

Abstract

This article advances an alternative paradigm for making judgments about China's compliance with its international obligations in the realm of health and human rights, grounded on the reality that non-local rule regimes are interpreted and applied according to the extent of commonality between the norms underlying these international rule regimes and local cultural norms. This paradigm, "selective adaptation," allows us to determine that China complied with its international obligations in the case of SARS, but not HIV/AIDS. It makes visible how during SARS China eventually complied with the spirit of the international sanitation regulations but the lack of commitment to improving access to health care for persons living with HIV/AIDS reflects a failure by China to guarantee the right to adequate health care.

Cet article propose un paradigme alternatif pour juger si la Chine respecte ses obligations internationales dans le domaine de la santé et des droits de l'homme. Celui-ci est basé sur la réalité que les régimes de règles extérieures sont interprétés et appliqués dans la mesure des points communs entre les normes fondamentales de ces règles internationales et les normes culturelles locales. Ce paradigme, "adaptation sélective" nous permet de déterminer que la Chine a respecté ses engagements internationaux dans le cas du SRAS, mais pas pour le VIH/SIDA. Il rend visible la conformité à terme de la Chine durant l'épisode du SRAS avec l'esprit des règlements sanitaires internationaux mais le manque d'engagement pour améliorer l'accès aux soins médicaux des personnes atteintes du VIH/SIDA reflète l'échec de la Chine à garantir le droit à des soins médicaux adéquats.

En este artículo se propone un paradigma alternativo para hacer juicios acerca del cumplimiento por parte de China de sus obligaciones internacionales en el campo de los derechos de salud y humanos, fundamentado en la realidad de que los regímenes de reglas no locales se interpretan y aplican de acuerdo con la extensión de la comunidad entre las normas que fundamentan estos regímenes de reglas internacionales y normas culturales locales. Este paradigma, "la adaptación selectiva" nos permite determinar que China cumplió con sus obligaciones internacionales en el caso del SARS, no así en lo que se refiere a la infección por VIH/SIDA. Hace visible la manera en la cual durante la epidemia de SARS China finalmente cumplió con el espíritu de los reglamentos internacionales de saneamiento, pero la falta de compromiso para mejorar el acceso al cuidado de la salud para personas que viven con infección por VIH/SIDA refleja un fracaso por parte de China para asegurar el derecho al cuidado de la salud adecuado.

SELECTIVE ADAPTATION AND HUMAN RIGHTS TO HEALTH IN CHINA

Lesley Jacobs and Pitman B. Potter

The international community has devoted considerable energy to dialogue and exchanges with the People's Republic of China (PRC) on issues of human rights and good governance. Despite the fact that many improvements in China's human rights regime are evident, problems remain with regard not only to questions of political freedoms and civil liberties, but also to China's record on social, economic, and cultural rights. The area of health and human rights, in particular, warrants attention because of both the effects on the well-being of the Chinese people and the global implications of China's handling of public health issues such as Severe Acute Respiratory Syndrome (SARS), HIV/AIDS, and Avian Flu. Historically, health is an area of human rights in which the PRC has been viewed as having a strong record among developing countries.¹ Academic and policy discourses on human rights in China, however, are all too often conflicted by normative and ideological differences over cultural relativism, which often undermine substantive engagement with and obscure analysis based on specific economic and social rights.² Claims about the rigidity and universality of human rights principles conflict with assertions that China's cultural particularity or stage of economic and legal development warrant special exceptions from international human rights standards, or at least require interpretations of these standards that allow flexible application in China.

Lesley Jacobs, BA, MA, PhD, is Professor of Law and Society and Director of the Graduate Program in Social and Political Thought at York University in Toronto, Canada. Pitman Potter, BA, JD, PhD, is Professor of Law and Director of the Institute of Asian Research at the University of British Columbia in Vancouver, Canada. Please address correspondence to the authors at jacobs@yorku.ca.

Copyright © 2006 by the President and Fellows of Harvard College.

This paper advances an alternative paradigm (“selective adaptation”) for making judgments about China’s compliance with its international obligations in the realm of health and human rights. This alternative paradigm involves examining compliance with international human rights standards through reference to the role of local popular norms in mediating acceptance of non-local rules. The broader point is that, when international treaties are ratified by States parties, that ratification does not de facto make those rules local. Rather, selective adaptation is the process by which those rules become localized. It provides a model for understanding critically the reality that non-local rule regimes are interpreted and applied according to the extent of commonality between the norms underlying these international rule regimes and local cultural norms.

Two recent cases are examined in which China’s compliance with its international obligations concerning health and human rights has been questioned. The one concerns China’s response to the SARS crisis, and the other, its treatment of persons living with HIV/AIDS. Selective adaptation allows us to determine that China complied with its international obligations in the case of SARS, but not HIV/AIDS. In particular, selective adaptation makes visible the fact that, during the SARS outbreak, China eventually complied with the spirit of the requirements of the international sanitation regulations. In contrast, however, China’s lack of commitment to improving access to health care for persons living with HIV/AIDS reflects its failure to comply with its international obligations with regard to the right to adequate health care.

The point of these two contrasting assessments is to illustrate how interpretations of international standards in the area of health and human rights can be critically yet flexibly applied in China, and indeed perhaps elsewhere, without embracing notions of cultural relativism. What both examples draw out is that many of the PRC’s challenges with regard to health and international human rights have little to do with the cultural or economic particularities of China. Instead, they reflect the fact that in China, both the provision of health care and measures to control

the spread of infectious disease are principally within the domain of local and municipal governments, and that the country has failed to develop adequately the means by which it can ensure that its national commitments to health are implemented by these actors.

