

Patients Without Borders: The Emerging Global Market for Patients and the Evolution of Modern Health Care

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INTRODUCTION

A growing number of patients are leaving the United States for medical care. They are traveling to developing countries like India and Thailand for a variety of sophisticated treatments, such as heart surgeries, joint replacements, and fertility treatments. In the process, they are choosing to forego the legal and regulatory protections—and perhaps even insurance coverage—they receive in the United States. Essentially, patients are waiving the rights, benefits, and protections offered by our health care regulatory system to seek medical care in countries that may not grant them remotely similar rights or protections.

“Medical tourism” is the latest response to a familiar trend. Each year, the United States spends more on health care, but insures fewer people. Health care spending is predicted to account for one of every five dollars spent in the United States by 2015,¹ and the United States by itself spends roughly half of the \$4 trillion spent on health

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1. U.S. health care spending rose from 9% of gross domestic product (GDP) in 1980 to 16% in 2004. The United States spent \$255 billion in 1980, \$1.9 trillion in 2004, and is expected to spend over \$4 trillion per year by 2016. NAT'L HEALTH STATISTICS GROUP, CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS) ET AL., Tbl. 1, *National Health Expenditures Aggregate and Per Capita Amounts, Percent Distribution, and Average Annual Percent Growth, by Source of Funds: Selected Calendar Years 1960–2004*, available at <http://www.cms.hhs.gov/NationalHealthExpendData/downloads/tables.pdf>; see also CMS, available at <http://www.cms.hhs.gov/NationalHealthExpendData/downloads/proj2006.pdf>.

care each year worldwide.² Meanwhile, nearly 47 million Americans had no health insurance in 2005, up from 31 million in 1987.³ The Institute of Medicine recently estimated that 18,000 uninsured adults in the United States die each year from treatable conditions.⁴

In the face of this widening gap, U.S. patients are beginning to leave our health care system, joining a growing international population of patients that are seeking medical treatments outside of their own countries. With consensus growing that this trend may transform the health care systems in both developed and developing countries,⁵ more and more patients—as well as a growing number of employers and insurers—are exploring opportunities to reduce spending by using foreign health care providers.⁶

2. The World Bank estimated that global health spending was \$3.2 trillion in 2002. PABLO GOTTFRET & GEORGE SCHIEBER, WORLD BANK, HEALTH FINANCE REVISITED: A PRACTITIONER'S GUIDE 3 (2006), <http://siteresources.worldbank.org/INTHSD/Resources/topics/Health-Financing/HFRFull.pdf>. Current estimates surpass \$4 trillion. See Christine Borger, Sheila Smith, Christopher Truffer, Sean Keehan, Andrea Sisko, John Poisal & M. Kent Clemens, *Health Spending Projections Through 2015: Changes on the Horizon*, 25 HEALTH AFF. W61 (2006) (Web exclusive), <http://content.healthaffairs.org/cgi/reprint/25/2/w61>; Rupa Chanda, *Trade in Health Services* 1 (Comm'n on Macroeconomics and Health, World Health Org., Working Paper Series, Paper No. WG 4:5, 2001).

3. This represented a rise from 12.9% of the population in 1987 to 15.9% in 2005. CARMEN DENAVAS-WALT, BERNADETTE D. PROCTOR & CHERYL HILL LEE, U.S. CENSUS BUREAU, INCOME, POVERTY, AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2005, at 20, 23 (Aug. 2006), <http://www.census.gov/prod/2006pubs/p60-231.pdf>.

4. INSTITUTE OF MEDICINE OF THE NATIONAL ACADEMIES, INSURING AMERICA'S HEALTH: PRINCIPLES AND RECOMMENDATIONS 8 (2004); INSTITUTE OF MEDICINE OF THE NATIONAL ACADEMIES, CARE WITHOUT COVERAGE: TOO LITTLE, TOO LATE 165 (2002); Aaditya Mattoo & Randeep Rathindran, *Does Health Insurance Impede Trade in Health Care Services?* 2 (World Bank, Policy Research, Working Paper No. 3667, 2005).

5. The World Trade Organization (WTO), World Health Organization (WHO), World Bank, and U.S. Senate all have studied the potential impact of medical tourism. The WTO sees medical tourism as a way to ameliorate the global supply-demand imbalance in health care. See WTO AGREEMENTS AND PUBLIC HEALTH: A JOINT STUDY BY THE WHO AND WTO SECRETARIAT 111–124 (2002), http://www.wto.org/english/res_e/booksp_e/who_wto_e.pdf; G.V.R.K. Acharyulu & B. Krishna Reddy, *Hospital Logistics Strategy for Medical Tourism* 6, 14 (paper presented at the Int'l Conf. on Logistics, Queensland Univ. of Tech., Brisbane, Australia, June 10–11, 2004) (unpublished manuscript on file with the *Indiana Law Journal*). The WHO predicts medical tourism will grow with developed countries facing rising health care costs and aging populations. See Chanda, *supra* note 2, at 7. The World Bank found that the United States could save \$1.4 billion if only 10% of patients who needed one of 15 medical procedures traveled abroad. See Mattoo & Rathindran, *supra* note 4, at 3. The U.S. Senate recently held hearings to discuss whether medical tourism can reduce health care spending. *The Globalization of Health Care: Can Medical Tourism Reduce Health Care Costs?: Hearing Before the Senate Special Committee on Aging*, 109th Cong. (2006) [hereinafter *Senate Hearing*].

6. *Senate Hearing*, *supra* note 5 (statement of Arnold Milstein, Chief Physician, Mercer Health & Benefits, Medical Director, Pacific Business Group on Health). Dr. Milstein testified that several large American employers have asked him to “assess the feasibility of using technologically advanced hospitals in lower wage countries to provide non-urgent major surgeries for their self-insured health benefits plans serving U.S. residents.” *Id.*

We are just beginning to understand the contours of this critical phenomenon. Research on medical tourism is sparse,⁷ and there are many avenues for further research.⁸ We lack reliable, internationally comparable data,⁹ even as to such basic information as the volume and value of the broader trade in health services that encompasses medical tourism.¹⁰ More fundamentally, we need to standardize the concepts and definitions before we can collect such data.¹¹

To complicate matters further, though many policy organizations are aware of this trend, it is developing almost entirely independently of lawmakers and regulators. This is more than a little troubling for a phenomenon that confronts us with such profound legal and policy questions. It is not simply a matter of patients seeking less expensive medical care elsewhere; patients are opting out of our health care system and the delicate equilibrium of policy choices that it represents. For example, our health care financing system reflects who we think should pay for health care and how much. Our systems for licensing, accreditation, malpractice, and regulatory approval of medical technologies reflect the quality standards we desire. Our public and private health insurance systems reflect the risks we can tolerate.

By choosing other health care systems, patients force us to reevaluate the policy equilibria we have set. Medical tourism compels us to think more broadly about how globalization may alter our health policy calculations, and even the underlying principles upon which we calculate. For such a long time, health care has been “peculiarly and tenaciously local in its character.”¹² But for a growing number of patients, this is no longer the case.

This article is a first comprehensive look at medical tourism in a domestic policymaking context.¹³ In it, I analyze the risks and opportunities medical tourism

7. For the earliest discussions that focus on medical tourism (as opposed to merely reproductive tourism), see Chanda, *supra* note 2; Joan C. Henderson, *Healthcare Tourism in Southeast Asia*, 7 TOURISM REV. INT’L 111 (2004); Michael Klaus, *Outsourcing Vital Operations: What If U.S. Health Care Costs Drive Patients Overseas for Surgery?*, 9 QUINNIPIAC HEALTH L.J. 219 (2006); Mattoo & Rathindran, *supra* note 4.

8. Henderson, *supra* note 7, at 119.

9. Chanda, *supra* note 2, at 12. In reviewing the literature on the trade in health services, Richard Smith concludes that there are “considerable [knowledge] gaps” in our understanding of the global health services market, and that “[m]ost of the literature is ‘data free,’ based on theory, assumption or conjecture.” Richard D. Smith, *Foreign Direct Investment and Trade in Health Services: A Review of the Literature*, 59 SOC. SCI. & MED. 2313, 2317 (2004) (paper funded by the WHO). Smith recommends that “the academic sector, international organizations and individual countries undertake to give priority to such research.” *Id.* at 2320.

10. Chanda, *supra* note 2, at 12–13. Chanda suggests the dearth of data may be due to the relatively small (but growing) global trade in health care, the difficulty of capturing these transactions, and the traditional perception elsewhere in the world that health services are not truly commercial. *See id.* at 13–14 n.11.

11. Henderson, *supra* note 7, at 19.

12. Timothy S. Jost, *Comparative and International Health Law*, 14 HEALTHMATRIX 141, 141 (2004).

13. Michael Klaus describes medical tourism in a narrower context, focusing on Asia and the potential problems medical tourism presents without setting forth policy recommendations. *See* Klaus, *supra* note 7. Nicolas Terry looks at medical tourism and outsourcing in the health care industry, but dismisses potential efforts to regulate these markets in a flattening world. *See*

presents within the three canonical themes of health care: cost, quality, and access. I also propose ways for the United States and other countries—acting both alone and in concert—to minimize the risks and seize the opportunities created by this emerging global market.

I begin in Part I by analyzing the many reasons why patients travel abroad for medical care. Several factors are increasing the supply of and demand for foreign care. On the demand side, some patients travel because they do not have access to a particular treatment, whether because their government has judged that it is immoral or too experimental; because of domestic limitations in technology, training, or infrastructure; or because of long waiting lists. Many others travel simply because they cannot afford a particular procedure in their own country. On the supply side, several developing countries have dramatically improved the quality of care they can offer. This growing supply is able to meet the increased demand in substantial part because of the Internet, which enables foreign providers to contact patients and signal their credentials. The last section of Part II describes the “anatomy” of the resulting market, where I survey the countries patients visit, the procedures they seek, and the efforts to attract foreign patients.

In Part II, I analyze the risks and opportunities medical tourism presents by discussing how it may affect health care costs, quality, and access in the United States and in developing countries. First, I discuss how the enormous potential cost savings will create overwhelming incentives to make health insurance portable. Drawing on case studies from the European Union (EU) and the TRICARE managed care program for U.S. military personnel, I explain how portable health insurance is likely to look in practice, including the market mechanisms that are likely to arise to mitigate moral hazard, monitor fraud and abuse, and encourage quality care.

Second, I address the quality of foreign care, a matter of much debate. I show that even if patients visit foreign hospitals and physicians that possess U.S. credentials, there are structural aspects of medical tourism that raise quality concerns. Traveling itself poses risks. Domestic regulators cannot control the quality of foreign medical care. Poor countries may be tempted to provide treatments that are illegal or highly experimental in most countries.¹⁴ And developing countries may not adequately protect foreign patients from medical malpractice. All these concerns inform the policy responses that I consider in Part III.

Third, I address how medical tourism may affect access to medical care in the United States and in developing countries. Although some object that medical tourism exacerbates unequal access to medical care, I show how medical tourism may improve access to care for two significant U.S. populations: employed persons that are uninsured, and those that are underinsured. I argue that our chief concern should be whether outsourcing expensive surgeries will deprive U.S. hospitals of revenue they might use to cross-subsidize care for the poor. I then address the related debate in developing countries that the campaign to attract foreign patients might divert resources from public hospitals that treat local citizens to private hospitals that cater to foreign clientele.¹⁵ I argue that developing countries can alleviate the problem by using revenues from foreign patients to cross-subsidize public health care for local citizens,

Nicolas P. Terry, *Under-Regulated Healthcare Phenomena in a Flat World: Medical Tourism and Outsourcing*, 29 W. NEW ENG. L. REV. 421 (2007) (Health Law Symposium Issue).

14. Henderson, *supra* note 7, at 116.

15. See Mattoo & Rathindran, *supra* note 4, at 26; Chanda, *supra* note 2, at 17.

and can use other tools to discourage an internal “brain drain” from public hospitals.¹⁶ The net impact of medical tourism in developing countries depends, in large part, on how these countries choose to allocate revenues from foreign patients.

I conclude Part II by addressing how medical tourism improves patient autonomy. Some argue that medical tourism allows wealthier patients to escape the rules imposed by society and breach a social contract with our health care system. I argue that these valid concerns are counterbalanced both by considerations of equity as between medical tourists and citizens in other countries, and by the autonomy interests of individual patients.

In Part III, I analyze several potential policy responses to medical tourism. I begin by discussing unilateral approaches, such as regulating travel, referral networks, and insurers, and providing agency oversight. Analyzing previous regulatory efforts in analogous areas, I criticize some responses as either impractical or foreclosed by current constitutional doctrine governing the right to travel and the right to free speech. Instead, I propose that we build on existing consumer protection laws, expand licensing systems, and recalibrate existing schemes that may unfairly allocate the risks and benefits in order to address the evils that are actually threatened by medical tourism.

I conclude Part III by addressing multilateral approaches to regulating medical tourism—a tactic that is essential given the inherent limits of regulating a global market unilaterally. I propose ways for the United States to guide the market by cooperating with other countries to harmonize insurance standards, quality standards, physician licensing, and hospital accreditation. I also explain the role regional trade agreements may play in controlling the market, and the limits to multilateral regulation and enforcement.

Together, these unilateral and multilateral policies should make the market for foreign patients more transparent, and should reallocate the risks and benefits of these transactions to better protect U.S. patients and payors.

In its complexity, in its risks, and in its tremendous potential to benefit health care systems both here and abroad, medical tourism foreshadows many of the issues we will have to confront as health care continues to globalize. The policies I propose are aimed to bring balance, more broadly, to the international health services trade: balance between the risks and benefits; balance between free market solutions and government intervention; balance between patient autonomy and governments’ legitimate interests in enforcing their laws; and balance between the interests of developed and developing countries with different health care systems.

The value, I hope, in tackling this diverse set of questions in a single article, rather than through separate discussions, is to demonstrate the holistic approach we must take when responding to new developments in health care. This article is thus intended to serve as a framework for understanding this complicated issue, sketching out avenues for further research, and identifying the key issues regulators will face as this emerging phenomenon continues to grow. There is much more to be done.

16. See Chanda, *supra* note 2, at 46.

I. THE EMERGING GLOBAL MARKET FOR PATIENTS

“Medical tourism” is not entirely new. Bartha Knoppers and Sonia LeBris coined the term “procreative tourism” in 1991 to describe the practice of patients exercising “their personal reproductive choices in other less restrictive states.”¹⁷ Moreover, foreign citizens have sought medical care in the United States and other countries with advanced medicine for decades. For example, California has been a popular worldwide destination for reproductive tourists because it offers advanced technology, medical expertise, and relatively permissive fertility laws.¹⁸ In this article, I use “medical tourism” to denote “travel across jurisdictions for medical care.” Even though this definition technically encompasses interstate travel within the United States, this article focuses on international travel, including travel between EU member states.

Medical tourism has exploded in recent years, aided by globalization in the health services industry. But globalization has only recently permeated health care.¹⁹ Traditionally, geographic, economic, and cultural barriers have made health care stubbornly local. Gradually, countries have opened their borders.²⁰ Now there are thriving international markets for health care professionals,²¹ telemedicine,²² medical technology,²³ and drugs.²⁴ More recently, the U.S. health care industry has started outsourcing a number of related tasks, including insurance claim processing, medical reporting, clinical trials, and diagnostic test interpretations.²⁵ The latest and perhaps most important segment to succumb to globalization is the market for patients. In 2003, an estimated 350,000 patients from various countries traveled to Cuba, India, Jordan, Malaysia, Singapore, and Thailand for medical care.²⁶ In 2005, over 55,000 Americans visited Bumrungrad Hospital in Bangkok for medical care.²⁷ In India alone, the

17. Bartha M. Knoppers & Sonia LeBris, *Recent Advances in Medically Assisted Conception: Legal, Ethical, and Social Issues*, 17 AM. J.L. & MED. 329, 333 (1991).

18. See Debora Spar, *Reproductive Tourism and the Regulatory Map*, 352 NEW ENG. J. MED. 531, 532 (2005); Alex Barnum, *For Infertile Couples, It's California or Bust: State Has Become Major Destination for Making Babies*, S.F. CHRON., Aug. 15, 2005, at A1.

19. Terry, *supra* note 13.

20. See, e.g., Timothy S. Jost, *The Globalization of Health Law: The Case of Permissibility of Placebo-Based Research*, 26 AM. J.L. & MED. 175 (2000).

21. See, e.g., Chanda, *supra* note 2, at 9–12; Graham T. McMahon, *Coming to America—International Medical Graduates in the United States*, 350 NEW ENG. J. MED. 2435 (2004); Fitzhugh Mullan, *Doctors for the World: Indian Physician Emigration*, 25 HEALTH AFF. 380 (2006).

22. See Thomas R. McLean, *The Offshoring of American Medicine: Scope, Economic Issues and Legal Liabilities*, 14 ANNALS HEALTH L. 205 (2005).

23. See Vladimir K. Lepakhin, *Foreword to WORLD HEALTH ORG., MEDICAL DEVICE REGULATIONS: GLOBAL OVERVIEW AND GUIDING PRINCIPLES*, at v (2003), http://www.who.int/medical_devices/publications/en/MD_Regulations.pdf.

24. See IMS Health Inc., *IMS Health Reports Global Pharmaceutical Market Grew 7 Percent in 2005, to \$602 Billion*, Mar. 21, 2006, http://www.imshealth.com/ims/portal/front/articleC/0,2777,6599_3665_77491316,00.html.

25. See McLean, *supra* note 22; Chanda, *supra* note 2.

26. Mattoo & Rathindran, *supra* note 4, at 2.

27. Unmesh Kher, *Outsourcing Your Heart*, TIME, May 21, 2006, available at <http://www.time.com/time/magazine/article/0,9171,1196429-1,00.html>.

number of medical tourists visiting the country tripled between 2002 and 2005, and is expected to rise by 600% over the next few years.²⁸

The following three sections describe the medical tourism phenomenon in detail, including the reasons patients are traveling for medical care, the recent trends facilitating medical tourism, and the “anatomy” of the market.

A. Why Do Patients Travel Abroad for Medical Care?

Patients generally seek medical care abroad for one of two reasons: either they do not have access to a particular treatment, or they cannot afford it, in their own country.²⁹

1. Access to Medical Procedures

Historically, patients have traveled overseas when a particular medical treatment is not available where they live. First, local laws may prohibit a medical procedure as immoral or unethical, which occurs most often with reproductive medicine. For example, patients in Europe flock to Belgium and Italy for in vitro fertilization (IVF) treatments because these two countries “have no or very little legislation concerning medically assisted reproduction.”³⁰ Many patients visit from France, Germany, or the Netherlands, whose governments impose various restrictions on IVF treatments.³¹ Every year, 7,000 women from Ireland travel to England for abortions because abortion is illegal in Ireland.³² In the United States, we can imagine women seeking abortions in Canada if the Supreme Court overturned *Roe v. Wade*.³³ Thus, restrictive laws can encourage patients to travel to more permissive jurisdictions.

Second, certain treatments may not be available when they have not been approved by regulators. In the United States, the Food and Drug Administration (FDA) must approve most medical technologies before they can be marketed.³⁴ Many believe that a strict, lengthy FDA approval process delays the availability of cutting-edge medical

28. See Linda F. Powers, *Leveraging Medical Tourism*, THE SCIENTIST, Mar. 2006, at 79.

29. See Chanda, *supra* note 2, at 6; Henderson, *supra* note 7, at 113; Guido Pennings, *Reproductive Tourism as Moral Pluralism in Motion*, 28 J. MED. ETHICS 337, 338 (2002).

30. Pennings, *supra* note 29, at 338.

31. *Id.* at 337. For example, France prohibits the use of fresh oocytes, which requires couples to use frozen embryos that are generally less effective. Germany prohibits both oocyte donations and IVF treatments with donated sperm. And the Netherlands imposes an age limit on IVF recipients and does not allow the use of surgically-obtained sperm. *Id.*

32. Abortion in Ireland has always been illegal under statutory and common law, and is now illegal per constitutional amendment. See Bryan Mercurio, *Abortion in Ireland: An Analysis of the Legal Transformation Resulting from Membership in the European Union*, 11 TUL. J. INT'L & COMP. L. 141, 143–47 (2003); Ellen Goodman, *Traveling for Choice in Ireland*, TIMES UNION (Albany, NY), Apr. 30, 2002, at A11 (“Ireland has the most regressive abortion laws in the European Union.”).

33. 410 U.S. 113 (1973); see Seth F. Kreimer, “*But Whoever Treasures Freedom . . .*”: *The Right to Travel and Extraterritorial Abortions*, 91 MICH. L. REV. 907 (1993).

34. See Federal Food, Drug, and Cosmetic Act, 21 U.S.C. §§ 505, 513, 515; 21 U.S.C. §§ 355, 360c, 360e (2000) (requiring FDA approval before marketing new drugs and devices, respectively).

technologies that are widely used overseas.³⁵ American patients obtained a hip resurfacing surgery in Europe, Asia, and India that FDA had not approved until recently.³⁶ Patients are keenly aware that foreign regulators have approved certain procedures that FDA has not. A patient that traveled to India for heart surgery testified to the U.S. Senate that “[p]rocedures are often available in developing countries years before the FDA approves them in the U.S.”³⁷ Whether it is wise or not, patients travel overseas for procedures that have not been approved by their domestic regulators.

Third, even in the absence of restrictive laws or regulations, non-governmental actors may ban certain medical procedures not as a matter of law, but as a matter of fact. Physicians, hospitals, and particularly insurers can decide to make a procedure unavailable.³⁸ For example, in countries that do not legislate reproductive treatments, “each doctor and clinic decides autonomously whether to provide a certain type of treatment and whether to offer a service to a certain type of patient.”³⁹ In Mississippi, only one clinic is willing to perform abortions, even though decisions by the U.S. Supreme Court currently prohibit states from banning all abortion procedures outright.⁴⁰ Perhaps more common is where a health insurer refuses to cover a particular treatment, whether because the insurer deems the procedure to be immoral, experimental (despite FDA approval), or not worth the expense compared to more established treatments. Thus, an insurer’s decision to not cover a particular fertility treatment could lead those with insurance to travel overseas. The absence of laws and regulations leaves a void that non-governmental actors can fill at their discretion. Their decisions may drive patients to forum shop.⁴¹

35. See, e.g., Diana M. Ernst, *Medical Tourism: Why Americans Take Medical Vacations Abroad*, 4 PAC. RES. INST. 1, 1 (Sept. 2006), http://www.pacificresearch.org/pub/hpp/2006/hppv4n9_0906.pdf.

36. See, e.g., Jean P. Fisher, *Hip Patients Find Surgeons Overseas: Delay in FDA Approval for Hip Resurfacing Means Lost Opportunity at Duke*, NEWS & OBSERVER (Raleigh, NC), Apr. 10, 2006, at A1; *60 Minutes: Vacation, Adventure, and Surgery?: Elective Surgeries By World-Class Doctors At Third-World Prices* (CBS television broadcast Sept. 4, 2005), <http://www.cbsnews.com/stories/2005/04/21/60minutes/printable689998.shtml>. In May 2006, FDA finally approved a device manufacturer’s application for a hip resurfacing system. See Premarket Approval Application Letter from FDA to Smith & Nephew Orthopaedics (May 9, 2006), <http://www.fda.gov/cdrh/pdf4/p040033a.pdf>.

37. *Senate Hearing*, *supra* note 5 (statement of Maggi Ann Grace).

38. See Pennings, *supra* note 29, at 337.

39. *Id.*

40. E.g., Kay McFadden, *Frontline’s “The Last Abortion Clinic” Is Primer on the Erosion of Roe v. Wade*, SEATTLE TIMES, Nov. 7, 2005, at E1 (discussing the Public Broadcasting Service’s (PBS’s) profile of the last abortion clinic in Mississippi); *Frontline: The Last Abortion Clinic* (PBS television broadcast Nov. 8, 2005), <http://www.pbs.org/wgbh/pages/frontline/clinic/etc/synopsis.html> (reporting that 87% of U.S. counties did not have an abortion provider in 2000). Forty-seven states and the District of Columbia have laws that allow health care providers and entities to refuse to provide abortions and other “reproductive health services.” See Courtney Miller, Note, *Reflections on Protecting Conscience for Health Care Providers: A Call for More Inclusive Statutory Protection in Light of Constitutional Considerations*, 15 S. CAL. REV. L. & WOMEN’S STUD. 327, 329 n.9 (2006).

