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Fighting Fire with fire; Reforming the Health Care System through a Market-Based Approach to Medical Tourism

Heather T. Williams

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Fighting Fire with Fire: Reforming the Health Care System Through a Market-Based Approach to Medical Tourism*

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INTRODUCTION

The United States is in the midst of a historic health care crisis. A variety of factors such as growing health administrative costs, increased proliferation of medical technology, increased demand for medical services, and growing costs borne by third-party payors have raised the cost of medical care in the United States to record levels.[1] Such costs are increasing faster than the rate of inflation and consuming a greater percentage of American families' incomes.[2] Compounding this problem, roughly 46.3 million Americans lacked health insurance coverage in 2008.[3] Although Congress enacted historic legislation in March 2010 designed to improve the American health insurance system radically,[4] critics of the Patient Protection and Affordable Care Act ("PPACA") continue to lambast its potential to improve health care for American patients.[5] In any case, the PPACA's fundamental insurance reforms will not take effect until 2013 or later,[6] and its benefits will likely take even longer to

1. *Growth in Health Care Costs: Before the S. Comm. on the Budget*, 110th Cong. 4–7 (2008) (statement of Peter R. Orszag, Director, Cong. Budget Office), *available at* http://www.cbo.gov/ftpdocs/89xx/doc8948/01-31-HealthTestimony.pdf; Steffie Woolhandler et al., *Costs of Health Care Administration in the United States and Canada*, 349 NEW ENG. J. MED. 768, 768 (2003).

2. Paul H. Keckley, *Forward* to DELOITTE CTR. FOR HEALTH SOLUTIONS, MEDICAL TOURISM: CONSUMERS IN SEARCH OF VALUE 2 (2008), http://www.deloitte.com/assets/Dcom-UnitedStates/Local%20Assets/Documents/us_chs_MedicalTourismStudy(3).pdf.

3. CARMEN DENAVAS-WALT ET AL., U.S. CENSUS BUREAU, INCOME, POVERTY, AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2008, at 20 (2009), http://www.census.gov/prod/2009pubs/p60-236.pdf.

4. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (to be codified as amended in scattered titles of the U.S.C.).

5. *See, e.g.*, Jason Arvak, *Health Reform Critics Were Right*, MODERATE VOICE (May 18, 2010), http://themoderatevoice.com/73055/health-care-reform-critics-were-right/; Newt Gingrich, *Healthcare Rationing: Real Scary*, L.A. TIMES (Aug. 16, 2009), http://articles.latimes.com/2009/aug/16/opinion/oe-gingrich16; David Whelan, *Why Obamacare Will Raise Your Bill*, FORBES.COM (Jan. 1, 2010), http://www.forbes.com/2010/01/16/obamacare-health-reform-lifestyle-health-health-care-insurance-premiums.html. Others argue that the law's provisions do not go far enough to create meaningful reform. *See* Mike Lillis, *Poll: Many Voters Think Healthcare Reform Didn't Go Far Enough*, THE HILL (Sept. 25, 2010), http://thehill.com/blogs/blog-briefing-room/news/120915-poll-many-voters-think-health-reform-too-conservative.

6. *See generally* Patient Protection and Affordable Care Act, Pub. L. No. 111-148 (providing statutory authority for these reforms and setting the timeline for implementation of each part); *Focus on Health Reform: Health Reform Implementation Timeline*, HENRY J. KAISER FAMILY FOUND. (June 15, 2010), http://www.kff.org/healthreform/upload/8060.pdf (providing a detailed timeline of implementation for the Act). For example, the bill's CO-OP program, which establishes member-run, nonprofit insurance programs, will be implemented in mid-2013. Patient Protection and Affordable Care Act § 1322; *Focus on Health Reform*, *supra*, at 6. Various insurance administration

materialize. In the face of sweeping and uncertain changes to Americans' primary mode of health care financing, the future of American health care is fraught with uncertainty.