China's International Obligations

At issue for China with respect to health and human rights are two distinct sets of international obligations, one of which is rights-based and the other not. One set of international obligations arises from the variety of international sanitary conventions that date originally to the late 19th century and were consolidated into the International Health Regulations (IHR) by the World Health Organization (WHO) in 1951.³ These regulations, designed to prevent the international spread of infectious diseases, require states to notify the international community of outbreaks of certain diseases and maintain public health facilities that could regulate international points of entry and exit. Since 1983, IHR for infectious diseases had applied to only three diseases — cholera, plague, and yellow fever — which meant that the regulations did not address new infectious diseases such as SARS and Avian Flu. At the time of the SARS crisis, WHO was in the process of amending its IHR to better deal with new and emerging infectious diseases. In May 2005, WHO formally adopted new IHR designed to apply to all public health risks, not just those stemming from cholera, plague, and yellow fever.⁴

China's other set of international obligations in the realm of health and human rights revolves around its international commitments to provide individuals with an adequate standard of health care. These obligations are set out in international human rights instruments such as the International Covenant on Economic, Social and Cultural Rights (ICESCR) (which China finally ratified in 2001), as well as the more recent Millennium Declaration. The latter is perhaps the most important recent international initiative in the area of human development related to health care rights, even though it has been largely ignored by the international human rights community.⁵

Serious questions about whether China is meeting these two sets of obligations have been raised recently by

the international community. In the case of the IHR, the perception that China is at the epicenter of some newly emerging infectious diseases has raised concerns about the extent to which it has fulfilled its responsibilities to provide notification of such outbreaks and maintained public health facilities that can respond to them. In the case of human rights related to health care, significant economic changes in PRC have brought parallel changes to its system of health care provision, raising concerns about the effects on certain marginalized populations.

Flexibility of International Obligations

The difficulty in assessing China's performance related to these two sets of obligations stems from the broader problem of determining the extent to which the demands of the human right to health should be regarded as flexible in developing countries such as China. The international human rights community seems to be of two minds about this problem. In the 1993 Vienna Declaration and Programme of Action, for example, the signatories claimed,

The international community must treat human rights globally in a fair and equal manner, on the same footing, and with the same emphasis. While the significance of national and regional particularities and various historical, cultural, and religious backgrounds must be borne in mind, it is the duty of States, regardless of their political, economic, and cultural systems, to promote and protect all human rights and fundamental freedoms.⁶

The underlying point, in theory, is that all international human rights are held to be universal and designed to be culturally neutral.⁷ As is well known, however, Article 2 of the ICESCR allows for "progressive realization." The underlying principle is designed to acknowledge that countries lack the resources to fully realize human rights such as the right to adequate health care, and hence must constantly strive to improve their performance.

China's official discourses on the right to health operate in the shadow of its norms of governance and the right to development.⁸ In terms of governance, norms of "patrimonial sovereignty" suggest that administrative agencies and

regulators may have responsibility *for* society but are not responsible (accountable) to it.⁹ Instead, health regulators are accountable primarily to their bureaucratic and political superiors, and as a result, have few obligations to meet the substantive needs of either Chinese citizens or those of the international community. In effect, this relegates protection of individual human rights secondary to the primacy of the state. Notice, however, that conduct of this sort is neither inherently arbitrary nor discriminatory.¹⁰

The Chinese government's views on the right to development also have implications for the centrality of the state as the source of rights and as the determinant of the beneficiaries of rights. In contrast to constitutional theories that view rights as inalienable and intrinsic to the human condition, the PRC Constitution speaks of rights enjoyed by the people. Article 33 of the PRC Constitution conditions the extension of rights on performance of the "duties prescribed by the Constitution and the law." Under this approach, rights are not inherent to the human condition, but rather are specific benefits conferred and enforced at the discretion of the state.¹¹ The state's role here is one of patrimonial sovereign, which entails not the recognition of fundamental rights of members of society but rather the conferring of rights on particular members of society subject to those members meeting specific conditions or requirements. On this view, the human right to health is conferred by the state and is thus subject to state interests and the state's interpretation of social interests. As indicated by the PRC's 2000 Human Rights White Paper, human rights remain generally subject to the needs of national development and thus appear to be conditioned on the pursuit of reform, development, and stability.¹² Therefore, in securing the human right to health, issues such as access to health care; the detection, reporting, treatment, and monitoring of infectious diseases; and the protection of systemic supports for human health are subsumed under broader state goals for national development.

The progressive realization provision of the ICESCR allows for some flexibility in its demands on member states. Are China's official discourses on health and human rights consistent with the underlying principle? China's flexibility

in its compliance with its international health and human rights obligations raises the concern that any substantive recognition of non-compliance is at risk of being lost. Should this occur, the specific content of the international obligations at issue is neglected, and it is here that some of the most serious violations of human rights to health can occur.¹³ “As Leonard Rubenstein writes, “[if] a state violates its obligations to implement programs for maternal health, allowing women to suffer and die, it should not matter that the decision was not arbitrary.”¹⁴ In its 2000 general comments about how to implement the ICESCR, the United Nations Economic and Social Council insisted,

The progressive realization of the right to health over a period of time should not be interpreted as depriving States parties’ obligations of all meaningful content. Rather, progressive realization means that States parties have a specific and continuing obligation to move as expeditiously and effectively as possible towards the full realization of [the right to the highest attainable standard of health].¹⁵

