Colleen M. Flood / Aeyal Gross (Eds.), **The Right to Health at the Public/Private Divide. A Global Comparative Study,** Cambridge University Press, New York, 2014, 512 pages, $120.00 USD, ISBN: 9781107038301.

In *The Right to Health at the Public/Private Divide,* readers will find a sophisticated comparative study of the intersection between the right to health and health policy in a wide array of countries. This book, published by Cambridge University Press in 2014, provides a general overview of the opportunities and risks of promoting, protecting and enforcing the right to health in different types of health systems.

Colleen Flood and *Aeyal Gross* are the editors of this comparative – or global, as the authors prefer to call it – study of the interfaces between the right to health and health policy. *Flood*, an expert on comparative health care policy, was at the time of the publication of the book a professor of Law at the University of Toronto – she recently moved to the University of Ottawa. *Gross* is a professor of international and constitutional law at Tel Aviv University, and also teaches at the University of London (SOAS). The eighteen authors of the book's chapters are nationals of sixteen different countries, who are also recognized experts in the fields of health policy and right-to-health litigation.

Although readers are warned from the start – see the introductory study written by *Flood* and *Gross* – that the focus of the book is not on the social determinants of health, most chapters discuss the policy and regulatory determinants that led to the rise of litigation in their countries.

The first noteworthy aspect of the book is the sample of countries selected by the editors. Whereas most of these countries have ratified the International Covenant on Economic, Social and Cultural Rights and explicitly incorporated the right to health in their constitutions (India, South Africa, China, Brazil, among others), others have not (the United States being the most conspicuous example). Additionally, the selection of countries offers a representative sample of the most prevailing types of health systems in the world. Using the public/private divide as the guiding criterion, *Flood* and *Gross* cluster the book's case studies in four different types of health systems:

1) Public/tax-financed: countries where the state is the main provider/insurer of health care, and where the health system is financially supported by taxation revenues; 2) Managed competition: countries where the privatization of the insurance and delivery of health care system is the prevailing feature; (3) Social insurance: countries where the government actively regulates the participation of private companies as health insurers and deliverers; and 4) mixed private/public: countries where a private health system –usually focused on middle or high-income population – coexists with a public health system. (See Table 1)

Table 1: Comparative matrix of the book's health systems

Type of health system	**Some examples**[1]	**Main Features**
Public/Tax financed	Norway United Kingdom Canada New Zealand Costa Rica Sweden	The State monopolizes all or most of the health sector. The insurance and delivery of healthcare is financed via taxation. The participation of private companies in the health system is very limited.
Social Insurance Systems	Colombia Israel Netherlands Taiwan Hungary	The State regulates the health system, where private companies act as deliverers and insurers of health care. However, the government implements strict subsidy schemes to guarantee universal health-care coverage.
Managed care	Chile USA	The Health system operates under market-based schemes. Strong privatization of health care, aimed at maximizing efficiency. The state has a limited participation in the delivery and insurance of health care. The regulatory activity of the government is not as marked as in social insurance systems.
Mixed public/ private	India South Africa Brazil, Nigeria Venezuela China.	Coexistence of a public health system with strong schemes of pre-paid private healthcare. In most cases, the privatized health system offers better healthcare to middle and high-income citizens. The rest of the citizenry seeks health care at public or state-run facilities, which are usually underfinanced and provide health care services of lesser quality.

All the case studies included in the book suggest that the most contested issue among policymakers, scholars and activists is the role of the state vis a vis that of private companies in the delivery and insurance of healthcare. In Colombia, for instance, (see *Lamprea's* chapter in the book) several civil society organizations and medical associations decry the participation of private companies as health-care insurers and providers. Contrastingly, in Canada (See *Flood's* chapter) a network of interest groups has argued that the lack of participation of the private sector in the insurance of health care is not only unconstitutional, but also the main cause of the health system's dysfunctions – long waiting lists, declining quality of health services, low coverage in the hinterlands, etc.