In the midst of this health care crisis, American patients are increasingly turning to a novel source of health care: developing countries. Disenchanted with American providers or simply unable to afford the domestic care they would prefer, millions of American patients have engaged in medical tourism, traveling abroad—often to developing countries such as Thailand, Brazil, and India—for the purpose of receiving medical care.[7] Though travel for medical purposes is an ancient concept,[8] medical tourism quickly is becoming a popular phenomenon among Americans; the practice has experienced burgeoning publicity within the last decade.[9] A 2008 study conducted by the Deloitte Center for Health Solutions estimated that 750,000 Americans engaged in medical tourism in 2007 and anticipated that as many as six million would engage in the practice by 2010.[10] Although until recently Americans desiring cost-

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regulations will be phased in gradually between 2013 and 2016. *Focus on Health Reform*, *supra*, at 6. Similarly, the primary changes to employer and individual insurance plans and the creation of state-based exchanges will not take effect until 2014. Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, § 1204, 124 Stat. 1029, 1055–56 (to be codified in scattered sections of 26 U.S.C. and 42 U.S.C.); *Focus on Health Reform*, *supra*, at 6.

7. *See, e.g.*, JOSEF WOODMAN, PATIENTS BEYOND BORDERS: EVERYBODY'S GUIDE TO AFFORDABLE, WORLD-CLASS MEDICAL TOURISM 5 (2007); Nicholas P. Terry, *Under-Regulated Healthcare Phenomena in a Flat World: Medical Tourism and Outsourcing*, 29 W. NEW ENG. L. REV. 421, 422–23 (2007); Michael D. Horowitz et al., *Medical Tourism: Globalization of the Healthcare Marketplace*, MEDSCAPE GEN. MED. (Nov. 13, 2007), http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2234298/. This practice is distinguished from the experience of tourists who are forced inadvertently to receive medical care while traveling overseas. *See* MILICIA Z. BOOKMAN & KARLA R. BOOKMAN, MEDICAL TOURISM IN DEVELOPING COUNTRIES 45–46 (2007); Terry, *supra*, at 423. The experience of these tourists is likely to be vastly different from that of purposeful medical tourists, particularly if they are unable to arrange care at facilities targeting medical tourists.

8. *See, e.g.*, Michael Klaus, Note, *Outsourcing Vital Operations: What if U.S. Health Care Costs Drive Patients Overseas for Surgery?*, 9 QUINNIPIAC HEALTH L.J. 219, 221–22 (2006) (describing medical tourism practices of ancient Greeks and Romans).

9. *See* Horowitz et al., *supra* note 7 ("Medical tourism has captured the interest of the media."). A search of news articles shows a sudden appearance of reporting on medical tourism in 2004; scholarly publications turned their attention to medical tourism as early as 2006. *See, e.g.*, Klaus, *supra* note 8; Frederik Balfour & Manjeet Kripalani, *Sand, Sun and Surgery*, BUS. WK., Feb. 16, 2004, at 48, 48; *Medical Tourism: Need Surgery, Will Travel*, CBC NEWS (June 18, 2004), http://www.cbc.ca/news/background/healthcare/medicaltourism.html.

10. DELOITTE CTR. FOR HEALTH SOLUTIONS, *supra* note 2, at 3. Due to the unexpected economic downturn and a resulting decrease in Americans' spending on even necessary medical care, the Deloitte Center for Health Solutions recently revised its

savings on elective procedures, such as cosmetic surgery, constituted the main demographic of medical tourists,[11] the practice has increasingly spread to patients requiring vital surgery, such as cardiovascular and orthopedic care,[12] and even organ transplantation.[13] Several countries have even begun to cultivate a medical tourism market by actively promoting American patients' travel to hospitals designated specifically for medical tourists.[14] Bumrungrad International Hospital in Bangkok, Thailand, for instance, offers a 554-bed hospital facility which prides itself on "world class healthcare," "experienced American management," and "widely spoken" English.[15]

Since receiving increased publicity over the past several years, medical tourism has been both lauded for its substantial cost benefits to patients and widely criticized, from academic circles[16] to the halls

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estimate to 1.6 million individuals in 2012. DELOITTE CTR. FOR HEALTH SOLUTIONS, MEDICAL TOURISM: UPDATE AND IMPLICATIONS 3, 9 (2009), http://www.deloitte.com/assets/Dcom-UnitedStates/Local%20Assets/Documents/us_chs_MedicalTourism_111209_web.pdf. This more conservative report estimates medical tourism will grow, despite the recession, at approximately thirty-five percent per year. *Id.* at 9. Other analysts' estimates of medical tourism incidence vary substantially. *See, e.g.*, Ian Youngman, *Medical Tourism Statistics: Why McKinsey Has Got It Wrong*, INT'L MED. TRAVEL J., http://www.imtjonline.com/articles/2009/mckinsey-wrong-medical-travel/ (last visited Jan. 3, 2011) (describing competing estimates of the annual number of medical tourists from all countries at 60,000 to 85,000 medical tourists, to five to six million medical tourists).