Another danger is that flexibility has the potential to open the floodgates for excuses. The challenge is to ensure that the progressive realization provision does not allow China to trade off possible gains in the realization of the right to health for the sake of economic development. Under what conditions would China be excused from fulfilling its obligations in the area of international sanitation—or, indeed, with respect to the right to adequate health care? The 1997 Maastricht Guidelines on Violations of Economic, Social and Cultural Rights states, “The State cannot use the ‘progressive realization’ provisions in article two of the Covenant [ICESCR] as a pretext for non-compliance. Nor can the State justify derogations or limitations of rights recognized in the Covenant because of different social, religious, and cultural backgrounds.”¹⁶

The Paradigm of Selective Adaptation

This article offers an application of “selective adaptation” as an alternative paradigm for thinking about the flexibility of judgments of China’s non-compliance with inter-

national obligations in the realm of health and human rights. Selective adaptation in this context involves a dynamic by which international rule regimes are mediated by local cultural norms.¹⁷ Thus, universal human rights standards related to the right to adequate health care, for example, will in practice be interpreted according to local norms concerning such matters as the relationship between individual and collective claims, expectations about health, and the delivery of health care. The broader point is that when international agreements are ratified by state parties, ratification does not de facto make those rules local.¹⁸

The paradigm of selective adaptation may also be seen to operate by reference to factors of perception, complementarity, and legitimacy. *Perception* influences understanding about foreign rules and local norms and practices. In the area of human rights related to health care, this may involve perceptions about what international human rights require in terms of health care priorities, outcomes, and processes, as well as perceptions about local conditions and expectations. *Complementarity* describes a circumstance by which apparently contradictory phenomena can be combined in ways that preserve essential characteristics of each component and yet allow for them to operate together in mutually reinforcing and effective ways. In the health care area, for example, complementarity may help explain how international standards for assessment of health needs and delivery of health care can accommodate local practices. *Legitimacy* concerns the extent to which members of local communities support the purposes and consequences of international standards. Thus, in the health care sector, popular reactions to state-controlled reporting on infectious diseases such as HIV/AIDS, SARS, and Avian Flu may signal varying levels of legitimacy for the process of localizing international standards.

Although selective adaptation offers the potential to understand dynamics of localization of international human rights standards, it also works to limit efforts to insulate or excuse government behavior from human rights criticism. The key determinant in selective adaptation is the relationship between the norms underlying international human rights standards and local cultural norms. Understanding compliance requires more than simply comparing local per-

formance against international requirements. Rather, compliance can be understood more clearly by examining the extent to which norms underlying the international standards are consonant with local norms. Doing so can help explain compliance outcomes by differentiating between those situations where non-compliance is the result of normative conflict, and those cases where local norms are consistent with the norms of the international regime but local practices fail to satisfy international standards. Where demonstrable conflicts exist between international rule regimes and local popular norms, accommodation to cultural differences might be useful. Non-compliance unrelated to factors of normative consensus, however, cannot be excused by reference to cultural differences.

In relation to the two distinct sets of international obligations in the area of health and human rights identified at the outset, we provide a brief analysis of how China handled the SARS crisis and has treated individuals living with HIV/AIDS. Through the lens of selective adaptation, we seek to judge to what extent China complied with its international obligations in these cases. This analysis shows why we believe China can be viewed as eventually having been compliant with its international obligations as the SARS crisis unfolded, despite the government's secrecy and censorship during the crisis. China's treatment of individuals with HIV/AIDS provides a sharp contrast. Selective adaptation allows us to see that China is not compliant with its international obligations to fulfill the rights of persons living with HIV/AIDS in regard to providing an adequate standard of health care and treating them in a manner that is not discriminatory.

These contrasting assessments illustrate how the paradigm of selective adaptation enables us to assess critically whether China is complying with its international obligations in the area of health and human rights at the same time that we acknowledge the cultural particularities of the Chinese context. Specifically, selective adaptation helps to make visible the fact that, in China, non-compliance with international human rights obligations related to health is often not an issue of cultural difference so much as a failure of local authorities to make the right to health an overriding priority.

China's Conduct during the SARS Crisis

Severe Acute Respiratory Syndrome presented itself as the first genuinely global infectious disease of the new millennium, spreading quickly to numerous cities and countries around the world. It emerged in November 2002, in Guangdong Province, China, but was only reported to China's national health authority on January 2, 2003, and peaked in Guangdong Province in late February.¹⁹ In the first global health alert in its history, WHO issued an alert about SARS on March 12, 2003. By the time the crisis ended in the summer of 2003, approximately 8,098 persons worldwide had been diagnosed with probable SARS and there were 774 deaths.²⁰ The majority of these cases and deaths had occurred in mainland China. Worldwide, there have been no reported new cases of SARS outside of laboratories since June 2003.²¹

China's initial response to international enquiries about SARS was one of secrecy and denial. This response followed a familiar pattern. As Wang Ruotao describes it, "Before April 24, 2003, China's response to the SARS epidemic followed its traditional approach to handling epidemics. Health authorities silently tried to control the epidemic without upsetting social stability."²² This response certainly did not reflect compliance with the spirit of the international regulations for dealing with such epidemics, even though it was not technically a violation in that, as noted above, WHO's International Health Regulations in place at the time did not apply to new infectious diseases.