41. Linda Nielsen, *From Bioethics to Biolaw*, in A LEGAL FRAMEWORK FOR BIOETHICS 39, 40 (Cosimo M. Mazzoni ed., 1998) (“[A] ban in one country may lead to people going to other less restrictive countries to obtain what they cannot have back home. This kind of forum

Fourth, certain procedures may be unavailable in certain countries that lack the requisite medical technology, expertise, or infrastructure. For example, patients from Bolivia, Peru, and Ecuador travel to Chile for its superior medical care.⁴² Indian hospitals attract 50,000 patients each year from Bangladesh.⁴³ Jordanian hospitals attract medical tourists from Yemen, Sudan, Libya, Algeria, Tunisia, and Iraq.⁴⁴ Since the 1970s, the EU recognized that some member states may have medical capabilities that other states lack,⁴⁵ and has required states to permit their citizens to travel to other states for medical care when the treatment cannot be given domestically in a medically appropriate timeframe.⁴⁶ Thus, variations in medical sophistication between countries can encourage medical tourism.

Finally, foreign doctors provide an outlet to patients in countries with socialized medicine that may have to wait several months for certain medical treatments. In the United Kingdom in 2004, the National Health Service (NHS) expected 41,000 patients to wait at least six months for various surgeries.⁴⁷ In response, the NHS began sending patients to France, Spain, and Germany for orthopedic, eye, and other surgeries.⁴⁸ As noted above, EU regulations require member states to reimburse for the medical treatments their citizens receive in other states if there is an “undue delay” in the patient’s home country, given the patient’s medical condition.⁴⁹ Based on these regulations, the European Court of Justice recently required the NHS to reimburse a U.K. resident for a hip replacement she obtained in France, even though she failed to obtain prior authorization from the NHS.⁵⁰ Thus, patients in countries with socialized medicine may travel to bypass long waiting lists.

2. Cost Discrepancies

Although most patients have traveled overseas for procedures that were not available, for one reason or another, where they resided, a new breed of patients is traveling to take advantage of the significant cost discrepancies between countries.⁵¹ In effect, these patients are engaging in international health care arbitrage.

shopping is seen among others in the area of assisted reproduction—sometimes called ‘procreative tourism.’”).

42. Chanda, *supra* note 2, at 49.

43. *Id.* at 43.

44. Mattoo & Rathindran, *supra* note 4, at 12.

45. Katrien Kesteloot, Sabrina Pocceschi, & Emmanuel van der Schueren, *The Reimbursement of the Expenses for Medical Treatment Received by “Transnational” Patients in EU-Countries*, 33 HEALTH POL’Y 43, 45 (1995).

46. *Id.* (citing Council Regulation (EEU) No. 1408/71 of the Council of June 14, 1971 and No. 574/72 of the Council of March 21, 1972, and subsequent amendments).

47. Mattoo & Rathindran, *supra* note 4, at 12 (citing data from the U.K. Dep’t of Health, <http://www.performance.doh.gov.uk/waitingtimes/index.htm>).

48. *Id.*

49. See Council Regulation 1408/71, art. 22, 1971 O.J. (L 149) 1; see generally Council Reg. 574/72, 1972 O.J. (L 74) 1 (the implementing regulation for 1408/71); Kesteloot et al., *supra* note 45, at 45.

50. Case 372/04, *The Queen (on the Application of Yvonne Watts) v. Bedford Primary Care Trust*, 2006 O.J. (C 165) 6; see Mattoo & Rathindran, *supra* note 4, at 6.

51. See Arnold Milstein & Mark Smith, *Will the Surgical World Become Flat?: Americans’ Seeking Cheaper Surgical Procedures Abroad Will Provide Only Modest Relief from Our Spreading Affordability Problem*, 26 HEALTH AFF. 137 (2007); Stuart H. Altman, David

Unsurprisingly, Americans can easily find less expensive medical care overseas. A World Bank study found that the costs of health care and insurance “are significantly higher in the U.S. than in a number of other countries.”⁵² We spend far more on health care than even our peer countries.⁵³ In 2000, we spent 44% more per capita on health care than the next highest spending country, Switzerland.⁵⁴ That year, we spent 13% of our GDP on health care, significantly higher than Australia (8.3%), Canada (9.1%), Japan (7.8%), and the United Kingdom (7.3%).⁵⁵

These discrepancies are driven in substantial part by the cost of individual medical procedures. For example, the World Bank found that inpatient knee surgery costs over \$10,000 on average in the United States, but is only \$1,500 at the top hospitals in Hungary and India.⁵⁶ A coronary artery bypass graft costs over \$35,000 in the United States but is less than \$9,000 (including travel expenses) at the top hospitals in India and Thailand.⁵⁷ The WHO found that the cost of medical treatment in developing countries such as India can be 3–10% of the cost in the United States.⁵⁸

The World Bank compared the costs of the most common surgical procedures in the United States and in 20 developing countries.⁵⁹ The authors used several criteria to identify medical procedures that patients could easily obtain overseas.⁶⁰ For example, they searched for low-risk, non-emergency treatments with quick recovery periods.⁶¹ The authors applied these criteria to a list of 230 of the most commonly performed surgeries in U.S. hospitals and compared the mean and median prices for fifteen procedures in twenty countries.⁶² Factoring in the cost of round-trip airfare, the World Bank concluded that the United States could save \$1.4 billion if only 10% of patients

Shactman & Efrat Eilat, *Could U.S. Hospitals Go the Way of U.S. Airlines?: Hospital Market Changes such as Price Transparency and Specialization Could Have Severe Negative Consequences*, 25 HEALTH AFF. 11, 18 (2006).

52. Mattoo & Rathindran, *supra* note 4, at 2 (stating that the World Bank uses 2002 hospital reimbursement data from Centers for Medicare and Medicaid Services (CMS) and data from select foreign hospitals, e.g., the Apollo Hospital in Delhi).

53. See Gerard F. Anderson, Uwe E. Reinhardt, Peter S. Hussey & Varduhl Petrosyan, *It's the Prices Stupid: Why the United States Is So Different from Other Countries*, 22 HEALTH AFF. 89, 91 (2003) (comparing the health care spending of countries in the Organization for Economic Cooperation and Development (OECD)).

54. *Id.* at 90–91 (showing that the United States spent \$4,631 per capita on health care compared to Switzerland's per capita spending of \$3,222, using “Purchasing Power Parities” (PPPs), a currency conversion metric based on U.S. dollars).

55. *Id.* at 91.

56. Mattoo & Rathindran, *supra* note 4, at 2.

57. *Id.* at 2 n.3.

58. Chanda, *supra* note 2, at 65.

59. Mattoo & Rathindran, *supra* note 4.

60. *Id.* at 16. The World Bank chose surgeries that: (i) treat a non-emergency condition; (ii) allow the patient to travel without significant pain or inconvenience; (iii) are fairly simple and commonly performed with low rates of post-operative complications; (iv) require minimal follow-up treatment on-site; (v) generate minimal laboratory and pathology reports; and (vi) result in minimal post-operative immobility.

61. *Id.*

62. *Id.* at 16–18. The World Bank calculated U.S. prices using data from CMS and the Health Care Cost and Utilization Project Nationwide Inpatient Sample database, and calculated foreign prices by using data from Vanbreda International, a firm that tracks international prices.

traveled for these fifteen procedures.⁶³ Half of these savings (\$690 million per year) would accrue to the Medicare program.⁶⁴

So why does health care cost so much more in the United States? There is no single answer.⁶⁵ We are enamored with expensive new drugs, devices, and procedures.⁶⁶ We have a steadily aging population, though European populations are older and spend much less on health care.⁶⁷ We are notorious for our medical malpractice system, but malpractice accounts for less than 2% of our overall health care costs,⁶⁸ and awards are markedly higher in Canada and Britain.⁶⁹ The most powerful explanation may be labor costs.⁷⁰ We pay health care professionals more than any other Organization for Economic Cooperation and Development (OECD) country.⁷¹ According to the primary U.S. agency responsible for health care financing, the Centers for Medicare and Medicaid Services (CMS), nearly 70% of inpatient hospital costs are labor-related.⁷² Thus, countries with lower labor costs logically can offer medical care at significantly lower prices.⁷³

Our demand for less expensive medical care only increases as more Americans lose insurance coverage.⁷⁴ Currently, nearly forty-seven million Americans are uninsured,⁷⁵ over eight million of whom are in households that earn \$75,000 or more per year.⁷⁶ In 2002 and 2003, nearly eighty-two million non-elderly Americans were uninsured at some point, representing one-third of that population.⁷⁷ For many patients, treatment overseas is the best option, and for some patients, it is the only option. A medical

63. *Id.* at 19–20.

64. *Id.* at 19 (finding that the savings would jump to \$2 billion by adding just one procedure to the calculation—coronary artery bypass grafts).

65. *See, e.g.*, Timothy S. Jost, *Our Broken Health Care System and How to Fix It: An Essay on Health Law and Policy*, 41 WAKE FOREST L. REV. 537 (2006); Anderson et al., *supra* note 53, at 89.

66. *See* Jost, *supra* note 65, at 547.

67. *Id.* at 548.

68. *Id.* (“Medical malpractice litigation is far more extensive and expensive in the United States than in other countries, though the direct cost of malpractice accounts for less than two percent of health care costs, and the extent of the indirect cost, i.e., ‘defensive medicine,’ is far from clear.”).

69. Gerard F. Anderson, Peter S. Hussey, Bianca K. Frogner & Hugh R. Waters, *Health Spending in the United States and the Rest of the Industrialized World*, 24 HEALTH AFF. 903, 909 (2005) (finding that the average payment per settlement or judgment was \$265,103 in the United States versus \$309,417 in Canada and \$411,171 in the United Kingdom).

70. *See* Anderson et al., *supra* note 53, at 98.

71. *Id.* (comparing the health care spending of countries in the OECD); Uwe E. Reinhardt, Peter S. Hussey & Gerard F. Anderson, *Cross-National Comparisons of Health Systems Using OECD Data, 1999*, 21 HEALTH AFF. 169, 169 (2002).

72. CMS, Medicare Program: Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2007 Rates, 71 Fed. Reg. 47,870, 48,029 (Aug. 18, 2006).

73. Mattoo & Rathindran, *supra* note 4, at 2.

74. *See* DENAVAS-WALT ET AL., *supra* note 3, at 1.

75. *Id.* at 22 tbl.8.

76. *Id.*

77. Jost, *supra* note 65, at 540 (citing data from Families USA, *One in Three: Non-Elderly Americans Without Health Insurance, 2002-2003* 1 (2004), http://www.familiesusa.org/assets/pdfs/82million_uninsured_report6fdc.pdf).

tourist testified to the U.S. Senate that he paid \$6,700 for life-saving heart surgery in India because he could not afford the estimated \$200,000 it would have cost in the United States.⁷⁸ Similar stories abound. Put simply, a growing number of patients are prepared to travel abroad for medical treatments.⁷⁹

B. Recent Trends that Facilitate Medical Tourism

The previous section examined why patients sometimes demand foreign medical care. This section examines the supply. Four broad trends have allowed developing countries to meet the increased demand by foreign patients. First, these countries have dramatically improved the quality of care they can offer, and have become increasingly adept at marketing their services. Second, the Internet allows patients to find foreign providers, and providers can signal their credentials and schedule treatments. Third, the private sector is taking a more active role in health care in many countries, which brings new resources. Finally, several complimentary industries and tasks are being outsourced. These trends suggest that patients will travel more in the coming years.

1. Improved Quality of Care in Developing Countries

Developing countries are attracting foreign patients because they can offer health care professionals, facilities, and technology that rival the best in the United States. This does not mean that all hospitals in developing countries meet our standards; on average, the quality of health care in the United States is still superior.⁸⁰ Rather, the relevant comparison is between the average U.S. hospital and the hospitals in developing countries that attract foreign patients.⁸¹ Here, the quality gap seems to evaporate, insofar as we can measure it.⁸² The World Bank found “significant evidence that the upper end of the quality distribution of both professionals and hospitals in several advanced developing countries lies well above the minimum acceptable standards in industrial countries.”⁸³ Developing countries have improved quality in three key areas: medical professionals, facilities, and technology.

First, medical professionals in developing countries increasingly meet Western standards. Many countries are adapting their medical curricula to North American and western European standards, and increasingly offer classes in English.⁸⁴ In fact, the

78. *Senate Hearing*, *supra* note 5 (statement of Maggi Ann Grace).

79. *E.g.*, Pennings, *supra* note 29, at 337.

80. *See* Mattoo & Rathindran, *supra* note 4, at 13.

81. *Id.*

82. *See id.* Measuring the “quality” of health care is inherently difficult. In the United States, professional licensure, board certification, and hospital accreditation ensure that our health care professionals and facilities meet some minimum quality standards. *See* Timothy S. Jost, *The Necessary and Proper Role of Regulation to Assure the Quality of Health Care*, 25 HOUS. L. REV. 525 (1988). However, these systems are not necessarily designed to assure that high quality health care is actually being provided. *See* Timothy S. Jost, *Oversight of the Quality of Medical Care: Regulation, Management, or the Market?*, 37 ARIZ. L. REV. 825, 858–66 (1995) [hereinafter Jost, *Oversight of the Quality of Medical Care*].

83. Mattoo & Rathindran, *supra* note 4, at 13.

84. Christophe Segouin, *Globalization in Health Care: Is International Standardization of Quality a Step toward Outsourcing?*, 17 INT’L J. FOR QUALITY IN HEALTH CARE 277, 277 (2005).

United States accepts a large number of foreign students into graduate medical education programs. Over one-quarter of all interns, residents, and fellows in the United States graduated from foreign medical schools.⁸⁵ Many of these graduates become board certified in the United States and practice here for years before returning overseas.⁸⁶ For example, Bumrungrad Hospital in Bangkok, Thailand, boasts over 200 physicians that were board certified in the United States.⁸⁷ Medical professionals are quite mobile—most of the global trade in health services is the movement of medical professionals between countries.⁸⁸ A quarter of all physicians practicing in the United States in 2004 were educated overseas,⁸⁹ and the top eight countries that produce foreign physicians in the United States are all developing countries.⁹⁰ Increasingly, patients can leave the United States and still find physicians who are intimately familiar with U.S. medicine.

Second, hospitals in developing countries increasingly meet U.S. standards. Joint Commission International (JCI) has accredited over eighty hospitals and health care facilities in South America, the Caribbean, Asia, India, Africa, and the Middle East.⁹¹ JCI is run by the same organization that accredits U.S. hospitals, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).⁹² Accreditation generally signals that a facility meets minimum standards of competence and quality.⁹³

85. John R. Boulet, John J. Norcini, Gerald P. Whelan, James A. Hallock & Stephen S. Seeling, *The International Medical Graduate Pipeline: Recent Trends in Certification and Residency Training*, 25 HEALTH AFF. 469, 469 (2006); McMahan, *supra* note 21, at 2435. To enter a graduate medical program in the United States that is accredited by the Accreditation Council for Graduate Medical Education, international medical graduates must be certified by the Educational Commission for Foreign Medical Graduates. Boulet et al., *supra*, at 469.

86. See Mattoo & Rathindran, *supra* note 4, at 13.

87. *The News Hour with Jim Lehrer: Traveling to Thailand for Treatment* (PBS television broadcast Feb. 21, 2005), http://www.pbs.org/newshour/bb/health/jan-june05/thailand_2-21.html (statement of Bumrungrad Hospital spokesman).

88. See Chanda, *supra* note 2, at 10 (suggesting that a large number of doctors, researchers, nurses, technicians, management personnel, and other skilled professionals are educated overseas).

89. Mattoo & Rathindran, *supra* note 4, at 13; AM. MED. ASS'N (AMA), PHYSICIAN CHARACTERISTICS AND DISTRIBUTION IN THE US: 2004–2005 (2004) (noting that in 2003, 14% of all nurses practicing in the United States were educated overseas).

90. The top eight countries are, by percentage, India, the Philippines, Cuba, Pakistan, Iran, Korea, Egypt, and China. See McMahan, *supra* note 21, at 2437; Mattoo & Rathindran, *supra* note 4, at 13.

91. Joint Commission International, Joint Commission International (JCI) Accredited Organizations, <http://www.jointcommissioninternational.org/23218/iortiz/>. JCI had accredited eighty-three hospitals and health care facilities in these regions as of August 2007. *Id.* Many of these organizations were accredited since late 2005. *Id.*

92. JCI was formed in 1994 by JCAHO and the non-profit arm of JCAHO, Quality Healthcare Resources, Inc. In 1998, JCAHO formed a subsidiary, Joint Commission Resources, Inc. (JCR). JCI is now a division of JCR. Joint Commission, Our History, http://www.jointcommission.org/AboutUs/joint_commission_history.htm. JCI launched its international accreditation program in 1999 in response to growing interest in worldwide accreditation and quality improvement. See *id.*

93. WILLIAM J. CURRAN, MARK A. HALL, MARY ANNE BOBINSKI & DAVID ORENTLICHER, HEALTH CARE LAW AND ETHICS 1192 (5th ed. 1998).

Moreover, JCAHO is governed by major medical trade associations, including the American Medical Association and the American Hospital Association.⁹⁴ Hospitals around the world are seeking JCI accreditation, which may help them apply for coverage from U.S. insurers.⁹⁵ Thus, patients that leave the United States for medical care increasingly find hospitals that meet U.S. standards.

Many predict that medical tourism will greatly expand as international standards emerge for health care quality, accreditation, and education.⁹⁶ For example, several groups have created international standards for health care quality and hospital accreditation.⁹⁷ The EU evaluates quality monitoring systems across EU countries.⁹⁸ The International Society for Quality in Health Care created a program to align health care standards and accreditation processes internationally.⁹⁹ A group of countries even created a program for evaluating the accrediting bodies themselves.¹⁰⁰ Medical education is being standardized by the World Federation for Medical Education¹⁰¹ and the Institute for International Medical Education,¹⁰² and these standards “are already influencing national and regional systems of recognition and accreditation of medical schools.”¹⁰³ As various international standards coalesce, developing countries can adopt the same standards as countries with first-rate health systems.

Finally, many developing countries have improved the medical technology they can offer, including procedures and technologies that have yet to be approved by the

94. *Id.*

95. Acharyulu & Reddy, *supra* note 5, at 15.

96. Segouin et al., *supra* note 84, at 277; *see* Chanda, *supra* note 2, at 9, 27, 109; Mattoo & Rathindran, *supra* note 4, at 23–24.

97. *See* Elma G. Heidemann, *Moving to Global Standards for Accreditation Processes: The ExPeRT Project in a Larger Context*, 12 INT’L J. FOR QUALITY IN HEALTH CARE 227, 227–30 (2000) (profiling three such groups); Segouin, *supra* note 84, at 277 (discussing the development of international standards for health care quality and medical education); Chanda, *supra* note 2, at 9, 27, 109; Mattoo & Rathindran, *supra* note 4, at 23–24 (discussing the development of international standards for health care quality and physician examination).

98. Heidemann, *supra* note 97, at 227. The EU created the External Peer Review Techniques (ExPeRT) Project in 1996 for this purpose. *Id.*

99. *See id.* at 228–29 (discussing the “International Accreditation Program”). *See* International Society for Quality in Health Care, Inc., *ISQua and Accreditation*, <http://www.isqua.org/isquaPages/Accreditation.html>.

100. *See* Heidemann, *supra* note 97, at 227–28. This group is called “The Wellington Group” because it was led by the New Zealand Council on Healthcare Standards, now the Health Accreditation Program of New Zealand, located in Wellington, New Zealand. *Id.*

101. The Federation published international standards in 1999 with approval from the WHO and the World Medical Association. World Federation of Medical Education, <http://www.wfme.org/> (follow link to WFME Global Standards); *see* J.P. de V. van Niekerk, Leif Christensen, Hans Karle, Stefan Lindgren & Jorgen Nystrup, *WFME Global Standards in Medical Education: Status and Perspectives following the 2003 WFME World Conference*, 37 MED. EDUC. 1050, 1050 (2003).

102. The Institute published Global Minimum Essential Requirements to identify educational objectives for medical graduates. *See* Hans Karle, *Global Standards in Medical Education—An Instrument in Quality Improvement*, 36 MED. EDUC. 604, 604 (2002); Institute for International Medical Education, The IIME, <http://www.iime.org/iime.htm>.

103. van Niekerk et al., *supra* note 101, at 1050.

FDA.¹⁰⁴ Some hospitals in developing countries are even improving biotechnology products made by American and European companies.¹⁰⁵ Foreign hospitals readily advertise these advances. For example, the Wockhardt Hospitals Group in India boasts that it uses the same medical equipment that can be found “in [h]ospitals in New York, London or Sydney.”¹⁰⁶ Bumrungrad Hospital in Bangkok advertises that it has two cardiac catheterization laboratories and two cardiac operating theaters.¹⁰⁷ Penang Adventist Hospital in Malaysia is General Electric’s Southeast Asia test facility, “one of only a handful of facilities around the globe that receives the next generation of [imaging] equipment before the rest of the medical world.”¹⁰⁸ Thus, select hospitals overseas can offer comparably advanced medical technologies.

2. Internet Communication and Signaling

The second major trend that facilitates medical tourism is use of the Internet by patients, foreign providers, and intermediaries. The Internet facilitates nearly all facets of medical tourism. Many American patients research medical conditions, providers, products, and treatment options online.¹⁰⁹ Indeed, eighty percent of adult Web users in the United States (136 million people) have used the Internet to search for health information.¹¹⁰ Searching for health information is the most popular use of the Internet aside from using e-mail and searching for consumer products and services.¹¹¹

Foreign providers have become increasingly savvy and assertive in advertising to foreign patients online.¹¹² A simple Internet search for “medical tourism” or “surgery abroad” yields hundreds of Web sites for foreign hospitals, clinics, travel agents, medical tourism brokers, and other sites trying to entice foreign patients. Virtually

104. Cf. Powers, *supra* note 28, at 79 (noting that many patients are seeking stem cell and cancer treatments overseas that have not been approved by FDA).

105. *See id.* (arguing that biotech companies in developed countries should consider filing patent applications in developing countries).

106. Wockhardt Hospitals, International Patient Services, http://www.wockhardthospitals.net/general/int_patients.asp.

107. Bumrungrad International [Hospital], World-Class Health Care in Thailand, <http://www.bumrungrad.com/overseas-medical-care/About-Us/Factsheet.aspx>.

108. Eric P. Erickson, *Over the Ocean, Under the Knife: Vacationers Are Making the Time to Work a Little Surgery into Exotic Trips*, CHI. SUN TIMES, Nov. 27, 2005, at C1.

109. SUSANNAH FOX & DEBORAH FALLOWS, PEW INTERNET & AM. LIFE PROJECT, INTERNET HEALTH RESOURCES (2003), http://www.pewinternet.org/pdfs/PIP_Health_Report_July_2003.pdf.

110. Harris Interactive, *Number of “Cyberchondriacs”—Adults Who Have Ever Gone Online for Health Information—Increases to an Estimated 136 Million Nationwide*, http://www.harrisinteractive.com/harris_poll/index.asp?PID=686 (finding that 136 million adult Internet users in the United States have searched for health information online, up from 117 million in 2005).

111. FOX & FALLOWS, *supra* note 109, at 1 (finding that eighty percent of adult Internet users in the United States search for health information online, compared to ninety-three percent that use e-mail, and eighty-three percent that search for consumer products or services).