11. *See* Allison Van Dusen, *Outsourcing Your Health*, FORBES.COM (May 22, 2007), http://www.forbes.com/2007/05/21/outsourcing-medical-tourism-biz-cx_avd_0522medtourism.html.

12. DELOITTE CTR. FOR HEALTH SOLUTIONS, *supra* note 2, at 7.

13. Angelique Parsiyar, Comment, *Medical Tourism: The Commodification of Health Care in Latin America*, 15 L. & BUS. REV. AMERICAS 379, 381 (2009).

14. *See, e.g.*, WOODMAN, *supra* note 7, at 8; Terry, *supra* note 7, at 425 (describing the aspirations and efforts of the Indian government to become a "global health destination"); Klaus, *supra* note 8, at 222–24 (describing the developing medical tourism sector of Thailand and India); *see also* Nathan Cortez, *Patients Without Borders: The Emerging Global Market for Patients and the Evolution of Modern Health Care*, 83 IND. L.J. 71, 85–89 (2008) (providing details of the active privatization and globalization efforts of countries such as India, Nepal, Indonesia, Thailand, and Sri Lanka, including targeted advertising of English-speaking patients).

15. BUMRUNGRAD INT'L HOSP., http://www.bumrungrad.com (last visited Jan. 3, 2011); *Mission/Guiding Principles*, BUMRUNGRAD INT'L HOSP., http://www.bumrungrad.com/overseas-medical-care/about-us/missions.aspx (last visited Jan. 3, 2011); *Overview*, BUMRUNGRAD INT'L HOSP., http://www.bumrungrad.com/overseas-medical-care/about-us/overview.aspx (last visited Jan. 3, 2011).

16. *See, e.g.*, Christopher J. Brady, Note, *Offshore Gambling: Medical Outsourcing Versus ERISA's Fiduciary Duty Requirement*, 64 WASH. & LEE L. REV. 1073, 1076 (2007) (arguing that inclusion of medical tourism options in employee health insurance plans would constitute a violation of ERISA's fiduciary duty requirement); Philip Mirrer-Singer, Note, *Medical Malpractice Overseas: The Legal Uncertainty Surrounding Medical Tourism*, 70 LAW & CONTEMP. PROBS. 211, 212 (2007) (arguing that medical tourism is dangerous

of Congress.[17] Critics warn that medical tourists have traded vital protections inherent in the American health care system for mere cost savings.[18] Several scholarly articles have advocated tolerance of medical tourism only if highly regulated by government agencies.[19] While such arguments have merit, this Comment argues that they often overlook the injurious effects of regulation on the medical tourism market and overemphasize the need for a paternalistic approach to patients.

This Comment agrees with others[20] in recognizing medical tourism as a trade-off for consumers, allowing patients to opt out of increased regulation in favor of looser restrictions and greater cost savings. Factors unique to the medical tourism industry will help preserve the quality of patient care and insulate patients from the regulatory pitfalls[21] that critics of medical tourism most fear. This Comment will argue that, despite these regulatory pitfalls, medical tourism is a net positive practice which should be embraced and integrated into the American health care system. Both quality of care and patient autonomy are best preserved by a regulatory system that relies upon market forces without interference from significant regulatory strictures, but which also mandates increased transparency for patient-consumers to make fully informed health care choices. Ultimately, broad integration of medical tourism into the U.S. health care system is favorable, despite its inherent regulatory conflicts. Indeed, resolution of these conflicts is feasible and likely will effect positive changes in the American health care system.

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to patients who face significant hurdles to achieving recourse for medical malpractice overseas).

17. *See generally The Globalization of Health Care: Can Medical Tourism Reduce Health Care Costs?: Hearing Before the Spec. Comm. on Aging*, 109th Cong. (2006) [hereinafter *Medical Tourism Hearing*], *available at* http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=109_senate_hearings&docid=f:30618.pdf (providing Senate testimony of medical tourists and health care professionals both for and against medical tourism).