In early April 2003, in response to international pressure, WHO teams were granted access to Beijing, Guangdong Province and other assumed centers of SARS in China. On April 3, Minister of Health Zhang Wenkang announced confidently that the disease was under control. A military physician almost immediately sent e-mails to Chinese and Hong Kong television stations indicating that the actual number of SARS cases and deaths in Beijing was significantly higher than the figures admitted by the Minister of Health.²³ Two weeks later, on April 17, 2003, the Politburo Standing Committee ordered "accurate, timely, and honest reporting" of SARS cases.²⁴ A week later, both the Minister of Health and the Mayor of Beijing were removed from their posts,

along with more than 100 health officials, for covering up and under-reporting SARS infection rates, actions that, according to Human Rights Watch, established a new standard of public accountability in China.²⁵

Although there were remaining concerns about China's openness in late April 2003, after thorough investigation WHO praised China for the accuracy of its new numbers of SARS cases. In Shanghai, for example, a WHO team confirmed that the incidence of SARS was indeed very low, as city officials had insisted, despite some skepticism in the foreign media.²⁶ The measures that China undertook to contain SARS reflected the WHO guidelines, which did not recommend the use of large-scale stringent quarantine.²⁷ In April 2003, Premier Wen Jiabao promised not to implement extreme quarantine measures in China. In keeping with this statement, the Chinese government relied to a great extent not only on isolation and quarantine measures to stanch the spread of SARS, but also on education and health promotion, travel restrictions, temperature screening at airports, health declarations, and other less intrusive means, such as the wearing of masks in public. SARS ended in China at virtually the same time it did in other countries. Indeed, the U.S. Centers for Disease Control and Prevention lifted its travel alert on Hong Kong, Beijing, and other major Chinese cities before it lifted the alert on Toronto.²⁸ Summing up, de Lisle writes, "The 2002–2003 SARS episode and its aftermath also reflected and extended the Chinese regime's increased (if sometimes reluctant or unintentional) transparency and amenability to pressures to adhere to international norms, including legal ones."²⁹

SARS and Selective Adaptation

Selective adaptation provides some insight into understanding how well China complied with its international obligations during the SARS crisis. Perception is fundamental to making sense of China's shift in policy in mid-April 2003. In the initial stages of the SARS epidemic, China largely viewed WHO as an enforcer of foreign standards and practices of public health care measures.³⁰ In a substantial shift, however, the country then turned to WHO as a valuable resource in combating the epidemic. Part of this shift in

perception may be due to the personnel support that WHO offered to Chinese public health officials.³¹ In addition, WHO's praise for China's openness helped to forge comfortable relations, and WHO's nuanced use of travel advisories — for example, not issuing one for Shanghai — lessened the economic impact of SARS on China.³² This shift in China's engagement with WHO, however, meant that the government's cooperation often appeared to the rest of the world to be instrumental, as opposed to compliance stemming from a genuine commitment to global governance.³³

Complementarity is another dimension of the analysis. Domestically, WHO's directives were initially viewed as international meddling in China's affairs.³⁴ The national government, however, succeeded in portraying the challenges that SARS posed as arising from local public health authorities' poor communication with the national Ministry of Health and the failure of local authorities to follow national directives. In this respect, the issue was one of "corruption" more broadly, in which corruption is understood as the favoring of local interests over national ones.³⁵ Seen in this light, WHO's prescriptions during the SARS crisis were not at variance with the Chinese government's actions; the national government and WHO faced exactly the same problem, which was to secure compliance by local authorities. Not surprisingly, in their June 16, 2003, review of successful strategies for dealing with SARS, the Chinese Center for Disease Control and Prevention identified as the most important strategy establishing "multi-sector cooperation and coordination mechanisms at all levels."³⁶

Ironically, the legitimacy of the international demands on China during the SARS crisis stemmed from the fact that, aside from using a uniform case definition of a SARS patient, WHO gave individual countries discretion over the measures that they could take to control the epidemic. WHO left it to the discretion of local jurisdictions, for example, to use quarantine within certain limitations.³⁷ In China, as in the United States, public health decisions are decentralized, and local authorities are traditionally the ones who make decisions regarding public health issues. This practice meant that despite WHO's presence during the SARS crisis, policies were developed locally, not nationally.

In the case of quarantine, for instance, Hong Kong developed its own policy, and even Shanghai and Beijing differed in terms of the specific guidelines for whom to quarantine, despite their similarity as mainland China's two most cosmopolitan cities.³⁸ In Hong Kong, the actual number of individuals subject to quarantine orders during the SARS crisis was surprisingly low — only 1,282 individuals — given that there were 1,755 confirmed SARS cases.³⁹ In Shanghai, 4,090 individuals were quarantined during the crisis, even though there were a mere 11 suspected cases of SARS.⁴⁰ In Beijing, where a majority of mainland China's SARS cases were found, 30,173 persons were quarantined.⁴¹

International Obligations to Persons Living with HIV/AIDS

Questions about China's compliance with its international obligations to persons living with HIV/AIDS should be set within the broader context of the impact of recent economic reforms on the pre-existing health care system — a system, which in the past was often presented as a model of accessibility for developing economies.⁴² In the last 25 years, the financial burden of health care in China has shifted to individual patients and their families. Although, in terms of overall health status, WHO ranked China 61st out of 191 countries in 2000, it was ranked 188th in terms of fairness of financial contributions to health care.⁴³ The World Bank reported in 2004 that the national government in China supported a mere 3% of total health care expenditures.⁴⁴ Townships and counties were responsible for 60% of the total public expenditure.