112. *See* P. Greg Gulick, *E-Health and the Future of Medicine: The Economic, Legal, Regulatory, Cultural, and Organizational Obstacles Facing Telemedicine and Cybermedicine Programs*, 12 ALB. L.J. SCI. & TECH. 351, 354–62 (2002); McLean, *supra* note 22, at 226, n.124 (noting that physicians increasingly use the Internet to market their services).

every hospital that caters to foreign patients has an English Web site.¹¹³ And these Web sites are increasingly functional. Many allow patients to schedule treatments, book hotels and airfare, and even contact their surgeons.¹¹⁴ Patients can also find medical tourism brokers on the Internet that will liaise with foreign hospitals and make travel arrangements.¹¹⁵

More importantly, health care providers use the Internet to signal their quality. Virtually every facility with JCI accreditation advertises it on its Web site.¹¹⁶ Most sites advertise the treatments they offer, their success rates, the technologies they use, the number of physicians they employ that were trained or board certified in Western countries,¹¹⁷ and the ratio of registered nurses to each foreign patient. Finally, most foreign hospital Web sites either list the prices they charge or provide free quotes on request, bringing unprecedented price transparency to the health services industry.¹¹⁸ Thus, the Internet not only helps patients and providers connect, but it helps them share key information.

3. Privatization of Health Care Sectors Abroad

The third trend facilitating medical tourism is the increased privatization of foreign health care sectors. Unlike the United States, most countries rely primarily on the government to insure their citizens.¹¹⁹ But currently, the majority of health services in the world are financed privately.¹²⁰ Private insurance is available in virtually all countries, and few governments provide health care services directly anymore.¹²¹ Even in countries with national or socialized health insurance, there is a mix of public and private hospitals.¹²²

Currently, an unprecedented number of countries at all levels of development are restructuring their health care systems and reducing their governments roles as health

113. See, e.g., Apollo Hospitals Group, <http://www.apollohospitals.com>; Bumrungrad International, Welcome to Bumrungrad International Hospital, <http://www.bumrungrad.com>; Escorts Heart Institute and Research Centre Limited, Escort—Heart Surgery and Cardiac Surgery Hospital in India, <http://www.ehirc.com>; Wockhardt Hospitals, High Quality, Overseas Medical Care, <http://www.wockhardthospitals.net>.

114. See, e.g., Henderson, *supra* note 7, at 113.

115. See Klaus, *supra* note 7, at 227–28.

116. See *supra* note 113.

117. See, e.g., Apollo Hospitals Group, <http://www.apollohospitals.com> (“70% of our doctors have trained, studied, or worked in institutions and hospitals in the West.”).

118. Some commentators believe that growing competition, price transparency, and specialization in the hospital industry could lead U.S. hospitals to severely cut costs, eliminate services, and suffer financial instability similar to the airline industry. See, e.g., Altman et al., *supra* note 51.

119. Timothy S. Jost, *Why Can't We Do What They Do? National Health Reform Abroad*, 32 J.L. MED. & ETHICS 433, 433 (2004).

120. Ian S. Mutchnick, David T. Stern & Cheryl A. Moyer, *Trading Health Services Across Borders: GATS, Markets, and Caveats*, 24 HEALTH AFF. W5-42, W5-44 (2005) (Web exclusive), <http://content.healthaffairs.org/cgi/content/full/hlthaff.w5.42/DC1>.

121. See Jost, *supra* note 119, at 435.

122. See *id.*

care providers.¹²³ Public entities are gradually reducing their health spending and selling their health care enterprises.¹²⁴ The private sector is filling this void. Governments are inviting more private sector participation in health care¹²⁵ and in related sectors such as insurance and telecommunications.¹²⁶

Moreover, governments increasingly see the health care sector as a money-maker, as it generates fresh revenues from abroad.¹²⁷ Public hospitals are beginning to reserve a minimum number of private beds for foreign patients.¹²⁸ Public officials in Australia claim that the income from treating one foreign patient in a public hospital can be used to treat two or three Australian patients on waiting lists.¹²⁹ Private firms have taken notice, and are investing money to increase the number of private beds in public hospitals.¹³⁰

More significantly, privatization is attracting foreign direct investment (FDI). Traditionally, most developing countries limited FDI in the health sector by capping foreign equity investments, imposing discriminatory taxes, enforcing restrictive competition policies, and requiring burdensome economic needs tests and other clearances.¹³¹ Most countries have treated the health industry differently from other industries because they perceive health care to be a public good reserved for the government domain.¹³² However, there are new opportunities for FDI as countries privatize their health sectors.¹³³ Countries have realized that they need FDI to modernize their health care infrastructure.¹³⁴ For example, India, Indonesia, Nepal, Maldives, Sri Lanka, and Thailand have opened their health care markets to foreign investors.¹³⁵ More foreign investors are establishing hospitals, clinics, diagnostic centers, nursing homes, and treatment centers in developing countries.¹³⁶ FDI in hospitals has a considerable impact on local health care infrastructure and helps attract foreign patients.¹³⁷ Investors are attracted to FDI in the health sector because of the potentially high rates of return.¹³⁸ Thus, as countries privatize health care, they encourage local hospitals and providers to attract lucrative foreign patients.¹³⁹

123. David D. Benavides, *Trade Policies and Export of Health Services: A Development Perspective*, in *TRADE IN HEALTH SERVICES: GLOBAL, REGIONAL, AND COUNTRY PERSPECTIVES* 53, 53, 58 (Nick Drager & Cesar Vieira eds., 2002).

124. *See id.* at 54; Chanda, *supra* note 2, at 2.

125. *See* Benavides, *supra* note 123, at 54.

126. *See* Chanda, *supra* note 2, at 2.

127. Benavides, *supra* note 123, at 55.

128. For example, Australian public hospitals boost revenues by allocating a certain number of private beds to foreign patients. *Id.* at 65.

129. *Id.*

130. *See id.* at 65–66.

131. Chanda, *supra* note 2, at 29.

132. *See id.*

133. *See* Smith, *supra* note 9, at 2315.

134. Chanda, *supra* note 2, at 7–8.

135. *Id.* at 8.

136. *See id.* at 7–8.

137. *See* Smith, *supra* note 9, at 2314.

138. *Cf. id.* at 2315 n.9.

139. I discuss the potential negative consequences for local citizens who rely on public health resources in these countries in Part III.C, *infra*.

4. Globalization of Related Industries in Health Care

The fourth major trend that facilitates medical tourism is the globalization of related health care industries. Health care is one of the most rapidly growing markets in the world.¹⁴⁰ Experts expected worldwide health care spending to grow by \$800 billion between 2002 and 2005, from \$3.2 to \$4 trillion.¹⁴¹ This market includes services and products that make it easier for patients to obtain medical care overseas.

The most obvious example is the global market for health professionals. As I explain above, the medical profession is undeniably global.¹⁴² Over 25% of all physicians, interns, and residents in the United States graduated from foreign medical schools.¹⁴³ Foreign-educated nurses comprise a large percentage of nurses practicing in the United States.¹⁴⁴ And other countries' medical professions are similarly diverse.¹⁴⁵ In fact, most of the global trade in health services to date has been the movement of medical professionals between countries.¹⁴⁶ "Doctors without borders" have paved the way for "patients without borders."

The global hospital industry also facilitates medical tourism by creating international hospital chains. Two Singapore-based companies, the Parkway Group and the Raffles Medical Group, have acquired hospitals and established joint ventures with local health care providers in Malaysia, India, Sri Lanka, and the United Kingdom.¹⁴⁷ The Parkway Group's international hospital chain, Gleneagles International, is now one of the largest health care organizations in Asia.¹⁴⁸ The Raffles Medical Group has agreed to form fifty-fifty joint ventures with Kaiser Permanente throughout Asia.¹⁴⁹ The Apollo Hospitals Group in India has plans to build hospitals in Sri Lanka, Nepal, and Malaysia.¹⁵⁰ And California-based Adventist Health International runs a network of more than 500 Christian not-for-profit hospitals and clinics, led by Penang Adventist Hospital in Malaysia, a major medical tourist destination.¹⁵¹ Health care facilities have globalized as countries have privatized and liberalized trade in their health care sectors, and as organizations like the Joint Commission offer international accreditation.¹⁵² Because these hospitals were designed

140. See Chanda, *supra* note 2, at 1.

141. GOTCRET & SCHIEBER, *supra* note 2, at 3; see also Chanda, *supra* note 2, at 1; cf. Borger et al., *supra* note 2, at W62.

142. See *supra* Part II.B.1.

143. Boulet et al., *supra* note 85, at 469; McMahon, *supra* note 21, at 2435.

144. Mattoo & Rathindran, *supra* note 4, at 15 (stating that fourteen percent of newly licensed registered nurses practicing in the United States in 2003 were educated overseas).

145. *Id.* at 13–14 (stating that thirty percent of physicians practicing in the United Kingdom were educated abroad).

146. See *supra* note 88 and accompanying text.

147. Chanda, *supra* note 2, at 8.

148. Benavides, *supra* note 123, at 67.

149. *Id.* at 68.

150. Chanda, *supra* note 2, at 46.

151. See Adventist Health International, About Us, <http://www.adventisthealthinternational.org/aboutus.html>; Penang Adventist Hospital, About Us, http://www.pah.com.my/about_us/index.asp.

152. See *supra* Part II.B.1.

with international standards and patients in mind, their growth has enabled the growth of medical tourism.

The rapid globalization of other industries also facilitates medical tourism, even if the influence is less direct. The global pharmaceutical market has grown between 11–18% since 2004 in developing countries in Africa, Asia, and Latin America.¹⁵³ The WHO predicted the global market for medical devices would grow from \$145 billion in 2000 to over \$260 billion in 2006.¹⁵⁴ The global market for “telemedicine” and “telehealth” alone is \$1.25 trillion and rising.¹⁵⁵ Although health insurance markets in developing countries are quite modest, they should grow as citizens increasingly demand insurance and are able to pay for it.¹⁵⁶ Managed care companies earn billions overseas.¹⁵⁷ U.S. companies have started outsourcing insurance claims processing, which should help cultivate the global health insurance market.¹⁵⁸ Companies from the United States and Europe increasingly outsource their clinical trials.¹⁵⁹ In fact, the global contract research industry, which manages clinical trials for pharmaceutical, medical device, and biotechnology companies, is almost entirely new.¹⁶⁰

These markets are globalizing health care products, services, and standards. As with the other trends, this trend helps export Western medicine overseas, diminishing the perceived quality gap between domestic and foreign providers, such that the cost differentials become more salient. Patients are learning that they can purchase similar health care products and services overseas at a fraction of the price.

C. Anatomy of the Global Patient Market

As mobile as patients have become, they do not travel to all countries for all procedures. Patients generally receive preventative and emergency care where they live, and some may be too sick or frail to travel.¹⁶¹ Moreover, not all countries try to attract foreign patients. This section examines the countries that patients visit, the

153. IMS Health, *supra* note 24. The global pharmaceutical market was \$602 billion in 2005, and IMS Health expects sales to increase an average of 9–12% in Asia and Africa, and 7–10% in Latin America, over the next five years. *Id.*

154. Lepakhin, *supra* note 23, at v.

155. Mutchnick et al., *supra* note 120, at W5-45; Chanda, *supra* note 2, at 5; cf. McLean, *supra* note 22, at 205–06 n.5.

156. Mutchnick et al., *supra* note 120, at W5-47; see also John A. Sbarbaro, *Trade Liberalization in Health Insurance: Opportunities and Challenges: The Potential Impact of Introducing or Expanding the Availability of Private Health Insurance Within Low and Middle Income Countries 2* (World Health Org. Comm’n on Macroeconomics and Health, Working Paper No. WG 4:6, 2000), <http://www.emro.who.int/cbi/PDF/HealthInsurance.pdf>.

157. Mutchnick et al., *supra* note 120, at W5-47. For example, by 1999, the managed care company CIGNA covered 2.6 million people in Brazil, Chile, and Guatemala. Aetna’s managed care operations in Brazil generated over \$1 billion in revenues in 1996. See Karen Stocker, Howard Waitzkin & Celia Iriart, *The Exportation of Managed Care to Latin America*, 340 *NEW ENG. J. MED.* 1131, 1131–33 (1999).

158. See Chanda, *supra* note 2, at 2, 6 n.5.

159. See Terry, *supra* note 13, at 451 nn.221–22.

160. Richard A. Rettig, *The Industrialization of Clinical Research*, 19 *HEALTH AFF.* 129, 131 (2000).

161. See Aaditya Mattoo & Randeep Rathindran, *How Health Insurance Inhibits Trade in Health Care*, 25 *HEALTH AFF.* 358, 359 (2006).

procedures they seek, and the efforts by developing countries to attract foreign patients.

1. Chile

Chile has become a regional medical hub in Latin America, attracting patients from Bolivia, Peru, and Ecuador.¹⁶² Chile has targeted Bolivian patients through private insurers and national health care centers.¹⁶³ Chilean clinics have established agreements with Bolivian health care centers to treat Bolivian patients.¹⁶⁴

2. Cuba

Since the 1980s, Cuba has made a concentrated effort to become a “world medical power.”¹⁶⁵ It hosts a significant number of patients from Latin America, the Caribbean, Russia, and the United Kingdom, who generally seek niche procedures in ophthalmology, joint surgery, neurology, and treatments for skin diseases.¹⁶⁶ The government created the company Servimed to arrange medical treatments and travel for foreign patients.¹⁶⁷ The government has also signed bilateral agreements with Latin American and Caribbean governments to facilitate medical tourism, with the parties even negotiating prices.¹⁶⁸ Finally, Cuba provides free or subsidized care to patients from certain countries.¹⁶⁹

3. India

India is the fastest growing medical tourist destination. In 2002 and 2003, Indian hospitals treated 150,000 foreign patients, 62,000 of whom traveled to India

162. See Chanda, *supra* note 2, at 49.

163. *Id.* at 50. Chile’s private insurers, Instituciones de Salud Previsional (ISAPRES), are private (but publicly funded) managed care organizations. See Stocker et al., *supra* note 157, at 1132–33. ISAPRES are private alternatives to public social insurance, Armando Barrientos & Peter Lloyd-Sherlock, *Reforming Health Insurance in Argentina and Chile*, 15 HEALTH POL’Y & PLAN. 417, 417 (2000), and currently cover 18% of the population, Isapres de Chile, Introducción, <http://www.isapre.cl/modulos.php?mod=phtml&fn=496bf80e41b9ea4233891a7068895265> (accessible in Spanish only).

164. Chanda, *supra* note 2, at 50.

165. Julie M. Feinsilver, *Cuba as a “World Medical Power”: The Politics of Symbolism*, LATIN AM. RES. REV., No. 2 1989, at 1, 1; see also Benavides, *supra* note 123, at 61.

166. See Chanda, *supra* note 2, at 33. Estimates of the number of foreign patients traveling to Cuba for health care vary. The World Bank estimated that 3500 foreign patients sought medical care in Cuba in 2002–03. See Mattoo & Rathindran, *supra* note 4, at 12. However, others estimated that Cuba hosted 25,000 foreign patients in 1995–96, and 30,000 in 1997–99. See Chanda, *supra* note 2, at 33; Benavides, *supra* note 123, at 62.

167. María C. Werlau, *Foreign Investment in Cuba: The Limits of Commercial Engagement*, in 6 CUBA IN TRANSITION: PAPERS AND PROCEEDINGS OF THE FIFTH ANNUAL MEETING OF THE ASSOCIATION FOR THE STUDY OF THE CUBAN ECONOMY 456, 477 n.128 (Ass’n for the Study of the Cuban Econ. ed., 1996), available at <http://lanic.utexas.edu/la/cb/cuba/asce/cuba6/57Werlau.fm.pdf>; Chanda, *supra* note 2, at 34. Servimed has negotiated with over 200 travel agencies in sixty countries. Werlau, *supra*, at 477 n.128.

168. Chanda, *supra* note 2, at 33–34.

169. *Id.* at 34.

specifically for medical care.¹⁷⁰ The Confederation of Indian Industry predicts that by 2012, India will generate \$2.3 billion per year in revenues from medical tourism.¹⁷¹ Patients visit India from all over the world, but most often from the Middle East, Europe, and the United States.¹⁷² Patients often visit India for complex procedures, particularly in cardiology, endocrinology, nephrology, neurology, orthopedic surgery, ophthalmology, and urology.¹⁷³

India is positioning itself as a worldwide medical tourist destination. Its government aims to replicate the Thai government's efforts to aggressively market its medical tourism industry.¹⁷⁴ The Ministry of Tourism has called for joint public-private efforts to promote Indian hospitals,¹⁷⁵ and in 2006 formed an interagency task force to promote the industry.¹⁷⁶ The government recently recommended price ranges for common medical treatments in order to keep prices down.¹⁷⁷ Moreover, several states within India have formed public-private medical tourism councils to regulate the industry and market the quality of providers in their regions.¹⁷⁸

Nevertheless, India faces many of the same problems that other developing countries face. Its legal and regulatory systems are not comprehensive or mature like those of western countries.¹⁷⁹ India does not dedicate enough resources to medical malpractice lawsuits, and its Medical Council Act is "outdated and ineffective."¹⁸⁰ Most foreign insurance companies do not recognize Indian medical qualifications.¹⁸¹ And as recently as 2001, India had a net loss of patients—the number of patients that left India for medical treatment exceeded the number of foreign patients that visited.¹⁸² Thus, while India is quickly becoming a leading destination for patients, its health sector lags.

170. Mattoo & Rathindran, *supra* note 4, at 12 tbl.2.

171. Ganapati Mudur, *Hospitals in India Woo Foreign Patients*, 328 BRIT. MED. J. 1338, 1338 (2004), available at <http://bmj.bmjournals.com/cgi/content/reprint/328/7452/1338>.

172. Mattoo & Rathindran, *supra* note 4, at 12 tbl.2.

173. *Id.*; Chanda, *supra* note 2, at 42, 44.

174. *Tourism Ministry Plans Price Cap for Foreigners*, FIN. EXPRESS, Mar. 24, 2005, <http://www.financialexpress.com/news/story/78882/>.

175. *Public, Private Sector Need to Promote India as Healthcare Destination Worldwide*, HINDUSTAN TIMES, Aug. 30, 2006, 2006 WL 15040509.

176. *Tourism Ministry in Conjunction with Health Ministry Forms Task Force to Assess Opportunities in Medical Tourism*, HINDUSTAN TIMES, Aug. 3, 2006, 2006 WLNR 13428248.

177. *Tourism Ministry Plans Price Cap for Foreigners*, *supra* note 174.

178. *Id.* (quoting an industry analyst who says that Madhya Pradesh and Kerala have formed "public-private medical tourism councils to regulate the industry and provide a forum for addressing complaints and malpractices").

179. Chanda, *supra* note 2, at 48.

180. *Id.*; Indian Medical Council Act of 1956 (amended by the Indian Medical Council (Amendment) Acts of 1964, 1993, and 2001), available at http://www.mciindia.org/know/acts/acts_amends.htm.

181. Chanda, *supra* note 2, at 43.

182. *Id.* at 42 n.31.

4. Jordan

Jordan treated 70,000 foreign patients in 2002 and 2003, primarily from the Middle East.¹⁸³ Jordanian hospitals specialize in cardiac surgery, spinal injuries, cornea transplants, and alternative medicine.¹⁸⁴ Since the early 1990s, Jordan has tried to become the medical hub for the Arab world.¹⁸⁵ The government has created incentives for private investment in the health sector, which has generated several new private hospitals.¹⁸⁶ The public sector has also modernized its hospitals and medical schools, some of which are electronically linked with prestigious hospitals in Europe and North America.¹⁸⁷

5. Malaysia

In 2002 and 2003, Malaysian hospitals treated 103,000 foreign patients, 75,000 of whom visited specifically for health care.¹⁸⁸ Patients traveled from Indonesia, India, the Middle East, and the United Kingdom seeking treatments in cardiology, hematology, gastroenterology, neurology, and cosmetic surgery.¹⁸⁹ The government has aggressively courted foreign patients, creating a National Committee for medical tourism in 1998, which is headed by the Minister for Culture, Arts, and Tourism.¹⁹⁰ The National Economic Action Council hopes to make Malaysia “a worldclass regional health care center.”¹⁹¹ The government’s “Eighth Malaysia Plan” selected thirty-five private hospitals to market overseas and called for public hospitals to create private wings for foreign patients.¹⁹²

6. Singapore

Singapore treated roughly 200,000 foreign patients in 2003, 10% of whom visited specifically for medical care.¹⁹³ Patients visit from Asia, Australia, the United Kingdom, and the United States,¹⁹⁴ seeking treatments in general surgery, cardiac

183. Mattoo & Rathindran, *supra* note 4, at 12 tbl.2.

184. *Id.*

185. Benavides, *supra* note 123, at 63; Chanda, *supra* note 2, at 37.

186. Benavides, *supra* note 123, at 63; *see also* Chanda, *supra* note 2, at 37.

187. Chanda, *supra* note 2, at 37.

188. Mattoo & Rathindran, *supra* note 4, at 12 tbl.2.

189. *Id.* Malaysia targets Islamic countries because it can satisfy the Muslim patients’ preferences for prayers before surgery and halal food. *See* Henderson, *supra* note 7, at 114.

190. Henderson, *supra* note 7, at 114.

191. *Id.*

192. *Id.*

193. Mattoo & Rathindran, *supra* note 4, at 12 tbl.2. Various sources indicate an increasing trend in the number of medical tourists visiting Singapore. *See* Henderson, *supra* note 4, at 12 (estimating that Singapore hosted 150,000 foreign patients in 2001); *A New Frontier in Medical Tourism*, BUS. TIMES (Sing.), Aug. 23, 2006, available at <http://app.singaporemedicine.com/asp/new/new0201c.asp?id=5081>.

194. Mattoo & Rathindran, *supra* note 4, at 12 tbl.2. Henderson estimates that nearly 80% of patients traveling to Singapore are from two countries: Indonesia and Malaysia. Henderson, *supra* note 7, at 114.

surgery, ophthalmology, orthopedic surgery, gynecology, and urology.¹⁹⁵ Singapore helped pioneer medical tourism in Asia, but providers there have felt increasing competition from other countries. In response, the Ministry of Health called for efforts to retain Singapore's status as the "healthcare hub of Asia."¹⁹⁶ An official report recommended supporting more clinical research, recruiting of health care professionals, and cooperation between public and private providers, as well as easing advertising restrictions and dedicating an agency to coordinate these efforts.¹⁹⁷ The government established Singapore Medicine, which represents the Ministry of Health, the Singapore Tourism Board, and other key agencies.¹⁹⁸ Singapore's Tourism Board also established the Healthcare Services Strategic Tourism Unit in 2003 to promote local hospitals, establish referral channels overseas, and help implement an accreditation system.¹⁹⁹ Singapore's goal is to treat one million foreign patients per year by 2012.²⁰⁰ Singapore's model is one developing countries may try to emulate, particularly the creation of a centralized, public-private partnership to coordinate industry efforts.

7. Thailand

In 2002 and 2003 Thailand treated nearly 630,000 foreign patients, 126,000 of whom visited specifically for health care.²⁰¹ Along with Singapore, Thailand helped pioneer medical tourism in Asia. Patients visit primarily from Southeast Asia, Europe, and the United States,²⁰² seeking treatments in cardiac surgery, cosmetic surgery, dentistry, cataract surgery, and bone-related procedures.²⁰³ In the late 1990s, the Tourism Authority began a campaign that included medical tourism.²⁰⁴ The government now plans to spend nearly \$3 million to advertise and develop health care centers in Bangkok, Phuket, and Chiang Mai.²⁰⁵ Thailand also has very permissive visa policies, which either do not require visas or provide them on arrival to citizens of over 150 countries.²⁰⁶

8. United Kingdom

The United Kingdom's experience reveals the multifarious nature of medical tourism. On one hand, U.K. citizens travel overseas to bypass long waiting lists,²⁰⁷ and the National Health Service (NHS) sends patients on waiting lists to other EU

195. Mattoo & Rathindran, *supra* note 4, at 12 tbl.2.

196. Henderson, *supra* note 7, at 114.

197. *Id.*

198. *See generally* Singapore Medicine, <http://www.singaporemedicine.com/>.

199. Henderson, *supra* note 7, at 114–15.

200. *Id.* at 114.