18. *See, e.g.*, Cortez, *supra* note 14, at 71 ("[P]atients 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.").

19. *See, e.g., id.* at 114–32; Brady, *supra* note 16, at 1112–13. *But see* Terry, *supra* note 7, at 470 ("[Medical o]utsourcing is essentially unregulated and is likely to remain that way."). These and other specific proposals are discussed in greater detail *infra* Part II.B.

20. *See* Cortez, *supra* note 14, at 95–113; Brady, *supra* note 16, at 1102; Parsiyar, *supra* note 13, at 393.

21. The term "regulatory pitfalls" is used throughout this Comment to refer to facets of health care regulation which are potentially troublesome in the medical tourism context.

Part I of this Comment addresses the basic trade-off which medical tourism represents. It describes the substantial benefits medical tourism provides to American patients, including substantial cost savings, improved patient autonomy, a luxury experience, and positive changes to the health care system as a whole. At the same time, it recognizes potential risks to medical consumers, including uncertain quality of care, reduced access to legal remedies, and conflicts with the Employee Retirement Income Security Act of 1974 ("ERISA"),[22] but it notes that these concerns are largely exaggerated or misplaced. It concludes that these factors create an overall favorable balance for medical tourists which justifies the continued growth of medical tourism. Part II details the current health care regulatory system in the United States, including both governmental and non-governmental methods. It describes various proposals that have been suggested for medical tourism, as well as the health care industry's self-regulatory means. It concludes that both the current regulatory structure and proposals intended to address the burgeoning medical tourism market provide an ineffective remedy for the flawed American health care system. Finally, Part III advocates for a modified market-based approach to medical tourism. Because market forces operate uniquely on the medical tourism industry to ensure quality and affordable prices, these forces should be allowed to regulate the medical tourism industry. To enable market forces to operate more effectively, however, the federal government should increase transparency by mandating disclosure of data which are collected by its accrediting organizations. The data—regarding operations and outcomes in medical tourism facilities—should be available to the American public in an accessible, synthesized format. In this way, the benefits of medical tourism can be preserved as American patients continue to engage in the practice.

22. Employee Retirement Income Security Act of 1974, 29 U.S.C. §§ 1001-1461 (2006). ERISA is a federal law which places minimum standards on the management and administration of employee benefit plans, including health insurance plans. *See id.* §1001; Brady, *supra* note 16, at 1076–77.

I. THE TOURIST'S TRADE-OFF: BALANCING BENEFITS AND BURDENS OF MEDICAL TOURISM

A. *Benefits of Medical Tourism*

1. Cost Savings

First and foremost, American medical tourists are persuaded to make their unconventional choice to travel thousands of miles for medical care because medical tourism provides them with substantial cost savings.[23] Treatments are significantly cheaper in medical tourism destinations than in the United States.[24] This is due to the lower costs of labor in developing countries,[25] coupled with inflated health care costs in the United States as a result of such factors as increased demand for medical services and medical technology, high administrative costs and costs third-party payors bear, and—arguably—medical malpractice costs and inefficient patient processing.[26] A recent survey suggests that medical tourists can save up to ninety percent on out-of-pocket expenses for fifteen common surgeries, even taking into account the cost of travel.[27] Treatments in India are estimated to cost on average ten to twenty percent of the price of the same surgeries in the United States;[28] treatments in Mexico, Malaysia, and Thailand cost one-quarter to one-third the price of the same procedures in the United States.[29] These cost savings are observed for virtually all types of procedures, including complex procedures such as bone marrow transplants[30] and mitral valve surgery,[31] which would cost uninsured patients hundreds of thousands of dollars in the United States. Medical tourism's cost

23. *E.g.*, Kerrie S. Howze, Note, *Medical Tourism: Symptom or Cure?*, 41 GA. L. REV. 1013, 1017 (2007) (stating that the medical tourism market among American patients is driven by cost).

24. *E.g.*, Brady, *supra* note 16, at 1094–95 (explaining the reasons for high health care costs in the United States as opposed to Asia); Klaus, *supra* note 8, at 229 (describing the cost disparities between the United States and Asia).

25. BOOKMAN & BOOKMAN, *supra* note 7, at 96–97.

26. *Growth in Health Care Costs: Hearing Before the S. Comm. on the Budget*, *supra* note 1, at 4–7; Woolhandler et al., *supra* note 1, at 768; *see* Howze, *supra* note 23, at 1017–18; Klaus, *supra* note 8, at 229–33.