These numbers are significant for two reasons. The first is that they highlight how little control the national government has over the day-to-day routine provision of health care throughout the country.⁴⁵ Although the health care agenda of the national government does include re-establishing an equitable and accessible health care system, it lacks the financial leverage to apply pressure on local governments to implement this agenda. The numbers are also significant in that they portray dramatic differences in public spending on health care across the country, depending on the wealth of the region. The contrast is most stark in terms of the proportion of public

spending in urban versus rural areas. Urban areas receive 80% of total public spending, according to the World Bank, even though 70% of the population lives in rural areas. Moreover, during the past 20 years, health care in China has also become much more expensive, with average annual increases of 11%. In Shanghai, for instance, hospital costs increased by 53% between 1993 and 1994.⁴⁶

Rapidly escalating health care costs, combined with shifts from public to private funding, have impacted access to care. In the early 1980s, 80% of Chinese citizens had access to health care of reasonable quality.⁴⁷ The coverage of public health insurance in rural areas then dropped, from 85% to less than 10%, by the mid-1990s. In urban areas, the number of people without health insurance increased from 27% to 44% in a mere five-year period, from 1993 to 1998.⁴⁸ The shift in China has been to a health care system where user fees and out-of-pocket costs for patients amounted to 58% of the total spending in 2002, compared to 20% in 1978, and spending on pharmaceutical drugs now accounts for half of the total health care expenditures.⁴⁹

The pressing problem of HIV/AIDS in China can be recounted here only in very broad terms. Although initially in the 1980s HIV/AIDS was regarded as a disease of foreigners, today there are reported to be as many as 80,000 cases of HIV infection in Yunnan alone, with infections rising at a rate of 30% per year.⁵⁰ Nationally, China's official figures estimate that 840,000 people are living with HIV/AIDS, while some 100,000 are reported to have died from the disease.⁵¹ The United Nations estimates that China could have as many as 10 million people living with HIV/AIDS by 2010.⁵²

China has now officially acknowledged the importance of taking active measures to address the HIV/AIDS crisis. On February 26, 2004, the State Council established the first working committee on HIV prevention, under the direction of Vice Prime Minister Wu Yi. In May 2004, Wu Yi announced new "urgent measures" for prevention and education and for proper reporting and disease surveillance. There has been a corresponding increase in special annual financing for HIV prevention from 15 million yuan (US\$1.81 million) to 100 million yuan (US\$12.08 million) since 2001.⁵³ However, despite official attention from the highest levels of the government

and despite the belief held by many in the international community that significant changes are needed in China's policies and practices on HIV/AIDS, there is little substantive change. The State Council similarly issued a "strategic plan" for HIV prevention and control in November 1998, and again in 2001.⁵⁴ Both plans stressed the extent of the government's commitment to HIV prevention and control, but also underscored the ideological role of Communist Party leadership, focusing on "behavioral change," with insufficient attention to the arms of government responsible for protecting the public welfare in this regard.

While these documents acknowledged past deficiencies in government policy, recognized the importance of HIV/AIDS education, and provided specific guidelines for treatment for persons living with HIV/AIDS, they focused mainly on issues of surveillance, reporting, and control — efforts which, at the local government level, invited abuse and a general orientation toward concealment and suppression. Thus, academics and health care professionals attempting to address the HIV/AIDS crisis continued to complain repeatedly of concealment by local officials and the suppression of information — in particular, prohibitions against the unauthorized dissemination of information on outbreaks of infectious disease.⁵⁵

HIV/AIDS and Selective Adaptation

In terms of its international obligations, China appears to be highly selective in its concerns. Although China acknowledges the problems of inadequate health care for people living with HIV/AIDS and the central government continues to initiate new AIDS policies, the predominant perception in the official Chinese media is that the biggest obstacle to controlling the epidemic is how others in China perceive those with HIV/AIDS. In an issue devoted to the fight against HIV/AIDS, for example, the English weekly newsmagazine *Beijing Review* states boldly in its lead editorial, "Screening for the disease (in some rural areas where AIDS is prevalent) and finding ways to treat are difficult issues met by health departments in AIDS prevention and treatment, *but prejudice and discrimination are still the biggest problems.*"⁵⁶ These concerns are reflected in current

efforts to bring about substantive legal change that better protects persons living with HIV/AIDS from discrimination. For example, the official prohibition against persons living with HIV/AIDS holding government jobs has now been lifted. Moreover, political leaders and pop culture figures have begun to appear in public with persons living with HIV/AIDS in order to dissipate the stigma of HIV and AIDS. Similarly, the Chinese government has begun to develop education and outreach initiatives intended to reduce the spread of HIV/AIDS.

