperate, “must be treated with care and concern.” Otherwise, even if the program is statistically successful, it still may not pass the reasonableness test.

Situating these court judgments in the Chinese context, health coverage programs that exclude such a significant segment of society could not be said to be reasonable considering the large number of internal migrants and their vulnerable and marginalized conditions. In addition, as discussed above, the current health care system faces a certain degree of systemic inequity when it comes to the allocation of health resources. Internal migrants’ in-between status often places them in an “urgent” and “desperate” situation. Therefore, even if there is sufficient statistical evidence (e.g., high participation rate) to indicate that the

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187 Hui Yang & Shikuan Liu, “Analysis of the Migrant Workers Catastrophic Medical Insurance” (2008) 7 Journal of South China Agricultural University 20, at 20
188 Grootboom, supra note 163 at para. 44; TAC, supra note 164 at para. 68.
189 Ibid.
existing health care policy is successful, as long as the basic health care needs of those in an “urgent” and “desperate” situation (e.g., internal migrants) have not been met, this policy still may not pass the reasonableness test.
Chapter 7

Conclusion

Although this thesis examines the potential role of a justiciable framework of health care rights in China to address access and equity gaps in health care faced by the marginalized and the vulnerable, such as internal migrants, it does not mean that such framework is the only way to achieve the goal. Indeed, I am not advocating complete reconstruction of the current health care system. What I am more concerned about is the potential of employing a right-based approach to address internal migrants’ health care issues under the current health care system and thus the goal of universal access to health care set up in the new Health Care Reform Plan could be realized.

Based on the review of existing empirical literature, the influence of health rights jurisprudence indicates a complex picture. --- Pros and cons exist. Scholars’ opinions also diverge on this issue. Some welcome this as a positive development that protects the right to health, while others concern that the spread of litigation may undermine the attempt to improve health care system through health plans and rational priority setting. Some studies underscore that litigation alone is insufficient to realize the right to health; only when litigation combines with additional efforts (e.g., media pressure, social mobilization) would

Given China’s special domestic situation, in order to ensure internal migrants’ access to health care services, additional efforts, such as enhancement of migrants’ participation in the rule-making process, reform of the household registration system, are also essential.\footnote{Zeng & Dai, \textit{supra} note 154.}

Health rights jurisprudence may have the potential of infusing the language of rights into political discussion and courts serve as another forum for debate.\footnote{Brinks & Gauri, \textit{supra} note 159 at 304.} In the short run, improving health care policy is the way to go. After all, the new Plan is a remarkable achievement in the modern history of China’s health care reforms and the majority of the population has been covered by health care schemes. But in the long run, establishing a justiciable framework of health care rights could be a direction that deserves further research.
### Table 1

Reimbursement Rates and Deductibles of UEBMI for Inpatient Spending by Area (Excluding the Retired)

<table>
<thead>
<tr>
<th>Area</th>
<th>Shanghai municipality</th>
<th>Hefei city (Anhui province)</th>
<th>Shenyang city (Liaoning province)</th>
<th>Guangzhou city (Guangdong province)</th>
<th>Yantai city (Shandong province)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Reimbursement rates</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>First-level hospital</td>
<td>85%</td>
<td>94%</td>
<td>94%</td>
<td>90%</td>
<td>90%</td>
</tr>
<tr>
<td>Second-level hospital</td>
<td>85%</td>
<td>92%</td>
<td>93%</td>
<td>85%</td>
<td>85-90%</td>
</tr>
<tr>
<td>Third-level hospital</td>
<td>85%</td>
<td>90%</td>
<td>86-88%</td>
<td>80%</td>
<td>80-85%</td>
</tr>
<tr>
<td><strong>Deductibles (RMB)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>First-level hospital</td>
<td>1500</td>
<td>100-200</td>
<td>300</td>
<td>500</td>
<td>200</td>
</tr>
<tr>
<td>Second-level hospital</td>
<td>1500</td>
<td>200-400</td>
<td>400-500</td>
<td>1000</td>
<td>400</td>
</tr>
<tr>
<td>Third-level hospital</td>
<td>1500</td>
<td>300-600</td>
<td>800-1200</td>
<td>2000</td>
<td>600</td>
</tr>
</tbody>
</table>
Table 2

Reimbursement Rates and Deductibles of NRCMS for Inpatient Spending by Area

<table>
<thead>
<tr>
<th>Area</th>
<th>Daozhen county (Guizhou Province)</th>
<th>Tengzhou county (Shandong Province)</th>
<th>Wanyuan county (Sichuan Province)</th>
<th>Anhui Province</th>
<th>Gansu Province</th>
<th>Guangdong Province</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reimbursement rates</td>
<td>Township health center</td>
<td>80%</td>
<td>90-70%</td>
<td>90%</td>
<td>85%</td>
<td>85%</td>
</tr>
<tr>
<td></td>
<td>County hospital</td>
<td>70-65%</td>
<td>70-60%</td>
<td>80%</td>
<td>80%</td>
<td>75%</td>
</tr>
<tr>
<td></td>
<td>Higher level hospital</td>
<td>40%</td>
<td>25-60%</td>
<td>50-65%</td>
<td>55-57%</td>
<td>60-65%</td>
</tr>
<tr>
<td>Deductibles (RMB)</td>
<td>Township health center</td>
<td>≥30</td>
<td>≥150</td>
<td>≥80</td>
<td>≥100</td>
<td>≥100</td>
</tr>
<tr>
<td></td>
<td>County hospital</td>
<td>≥200</td>
<td>≥500</td>
<td>≥200</td>
<td>≥400</td>
<td>≥300</td>
</tr>
<tr>
<td></td>
<td>Higher level hospital</td>
<td>≥500</td>
<td>≥500</td>
<td>---</td>
<td>≥500</td>
<td>≥800</td>
</tr>
</tbody>
</table>

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