27. DELOITTE CTR. FOR HEALTH SOLUTIONS, *supra* note 2, at 13.

28. Klaus, *supra* note 8, at 224; DELOITTE CTR. FOR HEALTH SOLUTIONS, *supra* note 2, at 6.

29. DELOITTE CTR. FOR HEALTH SOLUTIONS, *supra* note 2, at 6.

30. Klaus, *supra* note 8, at 224.

31. *See Medical Tourism Hearing*, *supra* note 17, at 2–4 (statement of Maggi Ann Grace, patient advocate).

savings may provide some patients with extra incentive to undergo a desired elective procedure.[32] For patients who lack the financial means and health insurance coverage to pay for necessary surgeries, however, medical tourism can prevent personal bankruptcy and literally save a patient's life.[33]

Though all patients can benefit from saving money on medical care, medical tourism's cost savings are more likely to benefit those populations most vulnerable to inadequate health insurance coverage. Current medical tourists tend to be of average financial means.[34] Wealthy Americans are more likely to be covered adequately by health insurance plans[35] or are more capable of paying for medical care out-of-pocket. Low-income individuals are more likely to be covered by state-sponsored plans such as Medicaid[36] or are unable to pay even cut-rate fees for treatment abroad. Thus, it is typically lower-middle-class individuals with sufficient means to pay for reduced-price care out-of-pocket who are able to benefit most from medical tourism.[37]

In particular, medical tourism disproportionately benefits uninsured or underinsured individuals.[38] Individuals whose insurance

32. Howze, *supra* note 23, at 1027–28; Klaus, *supra* note 8, at 240–41.

33. *See* Thomas R. McLean, *The Global Market for Health Care: Economics and Regulation*, 26 WIS. INT'L L.J. 591, 594 (2009); Parsiyar, *supra* note 13, at 387.

34. Arnold Milstein & Mark Smith, *America's New Refugees – Seeking Affordable Surgery Offshore*, 355 NEW ENG. J. MED. 1637, 1637 (2006) (describing medical tourists as "middle-income Americans").

35. *See* DENAVAS-WALT ET AL., *supra* note 3, at 25 (describing the inverse trend between household income and percentage of households uninsured).

36. Medicaid is available for low-income individuals who also fall into one or more "eligibility groups," such as pregnant women, children and their parents or legal guardians, and the blind. *See Medicaid Eligibility: Are You Eligible?*, CTRS. FOR MEDICARE & MEDICAID SERVS., http://www.cms.gov/medicaideligibility/02_areyou eligible_.asp?#TopOfPage (last modified Dec. 14, 2005). Authority to determine eligibility requirements for Medicaid funds rests with the states. *Id.* By 2019, the PPACA is expected to expand Medicaid coverage to all individuals younger than sixty-five whose adjusted gross incomes are at or below 133% of the federal poverty level. *Focus on Health Reform: Summary of Coverage Provisions in the Patient Protection and Affordable Care Act*, HENRY J. KAISER FAMILY FOUND. (Apr. 28, 2010), http://www.kff.org/healthreform/upload/8023-R.pdf.

37. *See* Milstein & Smith, *supra* note 34, at 1637–39; Howze, *supra* note 23, at 1017–18.

38. *E.g.*, Parsiyar, *supra* note 13, at 387 (suggesting that medical tourism could be the only means for uninsured and underinsured Americans to receive life-saving treatments); Horowitz et al., *supra* note 7 (stating that Americans participating in medical tourism are likely to have no health insurance or inadequate insurance). This trend is likely to continue despite the enactment of the PPACA. *See infra* notes 54–60 and accompanying text. However, the likely expansion of medical tourism into the health insurance market,

covers all or most of their cost of care in the United States are far more likely to take advantage of their present insurance coverage than to incur additional expenses in traveling overseas. To date, few private insurance companies allow individuals to choose care abroad over domestic care, even though insurance companies could reap the significant cost savings of individual medical tourists while reducing the cost of their premiums for medical tourism plans.[39] In fact, the World Bank identified non-portability of health insurance as one of the major obstacles to medical tourism's continued expansion.[40]

