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The Globalization of Healthcare

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THE GLOBALIZATION OF HEALTH CARE

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THE GLOBALIZATION OF HEALTH CARE: LEGAL AND ETHICAL ISSUES (I. Glenn Cohen, ed., 2013). Pp. 480. Hardcover $ 100.00.

The Globalization of Health Care should put to rest any notion that one can truly grasp legal issues in health care without placing matters within a broader global context. Of course, for people who have been paying close attention, global law and policy choices have formed a continual and critical backdrop for the debate over the current and future direction of the American health care system. For example, an unending theme in national health reform is the degree to which cultural pride in American exceptionalism, coupled with the politics of deregulation, leaves the nation mired in an approach to health care that rejects the common sense approach adopted by other wealthy industrialized nations. Whether organized around a government-administered health program or multi-payer regulation, our world peers have arrived at pathways that inject greater equity and economic accountability into the fundamental governmental task of ensuring health care for the population. These pathways involve careful approaches to how health care systems are financed, how the growth of health care costs is tempered over time without sacrificing quality, and how the human capital essential to a strong health care system is developed and deployed. One only need look at the deluge of information comparing the cost, quality, and results of the American health care systems to those of other high-income nations[1] to understand how off the mark we are.

It would be naïve in the extreme, of course, to suppose that other nations' health care systems simply sail along without encountering deeply difficult policy debates or rancorous battles involving entrenched interests; one only has to read the newspaper while sitting over a morning coffee in any wealthy country to recognize all-to-familiar fights between industry and government. Moreover, the Ebola crisis currently enmeshing the world, like the HIV/AIDS crisis, offers a searing reminder of the extent to which health threats origi-

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1. *See, e.g.*, Karen Davis, Kristof Stremikis, David Squires & Cathy Schoen, *Mirror Mirror on the Wall, 2014 Update: How the U.S. Health Care System Compares Internationally*, COMMONWEALTH FUND, *available at* http://www.commonwealthfund.org/~/media/files/publications/fund-report/2014/jun/1755_davis_mirror_mirror_2014.pdf (finding systematic underperformance on measures of access, efficiency, and equity under the U.S. health care system compared to those of other wealthy nations); Gerard Anderson, Uwe Reinhardt, Peter S. Hussey, & Varduhi Petrosyan, *It's the Prices, Stupid: Why the United States is So Different from Other Countries*, 22 HEALTH AFFAIRS 89 (2003) (using Organization for Economic Cooperation and Development (OECD) data to compare U.S. health care spending and access to those of other OECD countries).

nating in poor nations thousands of miles away can profoundly test the fairness and operational capabilities of well-funded, elegantly structured health care systems.

Nevertheless, America tends to limp along, insistent on doing things our way, immune to lessons from abroad, and constantly coming up short as a result. Furthermore, through intense lobbying around the terms of treaties, health care industries nurtured in our uniquely deregulated environment seem to be constantly working to impose our hands-off approach to oversight and accountability on other nations. Even as this nation has made enormous progress toward greater health care equity in recent years, through enactment of the Patient Protection and Affordable Care Act[2] (hereinafter referred to as the Affordable Care Act (ACA)), it managed to lurch toward the goal of fairness by means of a jury-rigged set of solutions that skirts the hard questions and in some respects digs the U.S. into an even deeper hole by locking in structures that no longer serve any useful purpose. Even as it accomplished the seemingly impossible of offering a pathway to insurance coverage for most of the American population,[3] the ACA ducked crucial problems of cost, access, and operational reasonableness. Moreover, the political fight to the death that led to enactment, not to mention the poisonous atmosphere surrounding its implementation, means that we probably will live with the consequences of its short-term problem avoidance for a long time.