All case studies share a common structure. Firstly, all chapters start with a description of the country's health system. Secondly, each chapter presents the constitutional and legal instruments that regulate access to health care. The remaining sections of the chapters analyze the main features of right-to-health litigation, and provide an interpretation of the institutional and regulatory determinants that incentivize patients to file lawsuits to obtain health-care treatments and drugs. Some of the topics discussed in these sections include the following: the rise of litigation of "uncovered", expensive and state-of-the-art treatments;

1 Not all the countries mentioned in this table are included as case-studies in the book.

the tension between public and private healthcare provision and out-of-pocket copayments; assessments of the consequences of the surge of right-to-health litigiousness.

Although this book is a timely contribution to the comparative literature located at the intersection between health policy and the right to health, three main shortcomings loom large after a detailed reading of the chapters and the introductory study.

Firstly, all the country studies included in the book cover a short period of time (usually starting in the 1990s or even in the 2000s), leaving aside the historical determinants of health care reform and right-to-health litigation. This "snapshot" approach leaves unexplained how the long-time transformations of health and welfare systems may have influenced different trends of right-to-health litigation. All the book's contributors discuss post-Washington Consensus health reforms, ignoring possible path-dependent social security trends that predate the 1990s and 2000s critical junctures. This feature of the book is also shared by comparable publications such as 'Litigating Health Rights'[2] and 'Courting Social Justice'[3], two books that explore the rise of right-to-health litigation in the global south but fail to incorporate a historical-sensitive approach. One of the effects of the short-period purview of these three books is that they are unable to engage with the influential literature that explores the historical roots of social security systems (for example, the literature pioneered by books like *Esping-Andersen's* 'The Three Worlds of Welfare Capitalism' or the work on the welfare state by *Adam Przeworski*).

Secondly, some case-studies respond to an odd case-selection rationale. Venezuela, a country with virtually no right-to-health litigation, is included as a Latin American case, but Costa Rica, a country with a rich history of right-to-health litigation and health-care reform, is flatly ignored. The editors fail to explain why, for instance, Sweden is included, but not Norway or Denmark. Countries like Germany, whose constitutional precedent on the right to health has been widely influential around the world, not only is excluded from the case studies but is not even mentioned in the introductory study. Furthermore, in some chapters – such as the one devoted to the UK –the authors are at odds to explain why their particular countries are interesting case studies, insofar as right-to-health litigation is scarce or the right to health is not an important part of the judicial precedent.

Thirdly, although the editors tried to imprint a common structure to all chapters, there is a marked asymmetry between case studies. Whereas some country studies provide rich and multilayered renditions of the legal and policy context of the right to health, other chapters are limited to a bare-bones description of laws and regulations. Furthermore, whereas some case studies try to explore the underlying institutional variables that are driving right-to-health litigation in their countries, others are confined to a mere descriptive stage.

2 *A. Yamin and S. Gloppeni* (Eds.), Litigating Health Rights: Can Courts Bring More Justice to Health?, Cambridge 2011.

3 *V. Gauri and D.M. Brinks*, Courting Social Justice: Judicial Enforcement of Social and Economic Rights in the Developing World, Cambridge 2008.

However, *'The Right to Health at the Public/Private Divide'* stands apart from the two other books that have tried to tackle right-to-health litigation. On the one hand, unlike 'Litigating Health Rights' and 'Courting Social Justice'*, 'The Right to Health at the Public/Private Divide'* takes health policy seriously. In other words, *Flood* and *Gross'* book provides a thorough discussion of why some types of health systems seem more conducive to right-to-health litigation than others. In a stark contrast with 'Litigating Health Rights', limited to a superficial description of health care systems, *'The Right to Health at the Public/Private Divide'* succeeds in incorporating a more thorough discussion of global and comparative health policy into the discussions of right-to-health litigation. Additionally, 'Litigating Health Rights' and 'Courting Social Justice' include country studies limited to the "usual suspects" in the social rights, global south literature – Brazil, India, South Africa, Colombia – leaving aside highly interesting cases like China, Hungary or the United States. This effort to incorporate a wider array of countries – both developed and underdeveloped – bears fruit in the book's introductory study, where the editors are able to cast a wider comparative net than in the cases of 'Litigating Health Rights' and 'Courting Social Justice'.

For all to the abovementioned reasons *'The Right to Health at the Public/Private Divide'* is an important academic contribution that should reach a broad spectrum of audiences, including legal comparative scholars and lawyers, law and development experts and public health professionals.

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