Individual patients are not the only ones benefitting from medical tourism's impressive cost savings. The opportunity for medical tourism is expanding as self-insured employers and private insurance companies have begun integrating medical tourism into their policies.[41] Presently, medical tourism-based insurance appears particularly attractive to small businesses, for which rising costs of insuring employees has, in many cases, become prohibitively expensive.[42] For example, Blue Ridge Paper Products, Inc., a self-insured manufacturing company, attempted to implement a pilot program in 2006 allowing employees to receive care overseas on a voluntary basis.[43] In exchange for participation, employees would receive a portion of the company's savings.[44] Before Blue Ridge was able to implement this plan, however, the United Steelworker's Union publically condemned the proposal and threatened to sue for an injunction, citing concerns regarding quality of care, malpractice liability, and long-term cost management plans, whereby employers would force insured employees to receive health care overseas.[45] In

see infra notes 41–53 and accompanying text, may change the traditional medical tourist profile substantially as insured individuals are drawn increasingly into the practice.

39. Aaditya Mattoo & Randeep Rathindran, *How Health Insurance Inhibits Trade in Health Care*, 25 HEALTH AFF. 358, 360 (2006).

40. BOOKMAN & BOOKMAN, *supra* note 7, at 151; *see also* Mattoo & Rathindran, *supra* note 39, at 358–59 (recognizing the non-portability of health insurance as an impediment to trade in medical tourism services and recommending changes to current health insurance plans which would better facilitate medical tourism).

41. *See* Kristen Boyle, Note, *A Permanent Vacation: Evaluating Medical Tourism's Place in the United States Healthcare System*, HEALTH LAW., June 2008, at 42, 43; Howze, *supra* note 23, at 1019–22.

42. Boyle, *supra* note 41, at 43; Brady, *supra* note 16, at 1103.

43. McLean, *supra* note 33, at 600; Brady, *supra* note 16, at 1103.

44. McLean, *supra* note 33, at 600; Brady, *supra* note 16, at 1103.

45. Saritha Rai, *Union Disrupts Plan to Send Ailing Workers to India for Cheaper Medical Care*, N.Y. TIMES, Oct. 11, 2006, at C6, *available at* http://www.nytimes.com/2006/10/11/business/worldbusiness/11health.html?pagewanted=1&_r=1. Quality of care and medical malpractice concerns are considered *infra* Parts I.B.1 and I.B.2, respectively.

the face of negative media coverage,[46] Blue Ridge removed all union workers from pilot program eligibility.[47] Since the Blue Ridge debacle, however, other companies have begun implementing similar plans.[48]

Large-scale insurers are beginning to take advantage of medical tourism as well. Several large HMOs and health insurance companies have already established plans allowing patients to take advantage of low-cost options overseas, while others are seriously considering the idea.[49] The enactment of the PPACA—and, in particular, its mandate that all businesses provide insurance for their employees or face fines[50]—may prompt an increasing number of small businesses to provide insurance plans offering medical tourism options and to promote medical tourism among their employees, as they attempt to reduce the costs associated with providing those plans.[51] Some critics have expressed concern that insurance companies will take advantage

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Employer responses to medical tourism and potential conflicts of interests regarding plan administrator fiduciary duties under ERISA are considered again *infra* Part I.B.3.

46. *See* McLean, *supra* note 33, at 600.

47. Brady, *supra* note 16, at 1104; Rai, *supra* note 45.

48. *See* Parija Kavilanz, *Surgery and Sightseeing on Your Boss' Dime*, CNN MONEY.COM (Aug. 11, 2010, 1:00 PM), http://money.cnn.com/2010/08/11/news/companies/health_care_medical_travel/index.htm. For example, Integrated Control Systems, a small construction firm headquartered in Albuquerque, New Mexico, pays directly for employees' treatments abroad and has managed to reduce its medical expenditures by more than ten percent. Boyle, *supra* note 41, at 43.