In creating a solution to the seemingly intractable problems of cost, access, and quality that have plagued American health care for so long, we might have borrowed from any one of the sensible legal and regulatory solutions adopted by nations with economies similar to our own that rely on an overwhelmingly private health care market without giving over such a vast proportion of their gross domestic product. Instead, for political reasons, lawmakers preserved employer-sponsored coverage, an inherently unfair approach that skews toward the wealthiest Americans through individual tax-favored treatment of employer contributions to workplace health plans; they coupled retention of this system with a subsidized but seriously under-financed individual insurance market for (predominantly) lower income American workers and their families unfortunate enough not to work at jobs with good health benefits.[4] The problem of under-financing shows up in ridiculously high deductibles ($6000, for example) and high coinsurance and copayments,[5] coupled with

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2. Pub. L. No. 111-148, 124 Stat. 119 (2010). This legislation, along with its companion Health Care and Education Reconciliation Act (HCERA) (Pub. L. No. 111-152, 124 Stat. 119 (2010)) is jointly referred to under federal implementing regulations as the Affordable Care Act. *See, e.g.*, 76 Fed. Reg. 41866 (July 15, 2011) (proposing regulations implementing health insurance Exchanges and defining the Affordable Care Act (p. 41866) as the amalgam of the two enactments. This boilerplate appears in virtually all implementing regulations promulgated since the passage of the Act.

3. In its most recent estimates of health insurance gains under the Affordable Care Act (which change as underlying policies shift), the Congressional Budget Office concludes that the ACA will increase the proportion of insured nonelderly Americans to approximately 89% by 2016 from 80% in the absence of the Act. CONGRESSIONAL BUDGET OFFICE, UPDATED ESTIMATES OF THE EFFECTS OF THE INSURANCE COVERAGE PROVISIONS OF THE AFFORDABLE CARE ACT (APRIL 2014), *available at* http://www.cbo.gov/sites/default/files/45231-ACA_Estimates.pdf at 3.

4. A revamped, loosely-regulated individual insurance market lies at the heart of the ACA and offers subsidized health plans through a health insurance Exchange operated in all states. Enrollment statistics from the United States Department of Health and Human Services show that more than 85% of people who enrolled in subsidized health plans sold in the Exchange received tax subsidies toward the price of coverage. David Blumenthal & Sara R. Collins, *Health Care Coverage under the Affordable Care Act — A Progress Report*, 371 NEW ENG. J. MED. 275 (2014), *available at* http://www.nejm.org/doi/full/10.1056/NEJMhpr1405667.

5. Abby Goodnough & Robert Pear, *Unable to Meet the Deductible or the Doctor*, N.Y. TIMES (Oct. 17, 2014), http://www.nytimes.com/2014/10/18/us/unable-to-meet-the-deductible-or-the-doctor.html?_r=1.

tightly controlled access through narrow provider networks.[6] For the poorest Americans, Congress and the White House relied on Medicaid, the nation's indispensable means of insuring the poor and vulnerable, thereby compensating for the absence of social solidarity principles in health care financing.[7] But as it turned out, this political solution for insuring the most vulnerable populations triggered an epic legal battle that, in turn, paved the way for an unprecedented United States Supreme Court decision that fundamentally throws into future question the power of Congress to use its federal spending powers to create programs of cooperative federalism aimed at addressing national social problems.[8]

Into this picture has come I. Glenn Cohen, a Professor of Law at Harvard Law School and the director of its Petrie-Flom Center for Health Law Policy, Biotechnology, and Bioethics, with *The Globalization of Health Care: Legal and Ethical Issues*,[9] a book whose purpose is to educate readers about the legal issues that arise as health care achieves global social and economic status. For a reader like myself, whose work has been U.S.-centered (other than for periodic efforts to attempt to compare my own country's health financing and delivery choices to those made by other nations), the book is a revelation. Its brilliant structure, its choice of topics, and its wonderful editing all succeeded in helping me gain a conceptual foothold in this all-important area of law.