The perception that China's international obligations revolve principally around ending discrimination against persons living with HIV/AIDS is, however, a distortion of those obligations. A major rationale for stressing anti-discrimination measures in the response to HIV/AIDS is that doing so will better facilitate access to adequate health care for people living with HIV/AIDS. China, however, has made very little genuine progress in providing people living with HIV/AIDS access to adequate health care, especially in rural areas. The Ministry of Health in the central government is responsible for the rural sector and will often issue policies such as the new "Four Free and One Care" policy, which is intended to make AIDS drugs available for free. However, the Ministry of Health is simply in too weak a position in the central government to implement fully such policies. The practice in rural China is to ignore its policy directives.⁵⁷ (An earlier example is its unfulfilled 2001 policy that by the end of 2001 every provincial hospital in the country will have a department committed to providing treatment to people with HIV and AIDS.⁵⁸)

In the case of free drugs or price cuts to such drugs, it must be recognized that in 1992 China ended its state monopoly pricing system for drugs. Li Jinhua, auditor-general of the National Audit Office, reported in 2005 that sales of medicines are now a major source of revenue for hospitals, especially state-owned ones, and that kickbacks to doctors from pharmaceutical distribution company representatives are the biggest barrier to affordable drugs.⁵⁹ These doctors "tend to avoid prescribing medicines whose prices were slashed and instead introduce patients to medicines not on the price cut list."⁶⁰ The successful implementation of policies such as "Four Free and One Care" therefore require wider reforms of

the public financing of the hospital system, which is outside the ambit of what the Ministry of Health can change.

A stark contrast can be drawn here between the access afforded SARS patients and the access denied to persons living with HIV/AIDS. China took seriously its international obligations to provide adequate care for SARS patients in 2003, demonstrating to WHO officials the existence of this care in rural areas, while at the same time concealing the impoverished conditions facing persons living with HIV/AIDS in those same areas.⁶¹ Unlike in the case of SARS, which was an emergency with a relatively short timeline, health care provision for persons living with HIV/AIDS involves a long-term financial commitment. As noted previously, the central government now generally plays a very minimal role in the ongoing funding and maintenance of the health care system. It instead relies on local governments to both fund and implement it, although their efforts remain haphazard.

From the perspective of complementarity, the impact on social policy of major domestic economic and political reforms is fundamentally incompatible with China's obligations to persons living with HIV/AIDS. The pressing problem, as noted above, is that China has virtually dismantled its public health care system over the past 20 years, especially in rural areas. In essence, it is hard to see how the removal of the health care safety net can be reconciled with an international obligation to provide persons living with HIV/AIDS with an adequate standard of health care. Persons living with HIV/AIDS are among the most vulnerable in Chinese society. By its very nature, any health system that provides them an adequate level of care is going to need to redistribute resources from the healthy to the ill and the wealthy to the poor; the recent developments in China's health care system are precisely in the opposite direction. Given the fundamental incompatibilities just noted, it should not be surprising that China chooses to downplay inequities associated with the privatization of its health care system.

Within China, the demise of the public health care system is emerging as a test of the legitimacy of the economic and political reforms that the leadership has embraced in its efforts to globalize the Chinese economy. This

legitimacy is called into question more pointedly than it perhaps is in other developing countries because China had a model health care system in the recent past. Ironically, persons living with HIV/AIDS in China in 1980 would very likely have had much better access to health care than in 2005. Also at stake in China is its legitimacy on the international stage as a place for global capital investment. Staying on the current economic reform path, both in terms of providing stability and making the transition away from the dominant model of state owned enterprises, is integral to that legitimacy. In other words, concerns about legitimacy are pulling China in different directions.

Conclusion

The above analysis of SARS and HIV in China is intended to show the insights that the paradigm of selective adaptation can yield for judging China's compliance with its international obligations in the realm of health and human rights. Indicators of perception, complementarity, and legitimacy, along with the government's commitment to greater transparency in reporting on SARS and to cooperation with WHO reveal China's potential for compliance with its international obligations in cases involving emerging infectious diseases such as Avian Flu. As we have shown in the context of HIV, however, the same indicators reveal that there is little substantive commitment to improving access to health care for those most vulnerable in Chinese society when that commitment conflicts with the demands of economic and political reforms. Even if we provide for the cultural particularities of China, this lack of commitment to improving access to health care for persons living with HIV/AIDS reflects a failure on China's part to comply with its international obligations with regard to the right to adequate health care. What both examples draw out is that many of the PRC's challenges with regard to health and human rights reflect the fact that, in China, both the provision of health care and measures to control the spread of infectious diseases are principally within the institutional domain of local and municipal governments. China has failed to develop adequately the means by which it can ensure that its national agenda on health is implemented by these governments.

As a result, a rights-based approach to health in China must look beyond the platitudes and policies of the national government and examine the complex and diverse forms in which health policy is realized at the local level. Such an approach also requires caution in accepting the findings of national reports from the PRC, including those related to the achievement of targets set out by the Millennium Development Goals. Moreover, in efforts to bolster such an approach to health care in China, external NGOs concerned with furthering a rights-based agenda in the country should always work with local partners.

The analysis in this article also has implications for health and human rights in countries other than China. As noted at the outset, in the realm of health, claims about the universality of human rights principles often concede that human rights standards should be applied flexibly so as to accommodate a country's cultural particularity or stage of economic and legal development. A strength of the paradigm of selective adaptation in the case of China is the way in which it makes visible the fact that non-compliance with international human rights to health is often not an issue of cultural difference but rather a failure of local authorities to make the right to health an overriding priority. In other countries, the institutional failings made visible through selective adaptation may not revolve around the lack of control that the national government has over local governments but rather a different concern, such the undue influence of private health insurance companies or transnational firms. Within the paradigm of selective adaptation, these or other failures should not be confused with a government's being flexible for the sake of the country's cultural particularities or in recognition of its stage of economic development.

Acknowledgements

Two anonymous referees provided many helpful suggestions and comments on earlier drafts of this paper. We are also grateful to our collaborators on the Asia Pacific Dispute Resolution Project and the audiences at conferences at Emory University in Atlanta and at the Waseda University Law School in Tokyo for their comments and suggestions. Funding for this research was provided by a Major Collaborative Research Grant from the Social Sciences and Humanities Research Council of Canada.