49. Nathan Cortez, *International Health Care Convergence: The Benefits and Burdens of Market-Driven Standardization*, 26 WIS. INT'L L.J. 646, 673 (2008); Brady, *supra* note 16, at 1102–03; Bruce Einhorn, *Outsourcing the Patients*, BUS. WK., Mar. 24, 2008, at 36, 36, *available at* http://www.businessweek.com/magazine/content/08_12/b4076036777780.htm; Zoe Galland, *Medical Tourism: The Insurance Debate*, BUS. WK. (Nov. 9, 2008), http://www.businessweek.com/globalbiz/content/nov2008/gb2008119_571910.htm; Horowitz et al., *supra* note 7. These insurance companies include Blue Cross Blue Shield of South Carolina, Aetna, UnitedHealth, Health Net, and United Group Program in Florida. *See* Elayne Robertson Demby, *Medical Tourism: Prepped for Take-off but Still Grounded*, EMP. BENEFIT NEWS (June 3, 2010), http://ebn.benefitnews.com/news/medical-tourism-prepped-for-take-off-but-still-grounded-2683657-1.html; Galland, *supra*. For example, Blue Cross Blue Shield of South Carolina has created a subsidiary company through which its members can obtain medical tourism services in lieu of covered domestic treatments. Einhorn, *supra*; *Companion Global Healthcare*, BLUE CROSS BLUE SHIELD OF S.C., http://www.southcarolinablues.com/members/discountsaddedvalues/companionglobalhealtcompa.aspx (last visited Jan. 3, 2011).

50. *See* Patient Protection and Affordable Care Act, Pub. L. No. 111-148, §§ 1511-1515, 124 Stat. 119, 252–58 (2010) (to be codified as amended in scattered sections of 26 U.S.C. and 29 U.S.C.).

51. *Cf.* Kavilanz, *supra* note 48 (describing employers' efforts to reduce costs by utilizing medical tourism plans). Larger corporations are beginning to contemplate the practice as well, including such large-scale employers as Disney and Wells Fargo Insurance Services. *Id.*

of medical tourism's cost savings at the expense of patients and that employer-sponsored plans will essentially force employees to travel overseas for all non-urgent medical care.[52] However, such behavior is contrary to the fiduciary duty required by all employee benefit plans under ERISA.[53] It is difficult to predict precisely how insurance companies and employers will react to the growing medical tourism phenomenon, but the substantial cost savings will almost certainly continue to benefit underinsured middle-class Americans, even as these benefits spread beyond this initial group.

The passage of the PPACA has altered the dialogue regarding medical tourism, in large part because of its effects on the need for viable alternatives to insurance. Current trends are likely to continue over the next four to five years as the major insurance provisions of the PPACA are phased in.[54] Certain aspects of the PPACA will undoubtedly change the importance of medical tourism to particular individuals. Most notably, the PPACA requires all U.S. residents—with very few exceptions—to carry a minimum amount of health insurance coverage or face monetary penalties.[55] Medical tourism's overall value, however, is unlikely to change radically as a result of this legislation for several reasons. First, the PPACA will not necessarily result in comprehensive insurance coverage for all Americans. The Congressional Budget Office estimates that approximately "23 million nonelderly residents" will remain uninsured even after the law is fully implemented in 2019.[56] These individuals will continue to benefit from medical tourism's cost savings as they would have prior to the PPACA's enactment. Second, even those who acquire or retain coverage under the law may be underinsured. The PPACA contains a grandfathering provision, which exempts from most reform requirements all insurance plans in

52. *See, e.g.*, McLean, *supra* note 33, at 601; Brady, *supra* note 16, at 1105–06, 1109–12.

53. *See* Brady, *supra* note 16, at 1109–13. For a broader discussion of potential conflicts with ERISA's fiduciary standards, see *infra* Part I.B.3.

54. *See supra* note 6 and accompanying text.

55. Patient Protection and Affordable Care Act § 1501(b).

56. Letter from Douglas W. Emendorf, Dir., Cong. Budget Office, to Honorable Nancy Pelosi, Speaker, U.S. House of Representatives 9 (Mar. 20, 2010), http://www.cbo.gov/ftpdocs/113xx/doc11379/AmendReconProp.pdf. A related estimate suggests that twenty-one million nonelderly residents will be uninsured in 2016, with four million opting to pay the penalties for lacking insurance under the Act. CONG. BUDGET OFFICE, PAYMENT OF PENALTIES FOR BEING UNINSURED UNDER THE PATIENT PROTECTION AND AFFORDABLE CARE ACT 1 (2010), www.cbo.gov/ftpdocs/113xx/doc11379/Individual_Mandate_Penalties-04-22.pdf. Of these individuals paying the penalty, more than half are expected to reside in households at or above 300% of the federal poverty level. *Id.* at 2.

existence at the time of the enactment.[57] This grandfathering provision is expected to cover the vast majority of Americans' health insurance plans.[58] Many individuals who lacked sufficient insurance under their pre-PPACA plan, therefore, may continue to experience deficiencies in coverage. Third, the effectiveness and staying power of the PPACA remains somewhat uncertain due to lawsuits and contradictory legislation challenging this controversial law.[59] While the merits of these challenges remain uncertain,[60] these efforts do have the potential to overturn or limit the legislation and its impact on health insurance coverage nationwide. Thus, the benefits of medical tourism to individual patients will likely continue despite the current health care reform.