201. Mattoo & Rathindran, *supra* note 4, at 12 tbl.2.

202. *Id.*

203. *Id.*

204. Henderson, *supra* note 7, at 116.

205. *Id.* at 115.

206. *Id.* at 116.

207. Mattoo & Rathindran, *supra* note 4, at 12.

countries for certain surgeries.²⁰⁸ On the other hand, the United Kingdom is also a major destination for foreign patients, which has stretched waiting lists and NHS resources.²⁰⁹ Foreign citizens currently occupy 20% of hospital beds in London.²¹⁰ The United Kingdom has reciprocal arrangements with sixty countries to provide the same medical care to foreign nationals as they do to local citizens.²¹¹ Regulations require the NHS to charge for health care provided to anyone who is “not ordinarily [a] resident in the U.K.,”²¹² but many believe loopholes in these regulations are being abused.²¹³ The public has scrutinized foreign citizens who are exempt from being charged by the NHS, particularly business travelers who schedule treatments in U.K. hospitals.²¹⁴ The NHS has considered various ways to discourage medical tourists from visiting, for example, by asking patients to confirm their residency and creating a mandatory NHS patient card.²¹⁵ Critics have even proposed withdrawing free nonemergency care for asylum seekers whose asylum applications have been denied.²¹⁶ The United Kingdom’s struggle with medical tourism reflects both the challenges developing countries face in allocating scarce resources between local and foreign patients, and the challenges developed countries face in dealing with jurisdictional boundaries.

9. United States

Much like the United Kingdom, the United States both imports and exports patients. For decades, the United States has attracted wealthy foreign patients for the advanced, specialized medical care offered here.²¹⁷ At the same time, the National Coalition on Health Care estimated that nearly 500,000 U.S. patients traveled overseas in 2005.²¹⁸

10. Other Countries

The nine countries above are the most notable players in the global patient market, but several others are seeking to attract foreign patients, including Argentina,²¹⁹

208. *Id.*

209. Chanda, *supra* note 2, at 56.

210. *Id.*

211. *Id.*

212. Edwin Borman, *Health Tourism: Where Healthcare, Ethics, and the State Collide*, 328 BRIT. MED. J. 60, 60 (2004). *See generally* The National Health Service (Charges to Overseas Visitors) Regulations, 1989, S.I. 1989/306 (U.K.) (as amended by S.I. 1991/438, S.I. 1994/1535, S.I. 2000/602, S.I. 2000/909, S.I. 2004/614).

213. Borman, *supra* note 212.

214. *Id.*

215. *Id.* at 61.

216. *Id.* at 60–61. The provision regarding asylum seekers was not included in the final regulation. *See* The National Health Service (Charges to Overseas Visitors) (Amendment) Regulations, 2004, S.I. 2004/614.

217. Orvill Adams & Colette Kinnon, *A Public Health Perspective*, in INTERNATIONAL TRADE IN HEALTH SERVICES: A DEVELOPMENT PERSPECTIVE, at 35, 40 (Simonetta Zarilli & Colette Kinnon eds., 1998).

218. Ann Tatko-Peterson, *Going Abroad for Health Care*, SAN JOSE MERCURY NEWS, Oct. 16, 2006, at A3.

219. *Healthcare Savvy: Seeking (Safe) Surgery Overseas*, CONSUMER REP., Aug. 2006, at 7.

China,²²⁰ Colombia,²²¹ Costa Rica,²²² the Dominican Republic,²²³ the Philippines,²²⁴ and South Africa.²²⁵ Mexico has long attracted U.S. patients seeking dental care, access to affordable pharmaceuticals, and cosmetic surgeries.²²⁶ And after being admitted into the European Community, Turkey has quickly become a medical tourist destination, with low costs and a profusion of JCI-accredited hospitals.²²⁷ Thus, even in its relatively infant stages, medical tourism represents a diverse set of countries, medical procedures, and export strategies.

II. ANALYZING THE RISKS AND OPPORTUNITIES WITHIN THE THREE THEMES OF HEALTH CARE

Is medical tourism worth the risks? The next three sections examine the risks and opportunities by analyzing how it may affect health care costs, quality, and access in the United States and in developing countries. Several scholars identify these three canonical themes as the core framework for analyzing health care issues.²²⁸ After using this framework in Part II to examine the risks and opportunities, I will consider specific policy approaches in Part III.

220. Chanda, *supra* note 2, at 38, 40.

221. See Owain Johnson, *Bogotá Launches Health Tourism Project*, 325 BRIT. MED. J. 10 (2002), available at <http://bmj.bmjournals.com/cgi/content/full/325/7354/10/e>.

222. Jennifer Alsever, *Basking on the Beach, or Maybe on the Operating Table*, N.Y. TIMES, Oct. 15, 2006, at § 3 (Sunday Money) at 5.

223. *Tourism Gets a Facelift: Cosmetic Surgery's the New Pull*, ECON. TIMES (India), July 14, 2006, 2006 WLNR 12100218.

224. Johanna Paola D. Poblete, *Special Feature: Medical Tourism*, BUS. WORLD (Philippines), Jan. 17, 2007, 2007 WLNR 902660.

225. *Tourism Gets a Facelift*, *supra* note 222; Julie Appleby & Julie Schmit, *Sending Patients Packing*, USA TODAY, July 27, 2006, at 3B.

226. Appelby & Schmit, *supra* note 225; Chanda, *supra* note 2, at 65.

227. Nazli Topçuoğlu, *Turks Eye European Patients in Medical Tourism*, TURKISH DAILY NEWS, Feb. 17, 2007, available at <http://www.turkishdailynews.com.tr/article.php?enewsid=66377>; Joint Commission International (JCI) Accredited Organizations, <http://www.jointcommissioninternational.com/10241/>.

228. See, e.g., Charles S. Hyman, *You Get What You Pay For: Result-Based Compensation for Health Care*, 58 WASH. & LEE L. REV. 1427, 1452 (2001) (stating that “enhancing quality, lowering cost, and broadening access” is the “holy grail” or “holy trinity” of health care policy); Jost, *supra* note 65, at 540–55 (proposing reforms to the U.S. health care system by analyzing the three core problems of cost, quality, and access); McLean, *supra* note 22, at 255–62 (describing cost, quality, and access as the “Iron Triangle” for evaluating excellence in health care) (citing Richard P. Wenzel & James E. Rohrer, *The Iron Triangle of Healthcare Reform*, 2(1) CLINICAL PERFORMANCE & QUALITY HEALTHCARE 7–9 (1994)). A few commentators have advocated for a fourth consideration: justice. Clark C. Havighurst & Barak D. Richman, *Foreword: Health Policy's Fourth Dimension*, 69 LAW & CONTEMP. PROBLEMS 1 (2006); see, e.g., Symposium, *Who Pays? Who Benefits? Distributional Issues in Health Care*, 69 LAW & CONTEMP. PROBLEMS 1 (2006). Note, however, that health law scholars still debate whether any single framework can unify this notoriously disjointed field. See, e.g., Mark A. Hall, *Law, Medicine, and Trust*, 55 STAN. L. REV. 463 (2002); Rand E. Rosenblatt, *The Four Ages of Health Law*, 14 HEALTH MATRIX 155 (2004); Rand E. Rosenblatt, *Conceptualizing Health Law for Teaching Purposes: The Social Justice Perspective*, 38 J. LEGAL EDUC. 489 (1988); Symposium, *Rethinking Health Law*, 41 WAKE FOREST L. REV. 341 (2006).

A. Costs and Financing

The recent wave of medical tourism is being driven by cost discrepancies. Treatments in developing countries are documented to be 50–90% less expensive than in the United States.²²⁹ For example, inpatient knee surgery may cost an average of \$10,335 in the United States versus \$1236 at many foreign hospitals.²³⁰ Hysterectomies cost \$5783 in the United States versus \$1869 in developing countries.²³¹ The disparities are more pronounced with complex, expensive procedures. A coronary artery bypass graft may cost \$60,000 in the United States versus \$10,000 or less in India.²³² A bone marrow transplant may cost \$250,000 in the United States versus \$30,000 in India or \$60,000 in Thailand.²³³

Such cost discrepancies may tempt U.S. employers and insurers to explore the use of foreign providers. After all, health care spending continues to perplex the United States. We spend far more on health care than any other country, but we are neither healthier nor happier with our system than most of our peers.²³⁴ In a 2006 Senate hearing on medical tourism, Senator Gordon Smith opined that “Americans should not have to travel overseas to obtain affordable health care.”²³⁵ But in a system looking for any way to relieve the intense cost pressures, medical tourism seems to be a logical release valve.²³⁶ Senator Smith acknowledged that “[f]or the nation’s 46 million uninsured, traveling overseas for low-cost medical procedures, even with the added cost of travel and lodging, is an understandably attractive option.”²³⁷ This section examines how medical tourism may impact health spending in the United States and in developing countries.

1. Health Insurance is Generally Non-Portable

Few public or private U.S. insurers cover nonemergency medical care overseas. Medicare and Medicaid only pay for treatment overseas under narrow circumstances.²³⁸ For example, Medicare covers nonemergency services overseas only if the hospital is more accessible from the beneficiary’s residence than any suitable U.S. hospital.²³⁹ Thus, if a Medicare beneficiary living in Guam needs treatment, and

229. Adams & Kinnon, *supra* note 217, at 39–40.

230. Mattoo & Rathindran, *supra* note 4, at 20 tbl.4.

231. *Id.*

232. *Senate Hearing, supra* note 5, ex. A (statement of Arnold Milstein).

233. P. Jayaram, *India Seeks to Boost Medical Tourism*, STRAITS TIMES (Sing.), Sept. 5, 2006, 2006 WLNR 15373484.

234. Anderson *et al.*, *supra* note 53; Jost, *supra* note 65; see Anderson *et al.*, *supra* note 69.

235. *Senate Hearing, supra* note 5 (statement of Chairman Gordon H. Smith).

236. Milstein & Smith, *supra* note 51, at 141 (noting that “[e]ven if the offshorable surgical market appears limited . . . [it] might influence national efforts to understand why care in the United States costs and grows so much.”).

237. *Senate Hearing, supra* note 5 (statement of Chairman Gordon H. Smith).

238. Mattoo & Rathindran, *supra* note 4, at 4–5; see generally Social Security Act §§ 1814(f), 1862(a)(4); 42 U.S.C. §§ 1395f(f), 1395y(a)(4) (2000); 42 C.F.R. § 411.9 (2006).

239. 42 U.S.C. § 1395f(f)(1) (2000); 42 C.F.R. § 424.123 (2006) (requiring that the foreign hospital be accredited by JCAHO).

the nearest adequate hospital is in the Philippines, federal law permits Medicare to pay for the services in the Philippines.²⁴⁰ Otherwise, Medicare coverage is non-portable.

Private insurance is slightly more portable, but most private insurers also cover only emergency services overseas.²⁴¹ The World Bank found that most U.S. managed care organizations cover only emergency services overseas, treating it as an out-of-network benefit, which requires patients to spend more out-of-pocket.²⁴² Some plans require the patient to pay for the entire treatment upfront and seek reimbursement after returning to the United States.²⁴³ Virtually no insurers cover travel expenses, which effectively makes insurance even less portable.²⁴⁴ The World Bank study found these to be significant market barriers.²⁴⁵

Nevertheless, there are two significant examples of governments paying for nonemergency medical care overseas: the EU and TRICARE. First, since the 1970s, EU regulations have required member states to reimburse their citizens for medical care they receive in other states in certain circumstances, for example, when the citizen needs emergency care or when the citizen cannot obtain the treatment where she resides in a medically appropriate timeframe.²⁴⁶ Recently, a series of court cases has eroded the authority of member states to require prior authorization or deny reimbursement for medical treatments in other EU countries.²⁴⁷ The cases together generally hold that Articles 49 and 50 of the European Community Treaty²⁴⁸—which prohibit member states from restricting the free movement of persons and services throughout the EU—trump the authority of states to administer their own health insurance systems. The European Court of Justice has interpreted these articles very broadly to invalidate a wide variety of national rules.²⁴⁹ Previously, many states

240. See, e.g., CMS, CMS Manual System, Pub. 100-04 Medicare Claims Processing, Transmittal 654, *Services Not Provided within United States*, Aug. 19, 2005, <http://www.cms.hhs.gov/transmittals/downloads/R654CP.pdf>.

241. Mattoo & Rathindran, *supra* note 4, at 3–4.

242. *Id.* at 4 tbl.1.

243. *Id.*

244. *Id.* at 3; Kesteloot *et al.*, *supra* note 45, at 56 (noting that in the EU, “the financial burden of such treatments received abroad may still be substantial, since not many countries provide reimbursement for the additional travel and living expenses for the patient, and possibly an accompanying person.”).

245. See generally Mattoo & Rathindran, *supra* note 4.

246. See Council Regulation 1408/71, art. 22, 1971 O.J. (L 149) 1 (EC); Council Regulation 574/72, 1972 O.J. (L 74) 1 (EC) (the implementing regulation for 1408/71); Kesteloot *et al.*, *supra* note 45, at 45.

247. See Case 372/04, *The Queen (on the Application of Yvonne Watts) v. Bedford Primary Care Trust and Secretary of State for Health*, 2006 O.J. (C 251) 6; Case C-385/99, *Müller-Faure v. Onderlinge Waarborgmaatschappij OK Zorgverzekeringen UA v. Onderlinge Waarborgmaatschappij ZAO Zorgverzekeringen*, 2003 E.C.R. I-4509; Case C-157/99, *B.S.M. Geraets-Smits v. Stichting Ziekenfonds VGZ v. Stichting CZ Groep Zorgverzekeringen*, 2001 E.C.R. I-5473; Case C-368/98, *Vanbraekel v. Alliance nationale des mutualités chrétiennes*, 2001 E.C.R. I-5363; Case C-158/96, *Kohll v. Union des Caisses de Maladie*, 1998 E.C.R. I-1931.

248. Treaty Establishing the European Community, arts. 49–50, Nov. 10, 1997, 1997 O.J. (C 340) 3 [hereinafter EC Treaty].

249. Antonio Segura Serrano, *Improvements to Cross-Border Access to Health Care Within the European Union*, 43 HARV. INT’L L.J. 553, 555 (2002).

interpreted the EU regulations narrowly, rarely granting prior authorization.²⁵⁰ Thus, although member states still retain the authority to decide when their citizens will be reimbursed for medical care in other EU states, they must make their national health insurance more portable within the EU. Most EU states now reimburse patients for travel and living expenses when treated abroad, and some states cover the expenses of a travel companion.²⁵¹

Second, the U.S. government covers medical care overseas for military personnel and their dependants through TRICARE, the Department of Defense's managed care program.²⁵² The TRICARE Overseas Program enrolls beneficiaries, processes claims, contracts with foreign providers, and certifies foreign providers for acceptance into its "Preferred Provider Network."²⁵³ Moreover, TRICARE uses regional "Health Care Finders" to locate referrals for specialty care, authorize certain treatments, and assist beneficiaries.²⁵⁴

Thus, although health insurance is generally non-portable, TRICARE and the EU show how portable insurance is likely to look in practice. United States health insurers can look to these programs for examples of how to establish a network of foreign providers, process foreign claims, and monitor foreign providers.

2. Potential Gains from Trade are Significant

A World Bank economist found that the price differences between the United States and developing countries should create "a strong incentive for trade."²⁵⁵ To estimate the gains from trade, the authors selected fifteen surgeries that were "highly tradable," that is, surgeries that are low-risk, non-emergency treatments with quick recovery periods.²⁵⁶ Factoring in travel costs, the authors found that the United States could save \$1.4 billion annually if only ten percent of patients traveled overseas for these procedures.²⁵⁷ Roughly half of these savings (\$690 million) would accrue to Medicare.²⁵⁸ By adding coronary artery bypass grafts to the list of "highly tradable" procedures, annual savings would then exceed \$2 billion.²⁵⁹

250. Kesteloot *et al.*, *supra* note 45, at 47–48.

251. *Id.* at 50–52.

252. See James R. Whitman, Note, *Venturing Out Beyond the Great Wall of Medicare: A Proposal to Provide Medicare Coverage Outside the United States*, 8 *ELDER L.J.* 181, 209–10 (2000). See generally 10 U.S.C. §§ 1071–1106; 32 C.F.R. § 199; TRICARE Overseas, <http://www.tricare.osd.mil/overseas/>.

253. 32 C.F.R. § 199.17(p); TRICARE Policy Manual, 6010.54-M, ch. 12, § 1.1, at 1–2, Aug. 1, 2002, available at <http://manuals.tricare.osd.mil/>; see also Whitman, *supra* note 252, at 209; TRICARE Overseas, *supra* note 252.

254. TRICARE Policy Manual, *supra* note 253, at ch. 12, § 5.1.

255. Mattoo & Rathindran, *supra* note 161, at 358.

256. Mattoo & Rathindran, *supra* note 4, at 3, 16, 20. The fifteen procedures are: knee surgery; shoulder arthroplasty; transurethral resection of the prostate (TURP); tubal ligation; hernia repair; skin lesion excision; adult tonsillectomy; hysterectomy; haemorrhoidectomy; rhinoplasty; bunionectomy; cataract extraction; varicose vein surgery; glaucoma procedures; and tympanoplasty.

257. *Id.* at 19. These calculations used the patient volume from 2002 and prices from 2004, so the authors assumed that the annual demand for the procedures would remain constant.

258. *Id.*

259. *Id.*

The authors acknowledge that \$2 billion is a small portion of U.S. health care spending.²⁶⁰ It is unclear whether the market will grow enough to significantly affect U.S. health care prices.²⁶¹ Two experts note that “non-urgent surgeries that are costly enough to offset travel costs and required incentives [to travel overseas] account for less than two percent of commercial insurance spending.”²⁶² However, the World Bank authors explain that the savings could be much larger.²⁶³ The \$2 billion savings estimate included only fifteen procedures, though patients travel for many more.²⁶⁴ The study also used Medicare payment rates to calculate U.S. prices, “which are lower than those paid by private insurers and the uninsured.”²⁶⁵ Finally, the authors did not have patient volume data for certain procedures, which may further underestimate the savings.²⁶⁶

The World Bank made no parallel estimate of how much developing countries stand to gain from medical tourism, but other sources show the gains to be significant. Barely ten years ago, Cuba was already generating \$25 million per year from medical tourism.²⁶⁷ Malaysia earned \$103 million in 2003 and aims to increase revenue tenfold by 2010.²⁶⁸ India may soon generate over \$2 billion per year from medical tourism.²⁶⁹ An optimistic observer predicts that by 2010, medical tourism will generate \$40 billion per year.²⁷⁰ These revenues may allow developing countries to upgrade their medical schools, facilities, technology, and overall health care infrastructure.²⁷¹ Moreover, the additional foreign money could significantly reduce the burden on government health care spending if the revenues are appropriately directed.²⁷² Thus, medical tourism may have a material financial impact in the United States and in developing countries.

3. The Move Towards Cross-Border Health Insurance Coverage

As the gains from trade become apparent and as U.S. health care spending continues to rise, more insurers will consider using off-shore providers. Some insurers

260. Mattoo & Rathindran, *supra* note 161, at 362. The U.S. spends roughly \$2 trillion per year on health care. *See supra* note 1.

261. *See* Appleby & Schmit, *supra* note 225, at 3B (referring to Princeton economist Uwe Reinhardt’s comment that the introduction of global competition to the American medical profession may not grow large enough to have an impact on American health care prices); *cf.* Milstein & Smith, *supra* note 51, at 141 (stating that “offshore surgery is unlikely to reduce near-term total U.S. health spending by more than 1–2%”).

262. Milstein & Smith, *supra* note 51, at 140–41.

263. Mattoo & Rathindran, *supra* note 161, at 362.

264. *Id.*

265. *Id.* (citing DIRECT RESEARCH, MEDICARE PHYSICIAN PAYMENT RATES COMPARED TO RATES PAID BY THE AVERAGE PRIVATE INSURER, 1999–2001 (2003), [http://www.medpac.gov/publications/contractor_reports/Aug03_PhysPayRates\(cont\)Rpt.pdf](http://www.medpac.gov/publications/contractor_reports/Aug03_PhysPayRates(cont)Rpt.pdf)).

266. *Id.*

267. Chanda, *supra* note 2, at 33–34.

268. Henderson, *supra* note 7, at 114.

269. Mudur, *supra* note 171.

270. Krysten Crawford, *Medical Tourism Agencies Take Operations Overseas*, CNN, (Aug. 3, 2006), <http://money.cnn.com/2006/08/02/magazines/business2/medicaltourism.biz2/index.htm>

271. Chanda, *supra* note 2, at 16.

272. *Id.* at 18.

have already made the leap. Three insurers in California pay for U.S. residents to obtain medical care in Mexico.²⁷³ Health Net offers plans to employers and individuals under its “Salud con Health Net” program.²⁷⁴ The Mexican insurer SIMNSA offers similar plans, sometimes in conjunction with Health Net.²⁷⁵ BlueShield offers “Access Baja” to its customers who live near the border.²⁷⁶ These plans generally offer lower premiums and deductibles than plans that pay only for U.S. providers.²⁷⁷

Other insurers are stretching well beyond Mexico. United Group Programs recently added the Bumrungrad Hospital in Thailand to its preferred provider network.²⁷⁸ Blue Cross Blue Shield and the British insurer Bupa insure patients treated at the Wockhardt Hospitals in India.²⁷⁹ In fact, Blue Cross Blue Shield helps its members obtain emergency and non-emergency care overseas through its BlueCard Worldwide program, which is run by a company that maintains a global network of hospitals, physicians, and other health care providers.²⁸⁰

Public insurers are also looking overseas. In 2006, West Virginia legislators proposed a bill that would give state public employees incentives to seek medical treatments overseas at JCI-accredited hospitals.²⁸¹ The bill asks the state to (1) waive copayments and deductibles, (2) pay the round-trip airfare and up to seven days of hotel expenses for the employee and one companion, (3) compensate the employer for sick leave, and (4) pay up to twenty percent of the cost savings to the employee.²⁸² The proposal would deposit the remaining eighty percent of cost savings into a state fund, with rebates distributed to employees covered under West Virginia’s Public Employees

273. Richard Marosi, *The Mexico Option: Healthcare Is Migrating South of the Border*, L.A. TIMES, Aug. 21, 2005, at A1; Sarah Skidmore, *Cross-Border Health Insurance Is a Hit with Employers and Workers*, SAN DIEGO UNION-TRIB., Oct. 16, 2005, at H1.

274. Deborah Crowe, Andy Fixmer & Anne Riley-Katz, *Health Net Expands Latino Outreach*, 28 L.A. BUS. J., June 12, 2006, at 13; *see also* Health Net, <http://www.healthnet.com>.

275. *See* Sistemas Medicos Nacionales, S.A. de C.V. (SIMNSA), <http://www.simnsa.com/about.html>; *see generally* Marosi, *supra* note 273; Skidmore, *supra* note 273.

276. Blue of California, Access Baja HMO Plans, <https://www.blueshieldca.com/producer/smallgroups/products/health/baja/>.

277. Altman *et al.*, *supra* note 51, at 18 (citing comments made by the American CEO of Bumrungrad Hospital in Thailand, who predicts that someday U.S. insurance companies will offer two-tiered plans with lower premiums for certain procedures performed outside the United States); Marosi, *supra* note 273; Skidmore, *supra* note 273.

278. Daniel Yi, *Overseas Surgery a Clamp on Costs*, L.A. TIMES, July 30, 2006, at A1.

279. Ray Marcelo, *India Hopes to Foster Growing Business in ‘Medical Tourism’*, FIN. TIMES, July 2, 2003, at 10, 2003 WLNR 8160381.

280. BlueCard Worldwide—When Traveling Outside of the U.S., <http://www.bcbs.com/bluecardworldwide/index.html>; *see* Mattoo & Rathindran, *supra* note 4, at 6 (explaining that the network is maintained by World Access Service Corporation); *see generally* World Access, <http://www.worldaccess.com/en/aboutus/products/health.htm>.