References

1. For the purposes of this paper, we have assumed that it is possible to analyze China's record on the right to health without dwelling on its poor record with regard to civil and political rights. Many experts in the international human rights community insist on the idea that all human rights are seamlessly connected, and hence, that such an analysis is misconceived. Our analysis is, we believe, consistent with the fact that China has ratified the International Covenant on Economic, Social and Cultural Rights but not the International Covenant on Civil and Political Rights.
2. R. Peerenboom, "Human Rights in China," in R. Peerenboom, C. Petersen, and A. Chen (eds.), *Human Rights in Asia* (New York: Routledge, 2006), pp. 413–51.
3. See D. Fidler, *International Law and Infectious Diseases* (Oxford UK: Oxford University Press, 1999).
4. D. Fidler and L. Gostin, "The New International Health Regulations: An Historic Development for International Law and Public Health," *Journal of Law, Medicine & Ethics* 34 (2006): pp. 85–94.
5. P. Alston, "Ships Passing in the Night: The Current State of the Human Rights and Development Debate Seen Through the Lens of the Millennium Development Goals," *Human Rights Quarterly* 27 (2005): pp. 755–829.
6. Vienna Declaration and Programme of Action (June 25 1993). Available at [www.unhchr.ch/huridocda/huridoca.nsf/\(Symbol\)/A.CONF.157.23.En?OpenDocument-87k-](http://www.unhchr.ch/huridocda/huridoca.nsf/(Symbol)/A.CONF.157.23.En?OpenDocument-87k-).
7. P. Sieghart has observed, for example, "These standards are deliberately designed to be culturally and ideologically neutral. . . The distinguishing characteristic of all human rights is that they are universal." See P. Sieghart, *The Lawful Rights of Mankind* (Oxford: Oxford University Press, 1985), pp. 40 and 75.
8. This paragraph and the next draw generally on P. Potter, *The Chinese Legal System: Globalization and Local Legal Culture* (New York: Routledge, 2001).
9. P. Potter, "Legal Reform in China: Institutions, Culture, and Selective Adaptation," *Law & Social Inquiry* 28 (2004): pp. 465–95.
10. Indeed, a fundamental aspect of China's efforts to establish the rule of law is oriented toward curbing "official arbitrariness." See S. B. Lubman, *Bird in a Cage: Legal Reform in China after Mao* (Palo Alto: Stanford University Press, 1999): p. 311.
11. See also Qi Zhou, "Conflicts over Human Rights between China and the US," *Human Rights Quarterly* 27 (2005): pp. 105–24.
12. State Council Information Office, PRC, *White Paper: Fifty Years of Progress in China's Human Rights* (Beijing, PRC: 2000).
13. L. Rubenstein, "How International Human Rights Organizations Can Advance Economic, Social, and Cultural Rights," *Human Rights Quarterly* 26 (2004): p. 849.
14. L. Rubenstein, "Response by Leonard Rubenstein," *Human Rights Quarterly* 26 (2004): p. 881.
15. United Nations Economic and Social Council, *General Comment No. 14:*

Substantive Issues Arising in the Implementation of the International Covenant on Economic, Social and Cultural Rights (August 11, 2000), paragraph 31.

16. "The Masstricht Guidelines on the Violations of Economic, Social and Cultural Rights," *Human Rights Quarterly* 20 (1998): pp. 694–95.

17. See, in particular, P. Potter, "Globalization and Economic Regulation in China: Selective Adaptation of Globalized Norms and Practices," *Washington University Global Studies Law Review* 2 (2003): pp. 119–50, as well as note 9.

18. This claim is a general one that we believe holds not just in the case of China but also quite transparently in advanced legal systems such as the United States and Canada.

19. R. Wang, "China's Response to SARS," *Temple Law Review* 77 (2004): p. 149.

20. Centers for Disease Control and Prevention, "Update on SARS Cases: United States and Worldwide, December 2003," *Morbidity & Mortality Weekly Report* 52 (2003): p. 1203.

21. J. Yardley, "After Its Epidemic Arrival, SARS Vanishes," *The New York Times*, May 15, 2005.

22. Wang (see note 19): p. 150.

23. J. Pomfret, "Outbreak Gave China's Hu an Opening," *The Washington Post*, May 13, 2003.

24. J. de Lisle, "Atypical Pneumonia and Ambivalent Law and Politics," *Temple Law Review* 77 (2004): p. 201.

25. Human Rights Watch, *Locked Doors: The Human Rights of People Living with HIV* (October 28, 2003): p. 7.

26. For example, H. Beech, "Shanghai has promised the WHO it will revise its diagnostic criteria for SARS. At issue: the real caseload," *Time Asia* (May 26, 2003) www.time.com/time/asia/magazine.

27. J. Sapsin, L. Gostin, J. Vernick, S. Burris, and S. Teret, "SARS and International Preparedness," *Temple Law Review* 77 (2004): p. 158.

28. WebMD Health, "SARS: Timeline of an Outbreak" (2003). Available at www.webmd.com.

29. de Lisle (see note 24): p. 193.

30. Wang (see note 19), 149–51 and Xinhua News Agency, "WHO Experts: China's SARS Surveillance Network Unique" (May 13, 2003) www.china.org.cn.

31. Xinhua News Agency "WHO Experts Praise Local Cooperation in Their Inspection to China's North Province", (June 23, 2003), www.china.org.cn.