The Globalization of Health Care is not an easy read; chapters are long and ponderous, and at times over-written in relation to the information they convey (I confess that as I have aged, my delight in the short and sweet has grown exponentially). But *Globalization* has a remarkably ambitious aim of providing a road map to understanding issues in law and policy that have come to dominate health care as it goes global. The task of effectively conveying the range of issues that arise is extremely difficult, since any consideration of the legal issues that flow from health care globalization also means having a grasp of the multitude of legal frameworks that emanate from a global legal stage. Clearly, in a single-volume book built around multiple, broad themes and reliant on sophisticated essays from an impressive array of scholars in matters of international law, policy, and ethics, it is not possible to offer more than a glimpse of the issues that arise when globalized health care meets up with law. But the themes chosen are important ones and are designed to create a framework through which even larger questions can be considered.

In his elegant introductory essay,[10] Professor Cohen sets the table for the reader, explaining the book's purpose and structure, as well as the choices made in presenting insights into the legal meaning of health care globalization and the ways in which health care and law can interact with one another. In its approach to the subject, the book has been divided into five parts: (1) medical tourism; (2) medical worker migration; (3) the

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6. Sabrina Corlette, JoAnn Volk, Robert Berenson, & Judy Feder, *Narrow Provider Networks in New Health Plans: Balancing Affordability with Access to Quality Care* (Robert Wood Johnson Foundation, 2014), http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2014/rwjf413643.

7. For a discussion of Medicaid's role in the U.S. health care system, *see* Sara Rosenbaum, *Medicaid at Fifty*, *in* OXFORD HANDBOOK OF AMERICAN HEALTH LAW (Alison Hoffman, William Sage, & Glenn Cohen eds., forthcoming, 2015).

8. Nat'l Fed'n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566, 2604-08 (2012) (striking down the Medicaid expansion as an unconstitutional coercion on the states and barring the HHS Secretary from enforcing the Medicaid expansion as a mandatory condition of participation).

9. THE GLOBALIZATION OF HEALTH CARE: LEGAL AND ETHICAL ISSUES (I. Glenn Cohen ed., 2013) [hereinafter GLOBALIZATION].

10. *Id.* at xiii-xxiv.

globalization of research and development; (4) telemedicine; and (5) health care globalization, equity and justice. The book is thus structured to move readers deep into the subject of cross-border health care in an era when national borders matter less and less, vast worldwide profits are on the line, and the stakes for patients are huge.

As Professor Cohen notes, the medical tourism essays in Part I must be read against the backdrop of an industry that has reaped major profits for many nations (Thailand alone expects to generate $8 billion from medical tourism between 2010 and 2014).[11] The tourism essays range from a lengthy, treatise-like review of jurisdiction in cross-border medical liability cases in European Union countries[12] to essays on media coverage of medical tourism.[13] An essay by Nathan Cortez examines the question of whether the Affordable Care Act would, as a matter of federal law, bar the sale of health plans that rely on cross-border care through international national provider networks.[14] (It does not, although given the fact that so much of the ACA depends on state insurance regulation, the more interesting question is the extent to which state law permits the sale of such products; the only example offered is California). In an especially interesting essay, Hilko Meyer examines efforts within the European Union, in the face of cross-border movement, to align health care financing and coverage structures, even as all EU nations grapple with national autonomy over their social security systems and cost containment in an aging and technology-driven era.[15] Fascinating essays by Professor Cohen and others address how medical tourism affects health care access among those in destination, less developed countries,[16] and the tensions that can arise in law when medical tourism opens access to services and procedures that are illegal or unapproved in the patient's home country, such as assisted suicide,[17] reproductive technology,[18] and stem cell-based interventions.[19]

Part II deals with medical migration and its consequences, focusing on the law and ethics of the recruitment of medical professionals, which invariably favors wealthier nations. The opening essay by Vivien Runnels and colleagues uses Canadian practices to address the question of how to build ethical legal recruitment frameworks that minimize resource drain.[20] The chapter by Nir Eyal and Till Bärnighausen addresses the issue of

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11. *Id.* at xiv.