281. *See* H.B. 4359, 77th Leg., Reg. Sess. (W. Va. 2006); H.B. 4711, 77th Leg., Reg. Sess. (W. Va. 2006). These bills did not pass during West Virginia’s two-month legislative session in 2006, but Delegate Ray Canterbury (R-28) reintroduced the bill in February 2007. *See* H.B. 2841, 78th Leg., Reg. Sess. (W. Va. 2007).

282. W. Va. H.B. 2841. The bill does not propose how to calculate the “cost savings” between foreign and U.S. hospitals.

Insurance Agency.²⁸³ The legislators intended the bill to encourage competition among West Virginia providers.²⁸⁴

Foreign providers are also contacting U.S. insurers. Private clinics in Canada are contacting U.S. insurers to offer medical services at a fraction of U.S. prices.²⁸⁵ The Apollo Group in India is negotiating with insurers in the United States and Europe to design ways to encourage patients to visit India for certain elective procedures.²⁸⁶ Several hospitals also have in-house departments that liaise with foreign insurers.²⁸⁷

Thus, health insurance is becoming more portable. EU member states cover treatments abroad out of legal necessity. TRICARE covers treatments abroad out of practical necessity. And Californian insurers cover treatments in Mexico out of demographic necessity—insuring a population that traditionally lacks health insurance and may prefer Spanish-speaking providers. These early adopters may be setting a precedent for other U.S. insurers, as some mainstream insurers are now considering foreign providers primarily for cost-saving reasons.

4. Minimizing Fraud, Abuse, and Moral Hazard

Paying for medical care overseas is not without risk. Cross-border insurers face the same problems that confront domestic insurers, such as fraud, abuse, and moral hazard (the threat that the insured will overconsume health care precisely because they are insured).²⁸⁸ Moreover, these problems may be magnified when dealing with foreign providers that operate under different legal, regulatory, and financial systems.

Nevertheless, the World Bank proposed using traditional insurance tools to combat these problems.²⁸⁹ To combat fraud and abuse by foreign providers—such as overbilling and providing unnecessary treatments—insurers can require utilization reviews by which U.S. physicians can verify the need for treatment *ex ante*, and the receipt of treatment *ex post*.²⁹⁰ Insurers can also create international provider networks to monitor foreign providers. The threat of being removed from a provider network and losing access to the lucrative U.S. market would give providers a strong incentive to avoid allegations of fraud. Finally, insurers can sign contracts with foreign providers that grant insurers audit rights, increasing transparency.

283. *Id.*

284. See Kris Wise, *Bill Would Cover Surgeries Outside U.S.*, CHARLESTON DAILY MAIL (W. Va.), Feb. 3, 2006, at 7A.

285. Benavides, *supra* note 123, at 68; Chanda, *supra* note 2, at 72–73 (noting the effect that NAFTA has had on cross-border mobility between Canada and the United States, which has resulted in Canadian private clinics tapping into the U.S. market).

286. Mattoo & Rathindran, *supra* note 4, at 15.

287. See, e.g., Erickson, *supra* note 108 (noting Penang Hospital's special billing department that works with U.S. insurance companies).

288. See generally Tom Baker, *On the Genealogy of Moral Hazard*, 75 TEX. L. REV. 237 (1996).

289. Mattoo & Rathindran, *supra* note 4, at 8–11; Mattoo & Rathindran, *supra* note 161, at 364–65.

290. Mattoo & Rathindran, *supra* note 4, at 10–11; Mattoo & Rathindran, *supra* note 161, at 364–65.

To minimize moral hazard, the World Bank authors state that insurers can create cross-border plans with lower premiums and higher deductibles.²⁹¹ The lower premiums could encourage patients to travel abroad in the first instance—patients that do not wish to travel abroad could choose domestic plans with higher premiums—and the higher deductibles could discourage moral hazard.²⁹² Indeed, some insurers in California already use lower premiums to encourage California residents to visit Mexican providers,²⁹³ and as the World Bank authors note, private insurers use different premiums and deductibles for out-of-network providers.²⁹⁴ Creating cross-border plans is merely an extension of that practice.

It is not clear whether we should be as optimistic as the World Bank that traditional insurance tools can effectively mitigate fraud, abuse, and moral hazard in overseas medical care, as these tools have arguably not worked well in the United States. Nevertheless, combining these tools with international provider networks and other incentive structures may make cross-border health insurance more plausible.

The lure of medical tourism is that it may relieve the intense cost pressures on the U.S. health care system. In a system growing more desperate to reduce spending, we must seriously explore any potential release valve. As we gather more data on the cost savings, we will see more U.S. payors use foreign providers. These early adopters, possibly using lessons from the EU and TRICARE, can help determine whether existing insurance tools are sufficient to minimize some of the risks of paying for health care overseas.

B. Quality of Care

During a Senate hearing on medical tourism, Senator Smith asked, “Does lower cost equal lower quality?”²⁹⁵ In many ways, the medical tourism experiment hinges on whether developing countries can offer health care of comparable quality to that offered in the United States. If they cannot, then predictions of the potential cost savings lose their power. This fundamental question confronts U.S. lawmakers, regulators, insurers, and most importantly, patients. Using foreign providers is a calculated risk, particularly for patients, whose health is at stake. Medical tourism is *caveat emptor* in the purest sense. Should patients trust health care providers in developing countries, and do they have adequate information to evaluate the quality of foreign providers? Can we rely on the information we receive from foreign providers, governments, and brokers? Can we trust insurers? What role, if any, should the U.S. government play?

These are difficult issues, and whether we trust foreign providers is not a binary question. The range of providers in developing countries precludes us from generalizing about their collective quality. We lack the data to measure health care quality overseas. Most countries, including the United States, do not require hospitals

291. Mattoo & Rathindran, *supra* note 4, at 10–11; Mattoo & Rathindran, *supra* note 161, at 364–65.

292. Mattoo & Rathindran, *supra* note 4, at 10–11; Mattoo & Rathindran, *supra* note 161, at 364–65.

293. See Marosi, *supra* note 273; Skidmore, *supra* note 273.

294. Mattoo & Rathindran, *supra* note 4, at 11.

295. *Senate Hearing*, *supra* note 5 (statement of Chairman Gordon H. Smith).

to measure or report outcomes for medical procedures.²⁹⁶ Even if hospitals did report such data, comparisons could be misleading because there is no international system for measuring such outcomes.²⁹⁷ More fundamentally, measuring “quality” is exceedingly difficult.²⁹⁸ Quality is often in the eye of the beholder—insurers’ expectations and valuations will differ from patients’.²⁹⁹ The most concrete comparison may be to analyze mortality rates for certain procedures across countries. This data shows that the United States has a negligible advantage in performing certain complex (but common) medical procedures, such as coronary artery bypass grafts.³⁰⁰ But again, this method is problematic because mortality is a crude proxy for quality.³⁰¹ For most procedures, death is an infrequent result,³⁰² particularly for the procedures medical tourists generally seek. Yet other quality indicators, such as quality of life improvement, are difficult to define and more difficult to measure than mortality.³⁰³ Thus, we currently lack the data and methodology to properly compare quality between providers in the United States and developing countries.

Notwithstanding these challenges, there are structural aspects of medical tourism that raise quality concerns. Even assuming that U.S. patients will visit foreign hospitals and physicians that meet U.S. standards,³⁰⁴ several risks remain. Until we obtain useful comparative quality data, we can at least contemplate the risks presented by the structural aspects of medical tourism and globalization.

1. General Concerns

Medical tourism raises quality concerns because patients must travel both before and after treatment. Patients may not receive adequate pre-screening from foreign providers.³⁰⁵ Although the top foreign hospitals often facilitate contact between physicians and foreign patients, these contacts generally are remote. Physicians can review medical histories, test results, and even communicate with patients,³⁰⁶ but they cannot physically examine the patient until he or she arrives, which may be only days

296. *Id.* (statement of Arnold Milstein, Chief Physician, Mercer Health & Benefits, Medical Director, Pacific Business Group on Health).

297. *Id.*

298. Elizabeth A. McGlynn, *Six Challenges in Measuring the Quality of Health Care*, 16 HEALTH AFF. 7 (1997); *see supra* note 82.

299. McGlynn, *supra* note 298, at 9.

300. *Senate Hearing, supra* note 5 (statement of Arnold Milstein, Chief Physician, Mercer Health & Benefits, Medical Director, Pacific Business Group on Health) (explaining that certain hospitals in developing countries have low gross mortality rates for coronary artery bypass grafts); *see also*, Klaus, *supra* note 7, at 225 (stating that the mortality rate for coronary bypass patients at the Escorts Heart Institute in India was 0.8% in 1999, versus 2.35 percent at New York Presbyterian Hospital, and that post-operative infection rates for cardiac surgeries in India compare favorably with most U.S. hospitals).

301. Jost, *Oversight of the Quality of Medical Care, supra* note 82, at 851–52.

302. *See id.* at 852.

303. *Id.*

304. *See supra* Part II.B.1.

305. Henderson, *supra* note 7, at 117.

306. Klaus, *supra* note 7, at 227–28.

before surgery. Thus, the pre-screening process may not adequately replicate the in-person screening process that U.S. physicians perform.

U.S. physicians also worry that patients may not receive adequate post-operative care overseas.³⁰⁷ Patients may underestimate their recovery times when booking travel arrangements. Even patients who take time to convalesce may have difficulty obtaining check-ups or follow-up procedures.³⁰⁸ U.S. physicians may be reluctant to provide follow-up care for surgeries performed overseas.³⁰⁹ Insurers fear that patients will return with complications,³¹⁰ and insurers may not cover remedial care. Finally, the uninsured medical tourist who pays for the procedure out-of-pocket may not be able to afford follow-up treatments in the United States.³¹¹

One possible solution is for insurers and hospitals to use international provider networks to pre-screen patients and to provide follow-up care in the United States. Global hospital networks like the Apollo Group and Adventist Health International may already take advantage of their international networks.³¹² Indeed, Penang Adventist Hospital reportedly instructs U.S. patients who experience complications to visit one of its affiliate hospitals in the United States and “not worry about money.”³¹³ Although this claim seems dubious, international provider networks can reduce the risks that patients will not receive adequate pre-screening or post-operative care. Insurers can even adopt a hybrid approach by outsourcing expensive surgeries while performing pre-screening and follow-up care in the United States.

2. Regulatory Disincentives

Another structural feature of medical tourism that raises quality concerns is the risk that global competition will create perverse regulatory disincentives. As medical tourism becomes more lucrative, countries may compete by offering treatments that other countries do not offer. Poor countries may be tempted to offer treatments that are illegal or highly experimental elsewhere.³¹⁴ One author worries that competition for patients in Asia may encourage poorer countries like Cambodia, Laos, and Myanmar to “engage in less reputable practices that are illegal or not widely obtainable.”³¹⁵ This competitive dynamic is particularly striking with controversial practices, such as organ transplantations and xenotransplantations (the use of animal cells, tissues, or organs in humans). For example, patients seeking xenotransplantation procedures visit countries like Mexico for controversial treatments that can be exceedingly dangerous.³¹⁶

307. Henderson, *supra* note 7, at 117.

308. *Id.*

309. Klaus, *supra* note 7, at 226.

310. Mattoo & Rathindran, *supra* note 4, at 21.

311. Klaus, *supra* note 7, at 226–27.

312. *See, e.g.*, Penang Adventist Hospital, http://www.pah.com.my/about_us/index.asp; Apollo Hospitals Group, <http://www.apollohospitals.com/>.

313. Erickson, *supra* note 108.

314. Henderson, *supra* note 7, at 116.

315. *Id.*

316. *See* Peta S. Cook, Gavin Kendall, Mike Michael & Nik Brown, *Xenotourism and Xenotravel: Some Notes on Global Regulation* 5–6 (Oct. 28, 2005) (unpublished paper presented to the Social Change in the 21st Century Conference), <http://eprints.qut.edu.au/archive/00003449/01/3449.pdf>. Xenotransplantation is not illegal *per se* in the United States,

Competition for patients may recreate the same regulatory “race to the bottom” that has affected other global markets.³¹⁷ Governments may be reluctant to place legal restrictions on local businesses that may raise prices or otherwise hamper their ability to compete.

As discussed above, some patients will always vote with their feet and travel to countries with more permissive laws.³¹⁸ When patients leave the United States, they are expressing a distinct policy preference for a foreign system—even if the expression is temporary. For example, U.S. patients traveled to Europe, Asia, and India for a hip resurfacing procedure that was not approved by the FDA until recently.³¹⁹ Reproductive tourists are particularly assertive forum shoppers.³²⁰ In 2001, after the FDA began banning several controversial fertility treatments, couples began traveling overseas for the procedures.³²¹ Patients are more willing than ever to leave the United States if they are not satisfied with the procedures available here. At the same time, such patients are taking a calculated risk. Horror stories abound of patients being seriously injured from cosmetic surgeries in developing countries.³²² The media

but it is strictly regulated by the FDA. See generally FDA, *Guidance for Industry: Source Animal, Product, Preclinical, and Clinical Issues Concerning the Use of Xenotransplantation Products in Humans*, <http://www.fda.gov/cber/gdlns/clinxeno.htm>. Because of the risks, some have called for a moratorium on all xenotransplantation procedures. Margaret A. Clark, *This Little Piggy Went to Market: The Xenotransplantation and Xenozoonose Debate*, 27 J.L. MED. & ETHICS 137, 147 (1999); but see Harold Y. Vanderpool, *Commentary: A Critique of Clark’s Frightening Xenotransplantation Scenario*, 27 J.L. MED. & ETHICS 153 (1999).

317. Cf. Jonathan P. Hiatt & Deborah Greenfield, *The Importance of Core Labor Rights in World Development*, 26 MICH. J. INT’L L. 39, 41 (2004) (describing the regulatory race to the bottom in the international labor market); Andrew L. Strauss, *From Gattzilla to the Green Giant: Winning the Environmental Battle for the Soul of the World Trade Organization*, U. PA. J. INT’L ECON. L. 769, 791 (1998) (describing the regulatory race to the bottom in environmental standards). Note, however, that scholars have long debated whether competition causes a regulatory race to the top or bottom. See, e.g., William L. Cary, *Federalism and Corporate Law: Reflections Upon Delaware*, 83 YALE L.J. 663 (1974); Ralph K. Winter, Jr., *State Law, Shareholder Protection, and the Theory of the Corporation*, 6 J. LEGAL STUD. 251 (1977).

318. See *supra* Part II.A.1.

319. See *supra* note 36 and accompanying text.

320. See Lisa Hird Chung, Note, *Free Trade in Human Reproductive Cells: A Solution to Procreative Tourism and the Unregulated Internet*, 15 MINN. J. INT’L L. 263 (2006).

321. See Rick Weiss, *FDA to Regulate Certain Fertilization Procedures*, WASH. POST, July 11, 2001, at A2; Holly Firfer, *How Far Will Couples Go to Conceive?*, CNN, June 17, 2004, <http://www.cnn.com/2004/HEALTH/03/12/infertility.treatment/index.html>. In 2001, the FDA notified fertility clinics that it would require agency approval for treatments that transferred genetic materials without fusing the egg and sperm. Letter from Kathryn C. Zoon, Director, FDA Center for Biologics Evaluation and Research, to Sponsors/Researchers (July 6, 2001), available at <http://www.fda.gov/cber/ltr/cytotrans070601.htm> (advising sponsors and researchers that the FDA has jurisdiction over human cells used in therapy involving the transfer of genetic material by means other than the union of gamete nuclei and that the use of such cells in humans requires the submission of an Investigational New Drug application to the FDA).

322. Cf. *Senate Hearing, supra* note 5 (statement of Dr. Bruce Cunningham, President, American Society of Plastic Surgeons); Richard Kerbaj, *Surgery Overseas Ends in Nightmare*, AUSTRALIAN, May 14, 2005, at T29; Louise Hall & Connie Levett, *Risky Scalpel Tours Cut into Taxpayers’ Pockets*, SYDNEY MORNING HERALD, Aug. 27, 2006, available at <http://www.smh.com.au/news/national/risky-scalpel-tours-cut-into-taxpayers-pockets/2006/>

frequently reports new incidents in which medical tourists have returned home with complications from failed procedures.³²³

Patients may frustrate domestic regulators by traveling overseas for controversial or experimental treatments. Medical tourism may thwart the FDA's efforts to regulate a particular treatment or technology, and may also profoundly affect domestic research and development. Companies seeking FDA approval for products increasingly rely on data from clinical trials in developing countries,³²⁴ particularly when they are under financial and time pressures to complete studies.³²⁵ When U.S. patients travel overseas for treatments that have not been approved by the FDA, they may further deplete the universe of U.S. patients eligible for clinical trials, increasing the FDA's reliance on foreign clinical data.

3. Malpractice Overseas

The third structural feature of medical tourism that raises quality concerns is the risk that developing countries will not adequately protect foreign patients from malpractice.³²⁶ For example, many have criticized the standard for proving medical negligence in Malaysia and Singapore, which heavily defers to physicians in determining the standard of care and whether that standard was breached in each case.³²⁷ Indeed, Penang Adventist Hospital in Malaysia reports that it never has been required to pay for a wrongful death or negligence suit.³²⁸ Many have called India's medical malpractice system "inadequate."³²⁹ Indian legal forums have established very modest compensation by Western standards.³³⁰ The courts in Thailand similarly limit

08/26/1156012789934.html (discussing medical problems that arise when patients seek plastic surgery outside of their home country in order to save money on the procedure costs).

323. See, e.g., Hall & Levett, *supra* note 322; Kerbaj, *supra* note 322.

324. See OFFICE OF EVALUATION & INSPECTIONS, DEP'T OF HEALTH & HUMAN SERVS. OFFICE OF THE INSPECTOR GEN., RECRUITING HUMAN SUBJECTS: PRESSURE IN INDUSTRY-SPONSORED CLINICAL RESEARCH (2000), <http://oig.hhs.gov/oei/reports/oei-01-97-00195.pdf>; OFFICE OF EVALUATION & INSPECTIONS, DEP'T OF HEALTH & HUMAN SERVS. OFFICE OF THE INSPECTOR GEN., THE GLOBALIZATION OF CLINICAL TRIALS (2001), <http://oig.hhs.gov/oei/reports/oei-01-00-00190.pdf>.

325. Cf. OFFICE OF EVALUATION & INSPECTIONS, DEP'T OF HEALTH & HUMAN SERVS. OFFICE OF THE INSPECTOR GEN., THE GLOBALIZATION OF CLINICAL TRIALS, *supra* note 324, at 8–9 (stating that sponsors have expanded their research sites into many countries that have limited experience in clinical trials).

326. See Mattoo & Rathindran, *supra* note 4, at 21; Henderson, *supra* note 7, at 117.

327. See, e.g., Kumaralingam Amirthalingam, *Judging Doctors and Diagnosing the Law: Bolam Rules in Singapore and Malaysia*, 2003 SING. J. LEGAL STUD. 125 (2003).

328. Erickson, *supra* note 108.

329. Ganapati Mudur, *Indian Doctors Not Accountable, Says Consumer Report*, 321 BRIT. MED. J. 588 (2000), <http://www.bmj.com/cgi/content/full/321/7261/588> (noting that patients in India have difficulty obtaining documents and finding doctors willing to testify against other doctors); see also Chanda, *supra* note 2, at 48 (explaining that there are concerns about possibilities of exploitation in India's health care system because of the lack of recourse against negligence or malpractice).

330. Cf. Ramesh Bhat, *Regulating the Private Health Care Sector: The Case of the Indian Consumer Protection Act*, 11 HEALTH POL'Y & PLAN. 265, 267 (1996) (describing the minimum amounts in controversy for various Indian consumer complaint forums to exercise jurisdiction).

malpractice awards and do not compensate for pain or suffering.³³¹ Thus, even if providers in these countries meet U.S. standards, the legal systems there may not adequately protect U.S. patients from medical negligence.

Though inadequate malpractice regimes are a real concern, foreign hospitals do have financial incentives not to injure U.S. patients. Hospitals that compete for foreign patients will compete, at least in part, based on quality. Perceived or actual quality failures at these hospitals could decimate their ability to attract foreign patients, and could cost them millions in lost revenues. For example, the threat of being excluded from a U.S. insurer's provider network and losing access to the lucrative U.S. market should deter carelessness. Similarly, insurers can use international provider networks to help screen for substandard quality. Finally, losing JCI accreditation could be catastrophic if payors use accreditation as a prerequisite for payment.

Quality is the great unknown in medical tourism. There is ample evidence that foreign hospitals and physicians can meet U.S. standards of competence and quality.³³² But we currently lack the ability to measure, monitor, or compare the quality of care in foreign countries. Moreover, certain structural aspects of medical tourism—such as international travel and inadequate medical malpractice regimes—make quality predictions even more opaque. Therefore, U.S. regulators, insurers, and patients should continue to look for ways to more accurately determine the quality of care offered overseas.

C. Access to Care

Among the three themes of cost, quality, and access, predicting how medical tourism will affect access to medical care is the most difficult. Does medical tourism improve access to care, or does it magnify the income disparities in our health care system? What effect does it have on access to care in developing countries? And should we allow citizens with financial means to buy their way out of our health care and legal systems?³³³ Even though we presently lack the data to answer these questions, we can analyze their theoretical underpinnings.

1. Access to Care in the United States

A common argument against medical tourism is that it exacerbates unequal access to health care because only patients with adequate financial resources can afford to pay out-of-pocket for plane tickets, hotels, and medical expenses.³³⁴ Relying on foreign providers may deny poor citizens access to an even larger universe of medical services, and may divert our attention from more fundamental problems with our health care system. These arguments resonate, particularly when we consider the current trajectory

331. Mark Roth, *A Cheaper Medical Alternative for Those with Minimal Health Insurance, Getting Surgery Abroad May Be a Sound Option*, PITT. POST-GAZETTE, Sept. 10, 2006, at G1.

332. See *supra* Part II.B.1.

333. Cf. Pennings, *supra* note 29, at 338 (citing Tamara K. Hervey, *Buy Baby: The European Union and Regulation of Human Reproduction*, 18 (2) OXFORD J. L. STUD. 207, 228–29 (1998) (questioning the fairness of allowing some to buy their way out of their country's regulatory scheme based on their ability to afford traveling to a country that allows the reproductive procedure)).

334. Pennings, *supra* note 29, at 338; Henderson, *supra* note 7, at 118.

showing that fewer Americans can afford health insurance every year.³³⁵ However, the counter-arguments are more persuasive.

First, medical tourism should improve access to care for two significant populations: the uninsured and the underinsured. Counterintuitively, there is great diversity within these populations. They are not necessarily the poorest among us—Medicare, Medicaid, and other public programs generally cover our poorest citizens, including those who are “unemployable,” such as children, the elderly, and certain disabled persons.³³⁶ Eighty percent of the uninsured are either employed or belong to households of someone who is.³³⁷ Most have low incomes and either work part-time, or for small employers, or are self-employed. As a result, they may not be offered employer-sponsored health insurance, or may not be able to afford it.³³⁸ A significant portion of the uninsured can afford health insurance, but are between jobs or in temporary jobs, or simply choose to be uninsured.³³⁹ In fact, 8.4 percent of the uninsured are from households that earn \$75,000 or more annually.³⁴⁰ Finally, many citizens are “underinsured” insofar as their health insurance does not cover procedures that they may need.³⁴¹ Low-cost foreign providers may offer medical treatments that these patients otherwise could not afford.³⁴² And more importantly, health insurers that use foreign providers may expand their coverage, perhaps creating low-cost health plans that cover part-time or temporary employees that make up a large portion of the uninsured.

Second, medical tourism cannot make health care less accessible if patients travel precisely because they cannot afford health care in the United States.³⁴³ Preventing patients from traveling overseas may deprive these patients of medical care they may not otherwise be able to afford.³⁴⁴ Moreover, because the United States lacks universal health insurance coverage, our system invariably reflects income inequalities, so similar income inequalities in the global market should not be dispositive.³⁴⁵ Thus, the argument that medical tourism will have a net negative effect on access to medical care in the United States is not very compelling.