32. Xinhua News Agency "Shanghai Vows to Sincerely Cooperate with WHO" (April 22, 2003), www.china.org.cn.

33. H. Beech & M. Forney, "Control Issues" *Time Asia* (May 5, 2003) www.time.com/time/asia/magazine and J. Gatehouse, "SARS: Fear and Loathing of Toronto", *Maclean's* (May 5, 2003), pp. 19–22.

34. Wang (see note 19), pp. 149–51.

35. Potter (see note 8), ch. 4.

36. Wang (see note 19): p. 150.

37. Sapsin et al. (see note 27), as well as M. Rothstein, M. Alcalde, N.

Elster, et al., *Quarantine and Isolation: Lessons Learned from SARS—A Report to the Centers for Disease Control and Prevention* (Louisville, KY: University of Louisville School of Medicine, 2003), and F. Gonzalez-Martin, "Quarantine in Severe Acute Respiratory Syndrome (SARS) and Other Emerging Infectious Diseases," *Journal of Law, Medicine & Ethics* 31/4 (2003): pp. S63–5.

38. See L. Jacobs, "Rights and Quarantine During the SARS Public Health Crisis: Differentiated Legal Consciousness in Hong Kong, Shanghai, and Toronto," *Law and Society Review* 41/3 (forthcoming 2007).

39. SARS Expert Committee, *SARS in Hong Kong: From Experience to Action* (Hong Kong: Special Administrative Region, 2003): p. 245.

40. *Shanghai Yearbook 2004* [Chinese text]. Available at www.shanghai.gov.cn/shanghai/node2314/node14926/node14931/index.html (last accessed February 12, 2006).

41. J. Ou, Q. Li, and G. Zeng, "Efficiency of Quarantine During an Epidemic of Severe Acute Respiratory Syndrome—Beijing, China 2003," *MMWR Morbidity and Mortality Weekly Report* 52 (2003): pp. 1037–40. See also Rothstein et al. (note 31).

42. Y. Liu, "China's Public Health-Care System: facing the challenges," *Bulletin of the World Health Organization* 82 (2004), pp. 532, and G. Henderson, "Increased Inequality in Health Care" in D. Davis & E. Vogel (eds.), *Chinese Society on the Eve of Tiananmen* (Cambridge MA: Council on East Asian Studies, 1990), p. 98.

43. World Health Organization, *Annual Report, 2000* (Geneva, Switzerland: 2001).

44. World Bank. *China: An Evaluation of World Bank Assistance* (Washington, D.C.: 2004).

45. This trend is part of a broader one that has characterized legal and governance change in China since 1979. See also note 8.

46. R. Bitran and W. Yip, *A Review of Health Care Provider Reform in Selected Countries in Asian and Latin America. World Bank Major Applied Research 2, Working Paper 1(1998)*. Available at www.worldbank.org/etools/dos/library/99169.

47. World Bank (see note 44).

48. V. Walford, "China Health Briefing Paper" (London, UK: Department for International Development Resource Centre for Health Sector Reform, 2000). Available at www.dfidhealthrc.org/shared/publication/country-health/china.pdf.

49. D. Blumenthal and W. Hsiao, "Privatization and Its Discontents: The Evolving Chinese Health Care System," *New England Journal of Medicine* 353 (2005): pp. 1165–70.

50. J. Watts, "Attitudes in Rehab," *The Guardian*, June 4, 2004.

51. J. Yardley, "China Announces Plan to Curb Rapid Spread of AIDS," *New York Times*, May 10, 2004.

52. M. Koss, "HIV/AIDS: China Stares Down Stigma," *Los Angeles Times*, July 11, 2004.

53. Yardley (see note 51).

54. PRC State Council, "Chinese National Medium- and Long-Term Strategic Plan for HIV/AIDS Prevention and Control" (November 12,

- 1998) and "China's Action Plan for Reducing and Preventing the Spread of HIV/AIDS (2001–2005)" (June 2001).
55. See R. Yang, "The Rapid Spread of AIDS Will Bring Disaster to China," *New China News Agency* (June 10, 2000); G. Yaojie, "My 'AIDS Prevention' Journey" (2000). Available at <http://www.aizhi.org/jkwz/journey.htm> (last accessed on April 30, 2005); and Human Rights Watch, "China: Release Health Official Jailed for AIDS Report" (October 27, 2003).
56. J. Li, "No Prejudice," *Beijing Review* (December 2, 2004): 2. See also J. Fa, "Facing the AIDS Crisis," *Beijing Review* (December 2, 2004): pp. 19–22; and note 42.
57. Y. Liu (see note 42), pp. 533–5, and T. Hu, "Financing and Organization of China's health care", *Bulletin of the World Health Organization* 82 (2004), p. 480.
58. Ministry of Health Communicable Disease Control Division, "China's Action Plan for reducing and Preventing the spread of HIV/AIDS (2001–2005)" (State Council Office Document 2001-40). Unofficial translation available at <http://www.uembassy-china.org.cn/sandt/AIDS-actionplantranslation.htm>.
59. I. Ding, "Pharmaceuticals: Price Cuts First Step to Reform: The latest round of pharmaceutical price cuts again highlights the need for wider reforms of the hospital system", *China International Business* (August 2005), pp. 46–7.
60. Ibid.
61. H. Jia, "A Tale of Two Crises: SARS vs. AIDS," *China Rights Forum* 3 (2003): pp. 56–63.