12. Thomas R. McLean, *Jurisdiction 101 for Medical Tourism Purchases Made in Europe*, *in* GLOBALIZATION, *supra* note 9, at 33-51.

13. Leigh Turner, *Patient Mortality in Medical Tourism*, *in* GLOBALIZATION, *supra* note 9, at 3-32; Valerie A. Crooks, Jeremy Snyder, Leigh Turner, Krystyna Adams, Rory Johnston, & Victoria Casey, *Canadian Print News Media Coverage of Medical Tourism*, *in* GLOBALIZATION, *supra* note 9, at 52-64.

14. Nathan Cortez, *Cross Border Health and the Hydraulics of Health Reform*, *in* GLOBALIZATION, *supra* note 9, at 65-82.

15. Hilko J. Meyer, *Current Legislation on Cross-Border Health Care in the European Union*, *in* GLOBALIZATION, *supra* note 9, at 83-103.

16. I. Glenn Cohen, *Medical Tourism and Global Justice*, *in* GLOBALIZATION, *supra* note 9, at 104-24.

17. Hazel Biggs & Caroline Jones, *A Matter of Life and Death in the United Kingdom*, *in* GLOBALIZATION, *supra* note 9, at 164-81.

18. Kimberly M. Mutcherson, *Open Fertility Borders: Defending Access to Cross-Border Fertility Care in the United States*, *in* GLOBALIZATION, *supra* note 9, at 148-63; Richard F. Storrow, *The Proportionality Problem in Cross-Border Reproductive Health Care*, *in* GLOBALIZATION, *supra* note 9, at 125-47.

19. Aaron D. Levine & Leslie E. Wolf, *The Roles and Responsibilities of Physicians in Patients' Decisions about Unproven Stem Cell Therapies*, *in* GLOBALIZATION, *supra* note 9, at 182-203.

20. Vivien Runnels, Corinne Packer, & Ronald Labonté, *Global Policies and Local Practice in the Ethical Recruitment of Internationally Trained Health Human Resources*, *in* GLOBALIZATION, *supra* note 9, at 203-19.

service in exchange for individual health professions education subsidies through scholarships (an issue familiar to those of us here who have worked on the National Health Service Corps program).[21] An excellent essay on the global regulation of the treatment of health workers who migrate internationally, by Allyn L. Taylor and Ibadat S. Dhillon rounds out Part II.[22]

Perhaps the most thought-provoking part of the book is Part III, which explores the implications of globalized research and development activities pursued by multi-national corporations. As pressure has grown for access to breakthrough pharmaceutical therapies out of the reach of most patients, the concurrent need for better information about results has also intensified. The clash of interests is potently captured in an essay by Trudo Lemmons and Candice Telfer on the challenges that arise in reconciling industry free trade pressures with principles of transparency, patient safety, social fairness, and human rights.[23] This analysis is followed by an essay by Robert Gatter regarding equity in access to vaccines, which takes as its jumping-off point Indonesia's 2007 refusal to share its influenza strains with the World Health Organization without a promise of lifesaving global pandemic influenza vaccines for its population.[24] In her fascinating essay, Bethany Spielman explores the law and ethics of unregulated clinical drug trials that were carried out in developing nations in the absence of informed consent.[25] Cynthia Ho examines explores the critical question of how patent law—specifically data exclusivity and patent linkage—has affected access to low-cost generic medicine in developing nations.[26] In Part III's final essay, Kevin Outterson and colleagues[27] discuss the use of a proposed Health Impact Fund to alter the worldwide market for antibiotics in the face of the growing public health crisis of antibiotic resistance, in order to move access to lifesaving therapy away from a financial model that depends on point-of-sale strategies and toward one that uses a fairer means to fund and allocate the fruits of innovation.