335. See DENAVAS-WALT ET AL., *supra* note 3; see also Jost, *supra* note 65, at 540–41 (citing COVER THE UNINSURED, ROBERT WOOD JOHNSON FOUND., *Fact Sheet: Income and Poverty Status*, (Apr. 3, 2006) available at <http://covertheuninsuredweek.org/factsheets/display.php?FactSheetID=108>).

336. See Jost, *supra* note 65, at 541 (citing *In Critical Condition: America's Ailing Health Care System: Before the S. Special Comm. on Aging*, 108th Cong. 5 (2003) (statement of Karen Davis, President, The Commonwealth Fund)).

337. *Id.* (citing Sherry A. Glied, *Challenges and Options for Increasing the Number of Americans with Health Insurance*, 38 INQUIRY 90, 91 (2001)).

338. *Id.* at 540–41.

339. *Id.* at 541.

340. *Id.* (citing DENAVAS-WALT ET AL., *supra* note 3, at 18 tbl.7).

341. Cathy Schoen, Michelle M. Doty, Sara R. Collins & Alyssa M. Holmgren, *Insured But Not Protected: How Many Adults are Underinsured?*, 24 HEALTH AFF. W5-289 (2005) (Web exclusive), <http://content.healthaffairs.org/cgi/reprint/hltaff.w5.509v3>.

342. Milstein & Smith, *supra* note 51, at 137.

343. See, e.g., Pennings, *supra* note 29, at 338.

344. *Id.*

345. *Id.*

However, a long-term concern is that outsourcing expensive medical procedures may deprive U.S. hospitals of revenues that they use to cross-subsidize care for the uninsured.³⁴⁶ Although such long-term effects are speculative, the threat of hospitals losing key revenue sources should trouble us. Moreover, we should expect U.S. providers that might lose revenue to foreign providers to oppose efforts to make health insurance more portable.³⁴⁷

Even if we concede that medical tourism is not a panacea for the access problems we have in the United States, the weight of the arguments suggests that it should not have a net negative impact. Although we currently lack the data to predict with certainty what the impact of medical tourism will be, we understand that it should make health care more accessible for the uninsured and underinsured, particularly those who cannot pay for health care or insurance precisely because it is too expensive.

2. Access to Care in Developing Countries

The major debate in developing countries is whether the campaign to attract foreign patients will ignore the health needs of local citizens and divert resources to private hospitals that cater to foreign clientele.³⁴⁸ Some argue that foreign consumption will crowd out domestic consumption, resulting in an internal “brain drain” and a resource drain.³⁴⁹ Many worry that this may exacerbate the two-tiered health care systems in which affluent patients obtain quality care from private hospitals while poorer patients are relegated to inferior public hospitals.³⁵⁰ The debate is particularly ripe in India, where “there is a general perception that there have been adverse effects on the public health care system . . . and that these benefits have been limited to the affluent urban population.”³⁵¹

Some worry that medical tourism will create an internal “brain drain” in which physicians migrate from public to private hospitals.³⁵² Developing countries have always struggled with an external “brain drain,” as physicians have emigrated to richer countries.³⁵³ Indian doctors are famously mobile—almost 10% of all registered physicians in India practice overseas.³⁵⁴ Some countries, such as Ghana, South Africa,

346. Terry, *supra* note 13; *see generally* Altman et al., *supra* note 51 (arguing that price competition and price transparency may force hospitals to cut the free and under-reimbursed services that they have historically provided). Note that hospitals in New South Wales, Australia, performed 3.2% fewer surgeries in 2005 than 2002, with some hospitals reporting a 90% decline. Some attribute this decline to the growth of Australian patients traveling to Southeast Asia for surgery. Ellen Connolly & Sharri Markson, *Patients Going for Surgery Overseas to Jump Hospital Queues*, SUNDAY TELEGRAPH (Austl.), Oct. 2, 2005, at 14, 2005 WL 15484089.

347. *See, e.g., Senate Hearing, supra* note 5 (statement of Bruce Cunningham, President, American Society of Plastic Surgeons).

348. *E.g.,* Chanda, *supra* note 2, at 17; Mattoo & Rathindran, *supra* note 4, at 26.

349. Chanda, *supra* note 2, at 22–23; Mattoo & Rathindran, *supra* note 4, at 26.

350. Chanda, *supra* note 2, at 17, 48.

351. *Id.* at 48.

352. *Id.*

353. *Id.* at 22; Mullan, *supra* note 21, at 381.

354. Mullan, *supra* note 21, at 381.

and Pakistan, lose roughly half of their medical graduates each year.³⁵⁵ Now, the concern is domestic.³⁵⁶ Physicians may prefer private hospitals that offer higher wages, superior working conditions, and better professional opportunities.³⁵⁷ This migration could impose severe costs on public health care sectors by creating shortages of health care personnel in public hospitals³⁵⁸ and thwarting the investment that countries make in their health care professionals, as most medical schools are publicly funded.³⁵⁹

However, there is evidence that the external “brain drain” is reversing in some countries.³⁶⁰ More Indian physicians working overseas have taken pay cuts to return to India.³⁶¹ The Apollo Group alone claims to have 138 Indian physicians that have returned from overseas.³⁶² According to the WHO study, these physicians “are being lured back by the emergence of world-class facilities due to increased capital flowing into health care, the chance to be a part of a new delivery system, and the opportunity to give back to their country.”³⁶³ This evidence supports the World Bank’s prediction that medical tourism should discourage at least some health professionals from emigrating.³⁶⁴ Moreover, some governments are discouraging emigration. For example, India and South Africa require new medical graduates to perform a minimum period of public service, meet strict emigration requirements, pay emigration taxes, and wait for domestic certification before emigrating.³⁶⁵ These same tools could also be used to keep physicians at public institutions, at least for a short period. Thus, medical tourism may be slowing the external “brain drain” in developing countries, and governments have various tools to discourage or at least delay an internal “brain drain.”

The second concern in developing countries is that medical tourism diverts resources from public to private institutions because governments use public resources to attract foreign patients, and affluent private hospitals capture all the revenues.³⁶⁶ But again, the impact is malleable. The WHO study posits that the net impact of medical tourism depends on whether governments use public funds to subsidize private hospitals.³⁶⁷ As we saw in Part II.C above, many governments aggressively recruit medical tourists with campaigns funded by the government. Nevertheless, if government initiatives generate revenues from foreign patients, then developing countries can use these revenues to cross-subsidize health care for local citizens.³⁶⁸ Unfortunately, the WHO study found little evidence that countries have actually used

355. Chanda, *supra* note 2, at 22–23.

356. *Id.* at 19, 94.

357. *Id.* at 94–95.

358. *Id.* at 19, 48 (noting that in India only ten percent of all physicians practice in the public sector and that the private sector accounts for sixty percent of all hospitals and dispensaries).

359. *Id.* at 23.

360. *Id.* at 46.

361. *Id.*

362. *Id.*

363. *Id.*

364. Mattoo & Rathindran, *supra* note 4, at 26.

365. Chanda, *supra* note 2, at 95.

366. *Id.* at 18–19.

367. *Id.* at 17.

368. Mattoo & Rathindran, *supra* note 4, at 26.

revenues from foreign patients to support the public health sector.³⁶⁹ In fact, some argue that government efforts to attract foreign patients have been at the expense of their national health systems and local patients.³⁷⁰ But, even these observers recognize that some countries have improved their health care systems in the push to attract foreign patients—mainly by raising new capital and improving the quality of care.³⁷¹

Thus, whether medical tourism has a net positive effect on access to health care in developing countries depends, in large part, on how these countries choose to allocate these new revenues. Countries that use public-private partnerships to attract foreign patients should, in theory, share these revenues with public facilities. As one author argues, “it is not acceptable to exclude the local population from the benefits of care that is provided in their country for rich strangers, even if this organization allows less rich countries to develop employment in the health care sector.”³⁷²

3. Enhancing Patient Autonomy

Medical tourists exercise autonomy by seeking medical treatments in other jurisdictions not for cost reasons, but because the treatments are banned by law or regulation where they live. This happens most often with fertility treatments, and it has generated some debate.³⁷³ The concern is that medical tourism allows patients to buy their way out of restrictive local laws and regulations.³⁷⁴ As travel becomes less expensive, some wonder whether “any single jurisdiction can continue to enforce its own rules.”³⁷⁵ Guido Pennings argues that international travel has made it “impossible to enforce laws that people do not consider morally justified.”³⁷⁶ Thus, he argues that legislating medical treatments will be primarily a symbolic public statement of the majority’s moral convictions.³⁷⁷ As an example, Pennings points to the Swiss Federal Council, which lobbied against a law that would have banned most forms of *in vitro* fertilization because the law would merely encourage infertile couples to travel overseas.³⁷⁸ In effect, such laws may remove the government’s control over controversial medical procedures,³⁷⁹ forcing governments to confront their limited jurisdiction. Is it fair that laws and regulations apply only to patients that cannot afford to choose another system? Are medical tourists breaching—or at least opting out of—a

369. Chanda, *supra* note 2, at 103–04.

370. Benavides, *supra* note 123, at 55.

371. *Id.*

372. Segouin, *supra* note 84, at 278.

373. *See, e.g.*, Henderson, *supra* note 7; Hervey, *supra* note 333; Pennings, *supra* note 29. *See generally* Seth F. Kreimer, *The Law of Choice and the Choice of Law: Abortion, the Right to Travel, and Extraterritorial Regulation in American Federalism*, 67 N.Y.U. L. REV. 451 (1992).

374. Hervey, *supra* note 333, at 228–29, 231; Pennings, *supra* note 29, at 338.

375. Pennings, *supra* note 29, at 340 (quoting Margaret Brazier, *Regulating the Reproduction Business?*, 7 MED. L. REV. 166 (1999)).

376. *Id.*

377. *Id.*

378. *Id.* (citing the Swiss Federal Council, <http://www.admin.ch/ch/f/pore/va/20000312/explic/index.html>).

379. *Id.*

social contract with our health care system? Are these dangers worth the increased autonomy for patients?

There are compelling arguments both ways. The strongest argument for medical tourism is that it is equally unfair to deny access to treatments that are available in other countries.³⁸⁰ Some in the European Union argue that it would be unfair for a member state to deny its citizens access to medical services that other EU citizens can obtain.³⁸¹ In fact, the remedies may be worse than the problem. As I show below, some EU countries have used extremely draconian methods to restrict reproductive tourism, and there are real legal and practical limits to denying U.S. patients access to foreign treatments as well.³⁸²

A related argument is that medical tourism allows patients to exercise autonomy and “vote with their feet.”³⁸³ In modern societies characterized by diverging viewpoints, medical tourism may be a “pragmatic solution to the problem of how to combine the democratic system which proceeds according to majority rule, with a degree of individual freedom for members of the minority.”³⁸⁴ Allowing patients to vote with their feet may alleviate the “tyranny of the majority”³⁸⁵ that expresses itself through laws and regulations. This argument requires us to accept a degree of moral pluralism—some citizens may simply prefer medical care in a country with policies that more closely align with their personal moral judgments.³⁸⁶

However, if patients can vote with their feet, they may lose interest in reforming their own health care system. When voters disagree with policies, they can change them through the cumbersome democratic process or simply leave the jurisdiction.³⁸⁷ In many cases, it takes less effort to simply leave. For example, if Congress bans a certain fertility treatment, infertile couples may travel overseas rather than fight to repeal the law. Although a patient exodus may cause the government to reconsider its policies,³⁸⁸ some governments may be content to see the problem exported overseas. At the same time, we can envision the United States Supreme Court striking down *Roe*

380. *See id.* at 338.

381. *Id.*

382. *See infra* Part IV.A.1.

383. Although this phrase is most often associated with the Tiebout Hypothesis, it does not come from Tiebout himself. *See* Christopher Serkin, *Big Differences for Small Governments: Local Governments and the Takings Clause*, 81 N.Y.U.L. REV. 1624, 1662 n.147 (2006) (citing Todd E. Pettys, *The Mobility Paradox*, 92 GEO. L.J. 481, 482 n.10 (2004)).

384. Pennings, *supra* note 29, at 341.

385. JOHN STUART MILL, *ON LIBERTY* 5–6 (David Spitz ed., W.W. Norton & Co. 1975) (1859); 1 ALEXIS DE TOQUEVILLE, *DEMOCRACY IN AMERICA* 288 (Arthur Goldhammer trans., Library of Am. 2004) (1835).

386. Pennings, *supra* note 29, at 338; *see also* Kreimer, *supra* note 373, at 463 (arguing that the Supreme Court, in its abortion jurisprudence, should “defer to our traditions of moral pluralism and mobility among states”); Nielsen, *supra* note 41, at 44 (arguing that respect for autonomy leads to legislative solutions that favor moral pluralism rather than paternalistic universal bans).

387. ALBERT O. HIRSCHMAN, *EXIT, VOICE, AND LOYALTY: RESPONSES TO DECLINES IN FIRMS, ORGANIZATIONS, AND STATES* 4–5 (1970).

388. Pennings, *supra* note 29, at 340–41. Pennings argues that the threat of patients leaving because of local policies will force lawmakers to moderate their views and work harder to convince the public that the policies are correct. *Id.*

v. *Wade*,³⁸⁹ which could mobilize voters.³⁹⁰ Thus, the impact of citizen mobility on political participation is highly fact specific and should not trump autonomy reasons for permitting medical tourism. Although medical tourism allows patients to escape our laws and regulations, it also allows patients to exercise their autonomy and vote with their feet. This may lead to some degree of political disengagement, but it may also force us to reconsider restrictive local policies.

III. POLICY APPROACHES

Part III considered the distinct new risks and opportunities medical tourism presents by analyzing how it may affect health care costs, quality, and access—the three canonical themes of health policy. Given these risks and opportunities, Part IV considers specific policy approaches available to the United States, including both unilateral and multilateral options.

A. Unilateral Approaches

Although U.S. regulators may not have jurisdiction over foreign providers, they clearly have jurisdiction over U.S. patients, referral networks, employers, and insurers. This section considers policies governing each of these groups, including efforts to (i) regulate patient travel, (ii) regulate referral networks, (iii) regulate health insurers, and (iv) provide agency oversight. Relying on analyses of previous regulatory efforts in analogous areas—including efforts in the United States and European Union to regulate reproductive tourism—I criticize some proposed responses as either impractical or foreclosed by current constitutional doctrine governing the right to travel and the right to free speech.³⁹¹ Instead, I propose that we build on existing consumer protection regimes, expand licensing systems, and recalibrate existing schemes that may unfairly allocate the risks and benefits between patients and employers or patients and insurers. Ideally, these efforts would be centrally coordinated through the one federal agency that is uniquely qualified to appreciate the risks and opportunities of medical tourism—the U.S. Department of Health and Human Services (HHS).

389. 410 U.S. 113 (1973).

390. For example, voter turnout was relatively high for a controversial abortion referendum in the 2006 election in South Dakota, despite the lack of any competitive candidate races. See George Pillsbury, Julian Johannesen & Jeff Arp, Nonprofit Voter Engagement Network, *America Goes to the Polls: A Report on Voter Turnout in the 2006 Election* 6–9, <http://www.nonprofitvote.org/wp-content/uploads/AGttP.pdf>.

391. Indeed, restricting patients from traveling overseas for medical procedures could also potentially violate a patient's fundamental liberty interest under the Due Process Clause. See *Abigail Alliance for Better Access to Developmental Drugs & Wash. Legal Found. v. von Eschenbach*, 445 F.3d 470, 475–77 (D.C. Cir. 2006). Note, however, that *en banc* review of the initial D.C. Circuit opinion reversed the panel's holding that the Constitution provided terminally ill patients a fundamental right to obtain experimental drugs not yet proven safe or effective to FDA's satisfaction. See *Abigail Alliance for Better Access to Developmental Drugs & Wash. Legal Found. v. von Eschenbach*, 495 F.3d 695 (D.C. Cir. 2007), *cert denied*, 2008 WL 114305.

1. Regulating Patient Travel

We can imagine that some lawmakers would oppose medical tourism so vehemently that they might try to prevent patients from traveling overseas. Indeed, we need not imagine such a response if we consider policies targeting reproductive tourism. Previous efforts in the United States and the European Union to discourage reproductive tourism show that there are legal and practical limits to regulating patient travel. Some European countries enforced draconian laws to prevent citizens from seeking abortions in countries where abortion is legal.³⁹² For example, Irish prosecutors enjoined a fourteen-year-old rape victim from traveling to England for an abortion until the Irish Supreme Court overturned the injunction.³⁹³ Likewise, an old West German law criminalized obtaining abortions in other countries.³⁹⁴ German border guards forced gynecological examinations on women reentering Germany at the Dutch border, and prosecutors brought criminal charges against the women who were found to have violated the law.³⁹⁵ The European Union condemned Ireland and Germany for these practices.³⁹⁶

Yet the rift over reproductive tourism in Europe remains, provoked by ongoing differences between the abortion laws in many EU countries. In 2001, a Dutch-based floating abortion clinic, Women on Waves, sought to provide abortions in international waters off the coasts of Ireland and other European countries with strict abortion laws.³⁹⁷ Later, the clinic stopped in international waters near Poland and Portugal.³⁹⁸ Although Dutch law generally permits abortions, laws in Ireland, Portugal, and Poland generally do not.³⁹⁹ Women on Waves reignited abortion debates in these countries.⁴⁰⁰ In fact, when Women on Waves sailed near Portugal, the Portuguese Defense Minister

392. See Kreimer, *supra* note 373, at 457–58.

393. The Attorney General v. X, [1992] 1 I.R. 1 (5th March, 1992) (Ir.) (overturning the injunction because the rape victim threatened to commit suicide if it was upheld); Kreimer, *supra* note 373, at 458 n.22.

394. Karen Y. Crabbs, *The German Abortion Debate: Stumbling Block to Unity*, 6 FLA. J. INT'L L. 213, 222–23 (1991); Kreimer, *supra* note 373, at 458.

395. Crabbs, *supra* note 394, at 222–23 n.103, 106 (describing cases in which German women were questioned at the border, required to undergo physical examinations, and/or prosecuted); Kreimer, *supra* note 33, at 908 n.5 (citing European Parliamentary debate on resolutions to condemn gynecological exams by German guards at the Dutch border); Kreimer, *supra* note 373, at 458.

396. Pennings, *supra* note 29, at 339. For example, the European Parliament publicly condemned the German authorities, stating that Germany could not prosecute citizens for engaging in activities in other EU member states where the activities were legal. Kreimer, *supra* note 373, at 458 n.23.

397. Allison M. Clifford, *Abortion in International Waters off the Coast of Ireland: Avoiding a Collision Between Irish Moral Sovereignty and the European Community*, 14 PACE INT'L L. REV. 385, 387–89 (2002).

398. See Women on Waves, <http://www.womenonwaves.org> (site contains graphic images).

399. Clifford, *supra* note 397, at 387–89, 393 n.32; *Defying Portugal's Strict Abortion Law*, EL PAÍS (Port.), Feb. 27, 2006, at 4, 2006 WLNR 3340794.

400. See, e.g., Clifford, *supra* note 397; Alicia Czerwinski, *Sex, Politics, and Religion: The Clash Between Poland and the European Union over Abortion*, 32 DENV. J. INT'L L. & POL'Y 653 (2004); *Defying Portugal's Strict Abortion Law*, *supra* note 399, at 1.

intercepted the boat with a military frigate.⁴⁰¹ At least one author claims that Women on Waves is making a mockery of these countries' laws, arguing that Ireland and other EU countries should be able to enjoin their citizens from seeking abortions in international waters (and by extension, in other countries).⁴⁰²

In the United States, the debate has focused on reproductive tourists traveling domestically rather than internationally. The EU legal structure governing travel between member states is somewhat analogous to the U.S. legal structure governing interstate travel. European law prohibits member states from restricting the free movement of goods, services, or people within the European Union.⁴⁰³ Similarly, the U.S. Constitution generally prohibits states from preventing their citizens from traveling to other states or punishing their extraterritorial conduct.⁴⁰⁴ Seth Kreimer argues that states are limited by the Citizenship Clause of the Fourteenth Amendment, the Commerce Clause, and the Privileges and Immunities Clause of Article IV.⁴⁰⁵ Thus, the Constitution generally prohibits states from restricting travel within the United States.

Of course, the Constitution does not similarly restrain the *federal* government from regulating international travel or citizens' conduct overseas.⁴⁰⁶ Although restrictions on interstate travel are generally judged by a strict scrutiny standard, restrictions on international travel may be judged under a less exacting standard. In *Califano v. Aznavorian*,⁴⁰⁷ the Supreme Court held that a Social Security law denying benefits to citizens during any month they spent outside the United States did not violate their right to international travel.⁴⁰⁸ The Court rejected the argument that "the freedom of international travel is basically equivalent to the constitutional right to interstate travel."⁴⁰⁹ Thus, the Court applied a rational basis test, finding that the Social Security law had only an "incidental effect on international travel" and was not "wholly

401. *Defying Portugal's Strict Abortion Law*, *supra* note 399, at 1.

402. Clifford, *supra* note 397, at 394–95, 417–18 (arguing that if the European Court of Justice is confronted with a case involving Women on Waves, it should not prohibit Ireland from enjoining its citizens from obtaining abortions in international waters, and that such an injunction should be a permissible derogation from European Community law).

403. See EC Treaty, *supra* note 248, arts. 14(2), 23–31, 49–50.

404. See Kreimer, *supra* note 373.

405. *Id.* First, Professor Kreimer argues that the Citizenship Clause of the Fourteenth Amendment was intended to protect the right of interstate travel. *Id.* at 505, n.186. He notes that shortly after the Fourteenth Amendment was adopted, the Supreme Court interpreted substantive due process to include a territorial restriction that prohibited states from criminalizing out-of-state conduct. *Id.* at 469–72. Second, he argues that the Commerce Clause protects interstate travel against state obstruction. *Id.* at 488. Third, he argues that the Privileges and Immunities Clause of Article IV limits state efforts to: (1) discriminate against out-of-state citizens; (2) create barriers to entry and exit; and (3) prosecute residents for extraterritorial conduct. *Id.* at 509–19. *But see* C. Steven Bradford, *What Happens if Roe is Overruled? Extraterritorial Regulation of Abortion by the States*, 35 ARIZ. L. REV. 87 (1993) (arguing that the case law does not so clearly reject the extraterritorial application of state abortion laws).

406. Kreimer, *supra* note 373, at 474 n.74.

407. 439 U.S. 170 (1978); *Milkson v. Sec'y of the Dep't of Health and Human Servs.*, 633 F. Supp. 836 (E.D.N.Y. 1986).

408. *Califano*, 439 U.S. 170.

409. *Id.* at 177.

irrational.”⁴¹⁰ The government defended the law by arguing that the Social Security Administration would have difficulty monitoring the eligibility of beneficiaries outside of the United States and that Congress may have intended to limit Social Security payments to beneficiaries spending their money in the United States.⁴¹¹ Although the Court did not find these justifications “compelling,” it found them to be “rationally based” and upheld the law.⁴¹²

After *Califano*, a court faced with a similar fact pattern applied the same rational basis standard.⁴¹³ However, in three cases preceding *Califano*, the Supreme Court gave the right to international travel much more weight. First, in *Kent v. Dulles*, the Court struck down a State Department regulation that allowed the Department to deny passport applications based on the applicant’s political affiliations.⁴¹⁴ Although the Court did not rule on whether the regulation infringed the constitutional right to international travel, the Court seemed to interpret it as a fundamental right that could be subject to strict scrutiny.⁴¹⁵

Shortly thereafter, the Court directly confronted the issue in a similar case, *Aptheker v. Secretary of State*,⁴¹⁶ and struck down a statute that prohibited members of communist organizations from applying for or using a U.S. passport.⁴¹⁷ The Court stated that even if the government’s interest was legitimate and substantial, it could not infringe “fundamental personal liberties” unless the law was “narrowly drawn.”⁴¹⁸ Thus, the Court appeared to use a strict scrutiny standard with international travel.⁴¹⁹

The following year, in *Zemel v. Rusk*,⁴²⁰ the Court actually permitted a similar restriction on international travel by upholding the Secretary of State’s authority to refuse to validate passports for travel to Cuba.⁴²¹ The Court rejected the argument that the restriction infringed the constitutional right to travel abroad because the government could justify the restriction in the wake of the Cuban missile crisis.⁴²² However, the Court did not clarify the standard of review for laws that directly restrict international travel.⁴²³

Because these pre-*Califano* cases confronted more direct restrictions on international travel, we can argue logically that laws that have more than an “incidental effect” on such travel should be subject to a more stringent standard than the rational

410. *Id.*

411. *Id.* at 178.

412. *Id.*

413. *Milkson v. Sec’y of the Dep’t of Health and Human Servs.*, 633 F. Supp. 836 (E.D.N.Y. 1986) (holding that Medicare’s denial to pay for emergency services in Canada had only an incidental effect on international travel and was rationally based).

414. 357 U.S. 116 (1958).

415. Thomas E. Laursen, Note, *Constitutional Protection of Foreign Travel*, 81 COLUM. L. REV. 902, 907 (1981); Whitman, *supra* note 252, at 204–05.

416. 378 U.S. 500 (1964).

417. *Id.*

418. *Id.* at 508, 514.

419. *Id.*; Whitman, *supra* note 252, at 205.

420. 381 U.S. 1 (1965).

421. *Id.*

422. *Id.*

423. *See id.*; Whitman, *supra* note 252, at 205–06.

basis test.⁴²⁴ The restrictions in *Califano* and *Milkson* did not directly prohibit citizens from traveling overseas—they merely denied benefits when citizens did leave the United States. In fact, the *Califano* opinion clarified that the Social Security law did “not have nearly so direct an impact on the freedom to travel internationally as occurred in the *Kent*, *Aptheker*, or *Zemel* cases.”⁴²⁵ Logically, laws that more directly restrict international travel should be required to be “narrowly drawn” to achieve a legitimate and substantial government interest.

Between these two competing standards, we can imagine a spectrum of laws targeting medical tourism that could have either a “direct impact” or an “incidental effect” on international travel. Towards one end of the spectrum, we can envision the State Department denying the passport applications of medical tourists, similar to what occurred in the *Kent*, *Aptheker*, and *Zemel* cases.⁴²⁶ Presumably, courts would apply the more rigorous standard from the *Kent* line of cases rather than the rational basis test from *Califano*. Given medical tourism’s potential benefits to health spending and patient autonomy, the government would be hard-pressed to justify a travel restriction absent some overriding national security or public health concern. But, such concerns may not be too far-fetched. A more virulent strain of Severe Acute Respiratory Syndrome (SARS) or the avian influenza could motivate officials to heavily regulate travel to certain countries.⁴²⁷ Nevertheless, most travel restrictions targeting medical tourists would fall well below the level of urgency required to sustain such a law against constitutional challenges.

At the other end of the spectrum, we can envision laws that have no more than an “incidental effect” on international travel. For example, HHS could prohibit federal health care programs like Medicare from paying for treatments overseas, much like the laws in the *Califano* and *Milkson* cases. Here, a reviewing court would most likely apply the rational basis test from *Califano*.

In between these two extremes, there could be an endless variety of restrictions on patients traveling overseas. A rule preventing Medicare from paying for beneficiaries to have surgery overseas would likely be viewed under the more lenient *Califano* standard governing social welfare legislation.⁴²⁸ Other restrictions would likely turn on whether they had an “incidental effect” or a “direct impact” on international travel. In crafting legislation, congressional intent would be key—the “incidental effect”

424. See Whitman, *supra* note 252, at 204–07.

425. *Califano v. Aznavorian*, 439 U.S. 170, 178 (1978).

426. After *Zemel*, Congress authorized the Secretary of State to prohibit the use of passports to travel to countries “where there is imminent danger to the public health or the physical safety of United States travelers.” Act of Oct. 7, 1978, Pub. L. No. 95-426, § 124, 92 Stat. 971 (amending 22 U.S.C. § 211a (1976)); Laursen, *supra* note 415, at 906. Conceivably, this “public health” exception could allow the State Department to restrict passports for medical tourism.

427. For example, the *HHS Pandemic Influenza Plan* proposes travel restrictions, but does not describe the precise nature of these restrictions. U.S. DEPT. OF HEALTH AND HUMAN SERVS., HHS PANDEMIC INFLUENZA PLAN 17 (2005), available at <http://www.hhs.gov/pandemicflu/plan/pdf/HHSPandemicInfluenzaPlan.pdf>. SARS is a type of pneumonia that spread from China in 2002. For an overview of the disease see WHO, Severe Acute Respiratory Syndrome (SARS), <http://www.who.int/csr/sars/en/>. The “avian influenza” is a bird-adapted virus that began spreading in 2004. For more information see WHO, Confirmed Cases of Avian Influenza A(H5N1), http://www.who.int/csr/disease/avian_influenza/country/en/.

428. See *Califano*, 439 U.S. at 174.

standard would arguably not apply if Congress's ultimate purpose was to restrict travel.

Restricting patient travel may be the least successful of all responses to medical tourism. Prior efforts to restrict reproductive tourism in the United States and European Union demonstrate the legal and practical limits to this approach. Although the U.S. government has leeway to restrict international travel, it would be difficult to justify blatant travel restrictions in the face of the potential benefits of medical tourism.

2. Regulating Referral Networks

A slightly more moderate approach to regulating medical tourism is to regulate the activities of brokers and other intermediaries that arrange for U.S. patients to travel overseas. This approach would address the concern that patients may not fully appreciate the risks of having surgery overseas in a vastly different regulatory environment because they do not receive complete or accurate information about foreign providers. Currently, the market is completely unregulated—medical tourism is caveat emptor in the purest sense. Foreign providers are generally beyond the purview of U.S. regulators, and most medical tourism “brokers” are neither regulated nor licensed. This void leaves patients susceptible to false, misleading, and aggressive marketing, as well as to potentially unbalanced contractual relationships.

Most foreign providers and brokers market their services on the Internet,⁴²⁹ and a sampling of these sites shows they can be aggressive and potentially misleading. Sites include patient testimonials, breezy descriptions of idyllic sightseeing tours, and even quality comparisons that disparage U.S. providers. One broker tells potential customers: “[Y]ou may be surprised to learn that your local hospital has lost accreditation due to poor quality standards. . . . Check to see if your hospital is accredited by the JCAHO.”⁴³⁰ Another broker makes the unverifiable claim that “[i]n most cases, the success rates for medical procedures performed in our partner hospitals exceeds [sic] those for U.S. institutions.”⁴³¹ The same broker assures patients who may be concerned about medical malpractice that they “have the right to seek redress in the Indian court system similar to the procedure followed here in the U.S. [sic],”⁴³² a claim that is woefully misleading.⁴³³

Although some patients will be skeptical of such puffery, others may derive a false sense of security from the bravado. First, most patients will not question these assertions, and very few will have the expertise to compare the “quality” of U.S. and foreign providers. Second, patients will know little, if anything, about the medical malpractice systems overseas and will not be able to assess claims that a foreign legal system will provide “similar” protections from malpractice that the United States provides. Finally, patients as consumers are not always able to assess the quality or value of the services they receive.⁴³⁴ They may be lured by hefty acronyms identifying

429. *See supra* Part II.B.2.

430. MedRetreat, Frequently Asked Questions, http://www.medretreat.com/medical_tourism/faq_s.html.

431. IndUSHealth, What Patients Often Ask Us, http://www.indushealth.com/what_ask.htm.

432. *Id.*

433. *See supra* note 329–30 and accompanying text.

434. Clark C. Havighurst, *Vicarious Liability: Relocating Responsibility for the Quality of Medical Care*, 26 AM. J.L. & MED. 7, 14–15 (2000).

ISO, JCAHO, or JCI accreditation, which they may be unaccustomed to seeing advertised by U.S. providers.

A separate concern is that patients may find themselves in unbalanced contractual relationships that provide inadequate legal recourse if they are injured. As noted above, the legal systems in developing countries may not provide patients with the same rights or protections from malpractice as in the United States.⁴³⁵ Brokers and intermediaries often disclaim liability for malpractice or any injuries sustained overseas, and many require patients to sign contracts that absolve the broker from liability.⁴³⁶

Even in an increasingly transparent market, risk-shifting contracts and foreign medical malpractice regimes create information asymmetries that may lead patients to take more risks than they fully appreciate. So how should lawmakers and regulators respond? Can they correct the information asymmetries and level the contractual playing field? Can they ensure that patients do not chase cost savings without sacrificing quality?

The most obvious response is to prevent referral networks from disseminating false or misleading information, but this approach can be problematic, as seen with prior efforts in the United States and the European Union to restrict information about abortion providers. Irish courts once enjoined student health groups and women's clinics from providing information about abortion providers in other EU countries.⁴³⁷ In the United States in the early 1970s, states tried to disrupt abortion referral networks by prosecuting counselors, travel agents, doctors, and others that provided information on out-of-state abortions.⁴³⁸

Here, the response need not be so severe. Previous efforts to restrict information about abortion providers targeted information that was neither false nor misleading.⁴³⁹ Lawmakers had difficulty justifying these statutes, and courts could not uphold them. However, regulators can use existing statutes that prohibit unfair, deceptive, or fraudulent trade practices, including false or misleading advertising.⁴⁴⁰ For example,

435. See *supra* Part III.B.3.

436. For example, MedRetreat's "Medical Tourism Agreement" states that it "assumes no responsibility or liability for any treatment or other services rendered by any doctor, or for any malpractice claims . . . that may arise directly or indirectly from any such advice, treatment or other services." MedRetreat, Medical Tourism Agreement, http://www.medretreat.com/medical_tourism/sample_documents.html. MedicalNomad states that it "does not provide medical advice or medical referrals . . . and does not approve, endorse, or recommend any health care providers, travel agents, medical financing options, medical procedures, medical practices or any medical related information." MedicalNomad, Terms and Conditions of Use, <http://www.Medicalnomad.com/Terms.jsp>.

437. Kreimer, *supra* note 373, at 457–58 & n.21.

438. *Id.* at 456–57.

439. See generally *Bigelow v. Virginia*, 421 U.S. 809 (1975) (reversing a Virginia newspaper editor's conviction for publishing an advertisement for an abortion referral service in New York); *Atlanta Coop. News Project v. U.S. Postal Serv.*, 350 F. Supp. 234 (N.D. Ga. 1972) (striking down a federal statute that prohibited the distribution of written information that instructed women where and how they could obtain abortions).

440. See generally W.J. Dunn, Annotation, *What Constitutes False, Misleading, or Deceptive Advertising or Promotional Practices Subject to Action by Federal Trade Commission*, 65 A.L.R. 2d 225 (1959); Donald M. Zupanec, Annotation, *Practices Forbidden by State Deceptive Trade Practice and Consumer Protection Acts*, 89 A.L.R. 3d 449 (1979).

California allows consumers to sue for unfair and deceptive trade practices.⁴⁴¹ The Federal Trade Commission (FTC) uses the FTC Act to contest unscrupulous marketing activities.⁴⁴² Applying these laws to medical tourism brokers may sidestep concerns that more stringent regulation violates these marketers' First Amendment commercial speech rights. A related tactic that poses even fewer First Amendment concerns would be for the government to counter potentially false or misleading advertising with its own information campaign, which I discuss below.⁴⁴³

A second, more aggressive response is to regulate medical tourism brokers themselves, by holding brokers vicariously liable under an agency theory for torts committed by foreign providers. But this approach has its own legal and practical limitations. First, HMOs and other managed care organizations (MCOs) are not liable in most circumstances for the torts of participating physicians, so courts may be reluctant to extend liability to brokers.⁴⁴⁴ Second, the difficulties in monitoring, enforcing, and asserting jurisdiction in these cases would render such legislation nearly unworkable. Finally, an ironic by-product of such legislation may be to drive medical tourism brokers overseas.

A more practical approach would be to require brokers to obtain a license, which would accomplish several goals. First, it would allow regulators to monitor brokers' activities. Valid complaints by consumers or competitors could be grounds for revoking the license. Second, licensing could allow the government to access information about the quality of care overseas. Regulators could require brokers to file an annual report disclosing (1) the number of patients they sent abroad, (2) the foreign providers they used and the providers' qualifications, (3) a list of treatments their customers received, and (4) the frequency and severity of injuries related to the treatments. Licensing could make the market more transparent to both patients and regulators. The shortcoming of this approach is that it would not cover transactions handled by anyone other than a licensed intermediary. Moreover, in a twist of irony, regulating brokers and other intermediaries could encourage at least some to move their operations overseas, beyond the reach of U.S. regulators.

441. See generally CAL. BUS. & PROF. CODE §§ 17200–17210, 17500–17594 (West 2006) (prohibiting unfair competition and false advertising); Bob Cohen, Annotation, *Right to Private Action under State Consumer Protection Act—Preconditions to Action*, 117 A.L.R. 5th 155 (2004).

442. Federal Trade Commission Act § 5, 15 U.S.C. § 45 (2006). The FTC also has published guidelines for marketing and advertising online. Federal Trade Commission, Advertising and Marketing on the Internet: Rules of the Road (2000), <http://www.ftc.gov/bcp/conline/pubs/buspubs/ruleroad.pdf>.

443. See *infra* Part IV.A.4.

444. See Havighurst, *supra* note 434, at 22–24 (noting that health plans are not vicariously liable for torts of participating physicians unless the physician is an agent or employee of the plan). Note that the Employee Retirement and Income Security Act of 1974 (ERISA) generally prohibits patients from suing HMOs and other MCOs under state malpractice laws. See Pub. L. No. 93-406, 88 Stat. 829 (codified as amended in scattered sections of 26 U.S.C. and 29 U.S.C.); *Aetna Health Inc. v. Davila*, 542 U.S. 200, 209 (2004) (holding that ERISA preempts state tort claims against HMOs). However, Havighurst notes that “ERISA would probably not preclude a state legislative initiative or a state court ruling adopting vicarious liability as a matter of common law.” Havighurst, *supra* note 434, at 17 n.43. Moreover, it is not clear that ERISA would preempt state tort claims against overseas brokers operating outside the system of U.S. employment-based health insurance.

3. Regulating Insurance

A third approach to regulating medical tourism focuses on employers and insurers rather than patients or referral networks. Several U.S. employers and insurers are beginning to experiment with cross-border health insurance coverage.⁴⁴⁵ Some California insurers now offer low-cost insurance that utilizes providers in Mexico,⁴⁴⁶ and legislation in West Virginia would give public employees incentives to have surgeries overseas at JCI-accredited hospitals.⁴⁴⁷

Yet, this momentum has stalled in at least one instance. The United Steelworkers Union recently prevented a North Carolina paper manufacturer from sending an employee to India for surgery.⁴⁴⁸ The manufacturer, Blue Ridge Paper Products, had contracted with IndUSHealth, a North Carolina-based broker, to send willing employees to India for surgeries.⁴⁴⁹ The Union vowed to fight efforts by companies to send employees overseas and claimed that it could “block any employees being exported to India, Thailand or Mexico.”⁴⁵⁰

The Union objected, in part, because employees would have little legal recourse overseas in response to medical negligence.⁴⁵¹ Blue Ridge required the employee to sign a release form absolving the company from liability for any negligence by the Indian hospital or physicians.⁴⁵² Given the sharp objections by the United Steelworkers—the largest industrial union in North America⁴⁵³—we can anticipate similar objections as employers and insurers begin to experiment with foreign health care providers. Like the United Steelworkers, lawmakers or lobbies may try to prevent employers from encouraging employees to go overseas. Yet, given the consensus that U.S. health care spending is out of control, it may be difficult for Congress to prevent private companies from using low-cost foreign providers.⁴⁵⁴

445. See *Senate Hearing*, *supra* notes 5 (statement of Dr. Milstein); *supra* Part III.A.3.

446. See *supra* notes 273–76 and accompanying text.

447. See *supra* text accompanying note 281.

448. Saritha Rai, *Union Disrupts Plan to Send Ailing Workers to India for Cheaper Medical Care*, N.Y. TIMES, Oct. 11, 2006, at C6.

449. *Senate Hearing*, *supra* note 5; Rai, *supra* note 448, at C6.

450. Rai, *supra* note 448 (quoting Stan Johnson, a spokesman for United Steelworkers).

451. *Id.*

452. *Id.*

453. *Id.*

454. I focus on federal rather than state legislators because it is unlikely that a state government could prohibit private employers or insurers from using foreign health care providers under the Foreign Commerce Clause. See U.S. CONST. art. I, § 8, cl. 3; Benjamin J. Vernia, Annotation, *Validity of State and Local Statutes Allegedly Infringing on Federal Government's Exclusive Power over Foreign Affairs—Nonalien Cases*, 108 A.L.R. 5th 189 (2005). Even so, a state law requiring state public employers or insurers to use U.S. health care providers could resemble one of the many “Buy American” laws that courts have occasionally upheld. See Vernia, *supra*, at § 3[a] (listing cases in which courts have upheld state laws requiring the use of American products or services in public procurement or investment).

A more politically feasible alternative would be to hold employers and insurers vicariously and strictly liable for injuries from medical negligence overseas.⁴⁵⁵ Currently, employers and insurers in many circumstances are not liable to the employee/insured for a provider's negligence,⁴⁵⁶ and so legislators may choose to create statutory strict liability. The policy would have a distinct appeal because the current system may unfairly allocate the risks and benefits of medical tourism. Employers and insurers can save thousands of dollars by utilizing foreign providers, but patients alone bear the risk that they will not be adequately protected or compensated by foreign legal regimes. Thus, holding employers and insurers strictly liable for injuries sustained due to medical negligence overseas would reallocate some of the risks.

However, there are legal and practical obstacles to a strict liability regime for employers and insurers. First, how would we determine whether a foreign provider was negligent? Would we rely on findings by a foreign court? Would we require U.S. patients to litigate the provider's negligence overseas, or would U.S. courts determine whether a physician thousands of miles away was negligent? Second, would we use foreign or domestic legal standards for negligence? Should employers and insurers be liable if a foreign physician failed to meet U.S. standards, or merely the standard of care in the physician's country? Finally, could employers and insurers require brokers to indemnify them for sending patients to sub-standard foreign providers? These obstacles could render a strict liability regime unworkable.

In lieu of holding employers and insurers strictly liable for negligence overseas, lawmakers can combine several tactics to more fairly distribute the risks and benefits of medical tourism. First, lawmakers can require employers or insurers that send patients overseas to pay for pre-screening and/or post-operative care in the United States, including any follow-up or corrective treatments that may be necessary. This reduces the risk that patients must fend for themselves if a surgery overseas is unsuccessful, and it allows payors to monitor the quality of care patients receive overseas. Moreover, even if employers and insurers must pay for pre-screening and follow-up care in the United States, they will still save money in the vast majority of cases by using foreign surgeons.

Second, lawmakers can require employers to share a minimum portion of the cost-savings with patients who are willing to have surgery overseas. Sharing the cost-savings may partially "compensate" patients for the risks they may bear by having surgery in an unfamiliar medical, legal, and regulatory system. Blue Ridge Paper planned to share its cost-savings with employees willing to go overseas, and the West Virginia legislation would give state employees up to twenty percent of its cost-savings.⁴⁵⁷ If an employee can choose between having surgery in the United States or bearing the risks of surgery overseas in exchange for a share of the cost-savings, it

455. This scenario is inspired by Clark Havighurst's proposal to create a default rule holding MCOs vicariously liable for the medical negligence of providers they select. *See* Havighurst, *supra* note 434, at 25.

456. As noted above, ERISA generally preempts state law causes of action against employers. *See* Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1144(a) (2000) (providing federal courts jurisdiction over employee suits against ERISA plans, limiting the available remedies, and preempting state laws); *Aetna Health Inc. v. Davila*, 542 U.S. 200, 209 (2000).

457. Rai, *supra* note 448; *see supra* notes 280–82 and accompanying text.

becomes more difficult to argue that the employee is bearing unfair risks. Lower-income employees may find it difficult to forego these incentives, but for many medical tourists, the choice is often between surgery overseas and no surgery at all. In the insurance market, we need not require insurers to share cost-savings because they will offer health plans with lower premiums, as seen with the insurers in California that offer less expensive health insurance for patients willing to go to Mexico.⁴⁵⁸

Third, employers and insurers should only be liable for negligence by foreign providers if the employer or insurer failed to exercise ordinary care and selected an incompetent provider. In this scenario, brokers and intermediaries are important. Logically, brokers that arrange for employees to receive medical care abroad should indemnify employers for injuries caused by incompetent foreign providers. Legislators need not require indemnification because the parties can negotiate these provisions contractually. The parties can determine, among other things, when a foreign provider will be deemed to be negligent and under what standard of care.

Finally, we can encourage or require employers and insurers to give patients some choice in selecting specific physicians or hospitals within the “network” of available providers. Patients may feel more comfortable having surgery overseas if they can exercise some degree of control, and maintaining patient autonomy in such arrangements will be crucial.

Thus, although employers and insurers may be the most convenient targets for medical tourism legislation from a political standpoint, it may be difficult from a legal standpoint to hold them liable for negligence by foreign providers. Nevertheless, legislators have at least four different tools to redistribute the risks and benefits between payors and patients. Combined with other policy recommendations discussed in this article, policymakers can exercise at least some control over the medical tourism market.

4. Agency Oversight

During the June 2006 Senate hearing on medical tourism, Senator Gordon Smith called for an interagency task force composed of the Departments of Health and Human Services, Homeland Security, Commerce, and State to investigate the impact of medical tourism and “enable U.S. policymakers to reach informed decisions in response to this new trend.”⁴⁵⁹ But if Congress created such a task force, how could the government use the task force’s findings and which government body could best do so?

The ideal agency to work with the task force would be the U.S. Department of Health and Human Services (HHS). HHS has the most health care expertise in the government. Its competencies include health care financing (CMS), the quality and safety of medical products and procedures (FDA), and health care fraud and abuse (the HHS Office of Inspector General (OIG)). Moreover, HHS is well positioned to work with public health care programs such as TRICARE in exploring overseas coverage. HHS could draw on expertise from CMS, FDA, and the HHS OIG in regulating

458. See *supra* text accompanying notes 273–77.

459. *Senate Hearing, supra* note 5 (opening remarks by Sen. Gordon Smith, Chairman, S. Special Comm. on Aging); News Release, Sen. Gordon H. Smith, Chairman, S. Special Comm. on Aging, *Global Health Care May Save Money, But is it Safe?* (June 27, 2006).

medical tourism and is the best-equipped agency to handle the functions and responsibilities I propose below.

A British agency serves as an excellent model for the activities HHS could undertake. In 1990, Parliament created the Human Fertilization and Embryology Authority (HFEA), the first statutory body of its kind in the world.⁴⁶⁰ HFEA was created to: (1) license and monitor fertility clinics; (2) approve fertility procedures and regulate research; (3) publish a *Code of Practice* for clinics and advise clinics, patients, and donors; (4) maintain formal registries of donors, treatments, and children born from these treatments; and (5) advise the Secretary of State for Health, among other responsibilities.⁴⁶¹ In effect, the agency serves as a clearinghouse and a traditional administrative agency subject matter expert and regulator for nearly all matters relating to fertility treatments.

HHS could regulate medical tourism in a similar fashion. First, HHS could license and monitor domestic employers, insurers,⁴⁶² travel agents, brokers, and other intermediaries that send patients overseas. The law could be written to assert jurisdiction over any person or entity responsible for paying for, insuring, reimbursing, or arranging for medical care overseas, other than: (1) a patient arranging for his or her own medical care overseas, (2) any other individual or entity that arranges for the patient's medical care overseas without compensation, or (3) any federal health care program.⁴⁶³ HHS could not regulate foreign providers, but it could regulate U.S. hospitals that are part of global chains that refer patients overseas.⁴⁶⁴ HHS could fine intermediaries that paid for, reimbursed, or arranged for medical care overseas without a valid license. The threat of losing one's license could encourage compliance with HHS rules, and insurers may eventually require licensure as a precondition for coverage.