Part IV focuses on the use of telemedicine to move information—and health care itself—across borders. In a chapter of value to anyone concerned with the legal framework of health information technology in the U.S., Deth Sao and colleagues examine how the tortured system of health care regulation in the U.S. has affected the use of health information technology by creating massive legal uncertainties and contradictory cross-jurisdiction dilemmas.[28] In his excellent essay, Gil Siegal considers how globalization is affecting the use of health information technology, comparing the responses of the U.S. and

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21. Nir Eyal & Till Bärnighausen, *Conditioning Medical Scholarships on Long, Future Service: A Defense*, *in* GLOBALIZATION, *supra* note 9, at 220-32.

22. Allyn L. Taylor & Ibadat S. Dhillon, *A Global Legal Architecture to Address the Challenges of International Health Worker Migration: A Case Study of the Role of Nonbinding Instruments in Global Health Governance*, *in* GLOBALIZATION, *supra* note 9, at 233-53.

23. Trudo Lemmons & Candice Telfer, *Clinical Trials Registration and Results Reporting and the Right to Health*, *in* GLOBALIZATION, *supra* note 9, at 255-71.

24. Robert Gatter, *The New Global Framework for Pandemic Influenza Virus and Vaccine Sharing*, *in* GLOBALIZATION, *supra* note 9, at 272-85.

25. Bethany Spielman, *Offshoring Experiments, Outsourcing Public Health: Corporate Accountability and State Responsibility for Violating the International Prohibition on Nonconsensual Human Experimentation*, *in* GLOBALIZATION, *supra* note 9, at 286-301.

26. Cynthia Ho, *Beyond Patents: Global Challenges to Affordable Medicine*, *in* GLOBALIZATION, *supra* note 9, at 302-17.

27. Kevin Outterson, Thomas Pogge, & Aidan Hollis, *Combating Antibiotic Resistance through the Health Impact Fund*, *in* GLOBALIZATION, *supra* note 9, at 318-41.

28. Deth Sao, Amar Gupta, & David A. Gantz, *Legal and Regulatory Barriers to Telemedicine in the United*

Europe to the rise of electronic health records and telemedicine.[29]

The final, valedictory chapters by Jennifer Prah Ruger,[30] Daniel S. Goldberg,[31] and Pavlos Eleftheriadis[32] bring the book to a close with probing insights into the policy, ethical, and governance questions raised by health care globalization. Together the chapters underscore that the globalization of health care is a phenomenon that raises far more than applied and practical questions. *Globalization*, if properly understood, provides a clear picture of both its potential but also its implications for a further skewing of resources in the absence of a proper ethical and governance framework. Achieving such a framework is, of course, the challenge of our time.

Perhaps my only complaint about the book is the absence of an essay explicitly focused on how nations have used the law to overcome—or at least mitigate—the problem of medical underservice among populations at risk because of race, national origin, language, immigration status, culture, disability, or other personal characteristics unrelated to the need for care. In my own limited exposure to other nation's health systems (those of Canada and Israel, more specifically), I have learned that even countries whose approaches to financing and access display a level of solidarity that I can only wish for, access equity problems retain a powerful presence. Having spent almost four decades struggling with the legal, practical, and moral dimensions of this issue here in the U.S., I would have loved a chapter devoted to this topic. But this omission is not enough to dampen my enthusiasm for this wonderful collection of essays.

States: Public and Private Approaches toward Health Care Reform, *in* GLOBALIZATION, *supra* note 9, at 359-80.

29. Gil Siegel, *Electronic Medical Tourism and the Medical World-Wide Web*, *in* GLOBALIZATION, *supra* note 9, at 341-58.

30. Jennifer Prah Ruger, *Global Health Governance as Shared Health Governance*, *in* GLOBALIZATION, *supra* note 9, at 381-402.

31. Daniel S. Goldberg, *Global Health Care is Not Global Health: Populations, Inequities, and Law as a Social Determinant of Health*, *in* GLOBALIZATION, *supra* note 9, at 403-21.

32. Pavlov Eleftheriadis, *Global Rights and the Sanctity of Life*, *in* GLOBALIZATION, *supra* note 9, at 421-38.