Second, HHS could use the licensing scheme to monitor regulated entities and, through them, the activities of foreign providers. HHS could require licensed entities to file periodic reports disclosing (1) the quantity and demographics of U.S. patients they send overseas, (2) detailed information about the hospitals and physicians treating these patients, (3) information about any adverse events following these treatments, and (4) financial information, including the estimated cost savings and any fees earned by the regulated entity. HHS could also impose recordkeeping requirements that would allow it to verify the information in these reports. And HHS could serve as a clearinghouse for complaints by consumers and competitors. It could validate complaints through administrative investigations and levy fines and/or revoke licenses

460. Human Fertilization and Embryology Authority, Frequently Asked Questions about HFEA, <http://www.hfea.gov.uk/cps/rde/xchg/SID-3F57D79B-76C5AA07/hfea/hs.xsl/385.html>.

461. *Id.*; see also Spar, *supra* note 18, at 533.

462. Insurers must be licensed in each state in which they offer policies. See J. Peter Rich & Susan M. Nash, *Sales and Marketing of Insurance—Licensing of Insurance Companies*, 2 HEALTH L. PRAC. GUIDE (West) § 14:31 (2006). However, federal licensing would not interfere with state insurance licensing schemes.

463. The exception for “federal health care programs” would exclude Medicare, Medicaid, TRICARE, etc., from the licensing regime.

464. The rationale behind this jurisdictional approach would be to require domestic hospitals that are part of a larger global hospital network, like the Adventist Hospital chain, to obtain licensing so they do not become a conduit for medical tourists looking to bypass licensed entities.

in response to valid complaints. These efforts would allow HHS to collect key information about the medical tourism trade. Employers and insurers could compare the success rates and other quality data between U.S. and foreign hospitals. Policymakers could begin to measure the cost savings and track how these savings are distributed. Patients could use the HHS web site to access outcomes data for individual providers overseas.⁴⁶⁵ Licensing could make the market more transparent.

Unlike HFEA, HHS would not regulate research or approve medical procedures, but it could monitor outcomes through the licensing scheme and advise patients, employers, and insurers as needed. It would be tempting to predicate licensing on intermediaries agreeing not to send patients overseas for treatments not approved by the FDA, as it would prevent U.S. patients from thwarting FDA jurisdiction and escaping domestic laws. However, this approach might encourage patients to use unlicensed intermediaries and could drive experimental procedures further underground. Instead, HHS could coordinate with the FDA to encourage companies to file annual reports, perhaps by agreeing to recognize a broader array of foreign clinical data to support FDA marketing approval applications.⁴⁶⁶

Third, HHS could publish guidelines for patients, insurers, and intermediaries in the market, much like the *Code of Practice* HFEA publishes for fertility clinics. These guidelines would be voluntary, but compliance with the guidelines could influence HHS's enforcement discretion by serving as a de facto safe harbor.⁴⁶⁷ For example, HHS could publish guidelines for brokers describing unscrupulous marketing practices. It could advise patients on the risks of surgery overseas and ways to protect themselves from malpractice. Such guidelines could take advantage of the agency's role as a clearinghouse for data, annual reports, complaints, and other pertinent information.

Fourth, just as HFEA advises the Secretary of State for Health, HHS could advise Congress as necessary. Thus the primary role of HHS would be to monitor medical tourism and advise patients, employers, insurers, marketers, and policymakers, similar to HFEA's role as an expert advisory body on fertility treatments in the U.K.

Finally, HHS could go beyond HFEA and provide unprecedented oversight of JCI, the international arm of JCAHO.⁴⁶⁸ Currently, neither JCI nor JCAHO are directly regulated, even though they fill a vital role in accrediting hospitals and other health

465. Currently, patients lack the requisite information to evaluate the quality of health care or identify the best providers, either domestically or globally. Jost, *supra* note 65, at 555 (citing FED'L TRADE COMM'N & U.S. DEP'T OF JUSTICE, IMPROVING HEALTH CARE: A DOSE OF COMPETITION 28 (2004), http://www.usdoj.gov/atr/public/health_care/204694.htm).

466. The FDA accepts data from foreign clinical studies to support applications for FDA marketing approval for drugs, biologicals, and devices if the study meets the requirements of 21 C.F.R. parts 312 (drugs) or 812 (devices) or is well-controlled and conducted in accordance with ethical principles acceptable to the world community. *See* 21 C.F.R. §§ 312.120, 314.106, 814.15 (2007); FOOD & DRUG ADMIN., GUIDANCE FOR INDUSTRY: ACCEPTANCE OF FOREIGN CLINICAL STUDIES (2001), <http://www.fda.gov/cder/guidance/fstud.pdf>.

467. HHS frequently uses public guidelines and alerts to guide its enforcement decisions. *See, e.g.,* Joan H. Krause, *A Conceptual Model of Health Care Fraud Enforcement*, 12 J.L. & POL'Y 55, 93–94 (2003) (discussing the impact of the HHS OIG's Special Fraud Alerts on health care fraud enforcement).

468. *See supra* Part II.B.1.

care organizations.⁴⁶⁹ JCAHO has statutory authority to monitor compliance with hospital standards,⁴⁷⁰ and accreditation is now a prerequisite for hospital reimbursement by Medicare, Medicaid, and countless other payors.⁴⁷¹ Nevertheless, JCAHO and JCI remain largely independent from regulation or oversight.⁴⁷² Although Congress amended the Medicare statute to increase oversight of JCAHO, the government has done little to hold JCAHO accountable.⁴⁷³ Most of JCAHO's revenues are fees paid by the hospitals it accredits, which has led to criticism that it is a "fox-in-the-chicken-coop."⁴⁷⁴ Critics point to JCAHO's high rate of accreditation and low rate of revoking accreditation as evidence of a mutually beneficial relation between hospitals and JCAHO.⁴⁷⁵ In its forty-year history,⁴⁷⁶ JCAHO has granted ninety-nine percent of applications but has revoked less than one percent of the accreditations it has granted. Since JCI was established in 1994, it has accredited nearly one hundred foreign hospitals and health care organizations.⁴⁷⁷ HHS could more actively oversee JCI to ensure that it is accrediting only qualified foreign facilities and that it is capable of monitoring ongoing qualifications. HHS could also require JCI to disclose detailed information regarding the foreign hospitals. The threat that JCI will revoke accreditation should be a powerful incentive for foreign hospitals to maintain certain quality standards and submit the necessary data. If patients and insurers are going to rely on JCI accreditation, then U.S. regulators must ensure that JCI's stamp of approval means something.

In summary, there are several advantages to HHS oversight of the medical tourism trade. In addition to hosting the government's expertise in several health care disciplines, HHS can learn from TRICARE's experience with using foreign providers.⁴⁷⁸ Finally, regulation by the U.S. government achieves some measure of

469. See Jody Freedman, *The Private Role in Public Governance*, 75 N.Y.U. L. REV. 543, 612 (2000); DEP'T OF HEALTH AND HUMAN SERVS. OFFICE OF THE INSPECTOR GEN., *THE EXTERNAL REVIEW OF HOSPITAL QUALITY: THE ROLE OF ACCREDITATION* 3–4 (1999), <http://www.oig.hhs.gov/oei/reports/oei-01-97-00051.pdf> [hereinafter EXTERNAL REVIEW].

470. Social Security Amendments of 1965, Pub. L. No. 89-97, 79 Stat. 286, 326–27 (codified as amended at 42 U.S.C. § 1395bb). With this Act, Congress provided that hospitals accredited by JCAHO were "deemed" to be in compliance with the conditions for participating in Medicare. *Id.*

471. *Id.* HHS regulations require hospitals and other facilities participating in Medicaid to satisfy "Medicare Conditions of Participation," which include JCAHO accreditation. See, e.g., 42 C.F.R. §§ 482.1 *et seq.* (2007); EXTERNAL REVIEW, *supra* note 469, at 30.

472. Michael J. Myers, *Juxtaposing Sarbanes-Oxley with JCAHO Governance Standards: A Shortcut to Auditable Health System Compliance?*, 51 S.D. L. REV. 465, 471 (2006); Gilbert Gaul, *Accreditors Blamed for Overlooking Problems*, WASH. POST, July 25, 2005, at A01.

473. EXTERNAL REVIEW, *supra* note 469; Freedman, *supra* note 469.

474. Myers, *supra* note 471, at 472; Gaul, *supra* note 472.

475. See, e.g., Timothy S. Jost, *Medicare and the Joint Commission on Accreditation of Healthcare Organizations: A Healthy Relationship?*, 57 LAW & CONTEMPORARY PROBS. 15, 39–40 (citing 1 INSTITUTE OF MEDICINE, *MEDICARE: A STRATEGY FOR QUALITY ASSURANCE* 129 (Kathleen N. Lohr ed., 1990); *Full Survey Decision Outcomes*, JOINT COMMISSION PERSPECTIVES, July-Aug. 1991, at 16).

476. Gaul, *supra* note 472.

477. Joint Commission International Accredited Organizations, <http://www.jointcommissioninternational.org/10241/>.

478. Whitman, *supra* note 252, at 208–11.

symmetry with developing countries that dedicate government resources to attract U.S. patients.⁴⁷⁹ Because health care is a uniquely public and private endeavor, it is fitting that countries use public-private partnerships to both promote and regulate medical tourism.

B. Multilateral Approaches

Given the inherent limits of regulating a global market unilaterally, some degree of multilateralism will be necessary. This section analyzes which modes of multilateralism may be most effective, and what we can reasonably expect to accomplish.

Currently, governments must confront medical tourism alone. For example, the Australian government recently issued a travel advisory for medical tourists visiting Thailand, warning patients not to be “lured to discount or uncertified medical establishments where standards can be lacking, resulting in serious and possibly life-threatening complications.”⁴⁸⁰ Unfortunately, issuing a travel advisory was the government’s best response. Australian authorities could not coordinate with Thai authorities, could not direct patients to a network of approved and credentialed Thai providers, and could not point to any concrete data on surgery outcomes in various Thai facilities. Ideally, countries would cooperate to (1) regulate providers and intermediaries, and (2) standardize professional credentials, hospital accreditation, insurance practices, outcomes reporting, and other aspects of the medical tourism trade.

Predictably, there are barriers to meaningful multilateral regulation. Developing countries may be reluctant to expose local health care providers to rules from countries with vastly different medical and legal systems—even though private hospitals may voluntarily adopt such standards to attract foreign patients. For example, suppose Thailand’s “uncertified” providers meet Thai (but not Australian) regulatory requirements. Thai authorities would have little incentive to enforce Australia’s requirements. Developing countries may resist any encroachment on their jurisdiction and autonomy. Thus, formal multilateral agreements to regulate medical tourism may be unrealistic.

At the same time, several regional trading blocs have tried to facilitate cross-border trade in health services by standardizing health care transactions, making health insurance more portable, and agreeing to mutually recognize foreign professional credentials.⁴⁸¹ Logically, these goals are more attainable at the regional level, where countries can take advantage of their geographical proximities and perhaps shared cultures and languages.⁴⁸² For example, Cuba and Chile treat Latin American and Caribbean patients, Thailand and Malaysia treat Southeast Asian patients, and Jordan treats Middle Eastern patients.⁴⁸³ These regional markets are natural venues for

479. *See supra* Part II.C.

480. Austl. Dep’t of Foreign Aff. & Trade, Travel Advice for Thailand, <http://www.smartraveller.gov.au/zw-cgi/view/Advice/Thailand>.

481. Chanda, *supra* note 2, at 66.

482. *Id.* at 105.

483. *Id.*

multilateral cooperation and serve as a realistic alternative to more broadly scaled regulation and enforcement.

However, even regional blocs with formal trade agreements have had difficulty harmonizing health care regulations and standards.⁴⁸⁴ The WHO has analyzed such efforts within the EU, the North American Free Trade Agreement (NAFTA), and Mercosur, a Latin American trade union.⁴⁸⁵ The WHO found that although these trading blocs have had some success at liberalizing regional trade in health services, they have had difficulty harmonizing health care standards and regulations.⁴⁸⁶

The European Union has the most comprehensive regulatory regime for trading health services. It requires the national health insurance systems in member states to cover treatments in other member states,⁴⁸⁷ and has bilateral agreements with non-members to make public health insurance either totally or partially portable.⁴⁸⁸ Moreover, since the 1970s, European countries have tried to mutually recognize credentials for physicians, nurses, and pharmacists.⁴⁸⁹ Nevertheless, the WHO study found that “there has been little progress in developing a common regulatory framework for health services or in establishing common standards of training and practice” and concluded that “[r]egulation of professional practice in health care remains very different across the member countries.”⁴⁹⁰

NAFTA, the trade agreement between the United States, Mexico, and Canada, has not been nearly as aggressive in liberalizing trade in health services. Although NAFTA encourages the free movement of service providers, it explicitly excludes health care professionals.⁴⁹¹ Nevertheless, NAFTA urges professional bodies in the region to consider easing restrictions on licensing and certification, which may lead to more harmonization in health care.⁴⁹² The United States has pushed for more harmonization between the countries’ health care systems, but Mexico and Canada have resisted, partly because each country has a vastly different system than the United States.⁴⁹³ Therefore, NAFTA countries are far from harmonizing health care regulations and standards.

The Mercosur trading bloc has tried to promote patient travel and integrate local health insurance systems, in part by creating exchange programs among health insurers

484. *Id.* at 75.

485. Mercosur is the “Mercado Común del Sur,” or the “Southern Common Market,” founded in 1991 by the Treaty of Asunción. It includes Argentina, Brazil, Paraguay, Uruguay, and Venezuela as members, as well as Bolivia, Chile, Colombia, Ecuador, and Peru as associate members. Mexico has applied to become an associate member. *See* Mercosur, <http://www.mercosur.int/msweb/principal/contenido.asp> (available in Spanish and Portuguese only).

486. Chanda, *supra* note 2, at 66–75.

487. *Id.* at 74; *see supra*, Part III.A.1.

488. Chanda, *supra* note 2, at 74.

489. *Id.* at 73.

490. *Id.*

491. *Id.* at 70.

492. North American Free Trade Agreement, U.S.-Can.-Mex., Dec. 17, 1992, 32 I.L.M. 612, art. 1210, *available at* <http://www.sice.oas.org/trade/NAFTA/naftatce.asp> [hereinafter NAFTA]; Chanda, *supra* note 2, at 71–72.

493. Chanda, *supra* note 2, at 70 n.61.

to cover medical care for tourists from Mercosur countries within the region.⁴⁹⁴ Mercosur created the “Tarjeta Mercosur”—a health insurance card that allows Mercosur citizens to receive medical care in another member country—to encourage patients from poorer countries to travel to regional medical centers.⁴⁹⁵ Yet, Mercosur faces the same obstacles as the European Union and NAFTA, namely, that health care systems within the region remain too different.⁴⁹⁶ Thus, while Mercosur citizens can travel throughout the region for medical care, Mercosur countries are also far from harmonizing health care regulations and standards.

Beyond formal trade agreements, standardization in the health industry can help control medical tourism.⁴⁹⁷ Several groups are creating international standards for health care quality and hospital accreditation, including the European Union, the International Society for Quality in Health Care, the Wellington Group, and JCI.⁴⁹⁸ Medical education is being standardized by the World Federation for Medical Education and the Institute for International Medical Education.⁴⁹⁹ As international standards continue to emerge, patients and insurers will feel more comfortable using foreign providers.⁵⁰⁰

Despite these efforts, there remains significant room for standardization. For example, health insurers may find it difficult to cover medical procedures in countries with different billing practices and procedural classification systems. Most U.S. insurers bill for health care products and services using codes created by HHS and the American Medical Association.⁵⁰¹ However, Canadian hospitals⁵⁰² and French hospitals⁵⁰³ use different systems, and the WHO is developing its own system to replace an older version that was never accepted internationally.⁵⁰⁴ Thus, most

494. *Id.* at 67.

495. Benavides, *supra* note 123, at 68; Chanda, *supra* note 2, at 67.

496. Benavides, *supra* note 123, at 68.

497. *See* Segouin, *supra* note 84, at 277; Chanda, *supra* note 2, at 9, 27, 109; Mattoo & Rathindran, *supra* note 4, at 23–24; *supra* notes 96–103 and accompanying text.

498. Heidemann, *supra* note 97, at 227.

499. Karle, *supra* note 102; van Niekerk et al., *supra* note 101.

500. *E.g.*, Segouin, *supra* note 84, at 277.

501. Public and private insurers generally use codes from the Health Care Financing Administration (HCFA) Common Procedure Coding System (HCPCS). Use of these codes was voluntary until Congress required their use in electronic health care transactions. Health Insurance Portability and Accountability Act of 1996 (HIPAA), §§ 262, 264, Pub. L. No. 104-191, 110 Stat. 1936, 2021-31, 2033-34 (codified at 42 U.S.C. § 1320d-d-8); 45 C.F.R. § 162.1002 (2007); *see also* News Release, Dep’t of Health & Human Servs., Ctrs. for Medicare & Medicaid Servs., *New CMS Coding Changes Will Help Beneficiaries* 1 (Oct. 6, 2004), <http://www.cms.hhs.gov/MedHCPCSGenInfo/Downloads/HCPCSReform.pdf>.

502. Canada uses the Canadian Classification of Health Interventions (CCI) system. *See* Canadian Institute for Health Information, Canadian Classification of Health Interventions (July 6, 2004) http://www.cihi.ca/cihiweb/disPage.jsp?cw_page=codingclass_cci_e.

503. France uses the “Classification Commune des Actes Médicaux” (CCAM) system. *See* Martine M. Bellanger, Veneta Cherilova & Valérie Paris, *The “Health Benefit Basket” in France*, 6 EUR. J. HEALTH ECON. (SUPP. 1) S24 (2005), http://www.ehma.org/_fileupload/File/Projects/Article%204%20France.pdf.

504. The WHO created the International Classification of Procedures in Medicine (ICPM) system in the 1970s, but recently created a new system, the International Classification of Health Interventions (ICHI), in its latest attempt to standardize billing codes globally. *See*

countries have developed unique, incompatible standards for coding health care procedures. Although hospitals that treat foreign patients will find ways to bill for their services, these efforts will be ad hoc, and the medical tourism trade would benefit from a universal classification system.

In addition to harmonizing insurance standards, the medical tourism trade would benefit from other forms of harmonization. For example, standards for classifying and reporting medical incidents would help us compare the “quality” of care between countries.⁵⁰⁵ A standardized system for recognizing professional education and credentials would help assure that foreign health care professionals meet some equivalent standards between countries. And although hospital accreditation is being standardized, broader multilateral cooperation between accrediting bodies could make the system more robust.

Of course, there are barriers to harmonization. It is uncertain whether Western standards can be adapted by countries with vastly different cultures and health care regulatory systems.⁵⁰⁶ Hospitals seeking to attract medical tourists may adopt Western standards voluntarily, but developing countries might balk at adopting these standards through formal trade agreements. Similarly, given concerns about medical malpractice overseas, hospitals that attract medical tourists may agree to some form of international arbitration to resolve disputes with patients or insurers, but developing countries might be extremely reluctant to expose local providers to foreign legal obligations, particularly those adapted from the infamous U.S. malpractice system. Finally, as a practical matter, most countries have trouble standardizing health care transactions within their own borders.⁵⁰⁷ These difficulties are only magnified at the multilateral level.

Despite these difficulties, harmonizing standards through formal trade agreements may be a good opportunity to exercise some modicum of control over the medical tourist trade. There is voluminous literature regarding the prospects for liberalizing trade in health services through the General Agreement on Trade in Services (GATS).⁵⁰⁸ And the WHO and WTO have expressed an interest in facilitating trade in health services on a broader scale.⁵⁰⁹ But even without formal multilateral agreements, international standards and oversight mechanisms will coalesce. The private sector will play an important role because it can help standardize transactions and create international networks of hospitals and insurers. And as the medical tourist trade

World Health Organization, International Classification of Health Interventions (ICHI), <http://www.who.int/classifications/ichi/en/>.

505. The WHO’s International Statistical Classification of Diseases and Related Health Problems (ICD) promotes global standards for collecting, processing, and classifying morbidity and mortality data. See World Health Organization, International Classification of Diseases (ICD), <http://www.who.int/classifications/icd/en/>.

506. Segouin, *supra* note 84, at 278.

507. For example, the United States has struggled to even standardize patient data. See W. Ed Hammond, *The Making and Adoption of Health Data Standards*, 24 HEALTH AFF. 1205 (2005).

508. See Chanda, *supra* note 2; Mutchnick et al., *supra* note 120; Smith, *supra* note 9. Importantly, there have been very few GATS commitments in the health sector because most health care services are provided publicly, and thus are excluded by GATS Article I:3. Chanda, *supra* note 2, at 78. Only 25% of the 134 member countries have made commitments in the health services sector. *Id.*

509. See Adams & Kinnon, *supra* note 217; *supra* note 5.

matures, developing countries may be more willing to cooperate in “regulating” the market.

Still, standardization has been slow and it has not matched the pace of globalization. Private sector practices will develop before public standards can emerge. But the private sector alone cannot police abusive practices or harmonize standards—these tasks will require public sector intervention.⁵¹⁰ Regulating the market multilaterally will be difficult, but harmonizing standards through trade agreements can achieve many of the same objectives.

In the meantime, we can begin collecting data on the medical tourist trade: Where are patients traveling and why? Which procedures do they seek? Are these procedures successful? How much money are patients saving by traveling overseas? What are the financial and referral relationships between insurers, providers, and intermediaries? Of course, obtaining this data will require unprecedented transparency and multilateral cooperation in the health care sector, two things for which it is not known. Even so, we can begin thinking about how to collect, share, and use this data.

CONCLUSION: GUIDING THE EVOLUTION OF MODERN HEALTH CARE

Medical tourism is a case study in the evolution of health care. Traditionally, health care has been “peculiarly and tenaciously local in its character.”⁵¹¹ But globalization is creating glaring new risks and opportunities. Physicians, medical technologies, and patients have become increasingly mobile. Geographical and jurisdictional borders mean less. Western health care standards and money are seeping into developing countries. Cost differentials between countries are becoming harder to ignore as the quality differentials disappear. Public and private organizations are trying to harmonize standards worldwide. Yet patients take a calculated risk by seeking medical care overseas in regulatory systems that may not offer the rights or protections they expect. Physicians in developed countries worry that their jobs are being outsourced. Lawmakers and regulators worry that they are helpless to respond.

Our struggle with medical tourism foreshadows the diverse set of issues we will have to confront as health care continues to globalize. How will globalization affect health care costs, quality, and access? Where does the free market fail? When is government regulation futile? How do governments retain their jurisdiction to respond to important legal and ethical questions? How can multilateralism facilitate trade without eviscerating local authorities’ jurisdiction? How do patients, companies, and policymakers mitigate the risks and distribute the benefits?

The responses I propose aim to achieve balance: a balance between the risks and benefits; a balance between free market solutions and government intervention; a balance between patient autonomy and governments’ legitimate interests in enforcing their laws; a balance between the interests of developed and developing countries with different health care and regulatory systems.

The value, I hope, in presenting a comprehensive analysis of the medical tourism phenomenon is to better understand all of its repercussions—both good and bad—in order to articulate policy responses that will account for the unique legal, moral, and

510. Julio Frenk & Octavio Gómez-Dantés, *Globalization and the Challenges to Health Systems*, 21 HEALTH AFF. 160 (2002).

511. Jost, *supra* note 12, at 141.

financial considerations it raises. As with any emerging market, policymakers are wise to see both the forest and the trees. Focusing solely on costs risks sacrificing optimal quality and access. Focusing on domestic repercussions risks ignoring global realities.

Indeed, our ad hoc, often contradictory approach to health care in the United States has created a system in which costs are unreasonable, millions go uninsured, and quality indicators are falling below those of our peer countries.⁵¹² In many ways, medical tourism is an inevitable response by U.S. patients. Rising costs, declining confidence in quality, and decreased access to health care has led patients to choose other health care systems, if only momentarily. The medical tourism phenomenon should encourage us to reevaluate our policy choices in a number of important areas, and to use the phenomenon to improve our health care system rather than lament how it reveals the system's weaknesses.

512. Jost, *supra* note 65, at 538.