2. Increased Patient Autonomy

In addition to its significant cost savings, medical tourism provides a benefit over the American health care system by allowing patients to exercise greater autonomy over their care. Proponents of "patient autonomy" argue that patients themselves, rather than other individuals or external regulatory forces, should be empowered to make decisions about both the method of their medical treatment and

57. *See* BERNADETTE FERNANDEZ, CONG. RESEARCH SERV., GRANDFATHERED HEALTH PLANS UNDER THE PATIENT PROTECTION AND AFFORDABLE CARE ACT (PPACA) 1 (2010), *available at* http://hrsa.dshs.wa.gov/MedicaidHealthCareReform/CRS/GrandfatheredHealthPlans.pdf.

58. *Id.*

59. The PPACA's constitutionality has been challenged through several federal lawsuits. As of October 2010, at least fifteen separate legal challenges had been filed, many of which remain unresolved. *See* KATHLEEN S. SWENDIMAN, CONG. RESEARCH SERV., HEALTH CARE: CONSTITUTIONAL RIGHTS AND LEGISLATIVE POWERS 10–11 (2010), *available at* http://thf_media.s3.amazonaws.com/2010/pdf/R40846.pdf; Kevin Sack, *Judge Rules Health Law Is Constitutional*, N.Y. TIMES, Oct. 8, 2010, at A15, *available at* http://www.nytimes.com/2010/10/08/health/policy/08health.html?_r=1&ref=us (discussing the first case of a federal district court judge ruling the law constitutional, a decision ripe for appeal). One federal district court judge in Virginia has ruled that portions of the PPACA are unconstitutional. Virginia *ex rel.* Cuccinelli v. Sebelius, No. 3:10CV188-HEH, 2010 WL 5059718, at *13 (E.D. Va. Dec. 13, 2010). A number of states also have enacted legislation or passed voter referenda which directly challenge PPACA provisions. *See* SWENDIMAN, *supra*, at 12; Richard Cauchi, *State Legislation and Actions Challenging Certain Health Reforms, 2010*, NAT'L CONFERENCE OF STATE LEGISLATURES (Dec. 16, 2010), http://www.ncsl.org/default.aspx?tabid=18906.

60. *See* Sack, *supra* note 59. *See generally* JENNIFER STAMAN ET AL., CONGR. RESEARCH SERV., REQUIRING INDIVIDUALS TO OBTAIN HEALTH INSURANCE: A CONSTITUTIONAL ANALYSIS (2010), *available at* http://www.ncsl.org/documents/health/Constitutionality.pdf (analyzing congressional challenges based on the First, Fifth, and Tenth Amendments).

the providers who supply it.[61] Though decisions should be informed by expert advice from medical practitioners to protect the patient from poor decision making, the patient himself is most directly impacted by decisions about his medical care.[62] Furthermore, most medical decisions involve value judgments too personal to be determined by professional advice alone.[63] Under this theory, autonomy of the individual is linked to her personal dignity, and "[t]o obstruct the capacity for autonomy is to assault an essential part of a person's humanity . . . ."[64] For these reasons, advocates of strong patient autonomy argue that the ultimate decision regarding an individual's care should be one's own.[65] If patients disagree with practitioners regarding a treatment, patients cannot force practitioners to act against their moral, professional, or ethical best judgment. Their autonomy allows patients to "vote with their feet," however, in choosing treatments and providers who are better aligned with their finances, morals, and goals.[66]

Historically, American patients have enjoyed substantial autonomy due to strong reliance on market principles in the American health care system and the substantial emphasis placed on independence and individuality in American society.[67] Patient autonomy is becoming more widespread worldwide as patients are demanding the ability to shop around for lower cost and higher quality care.[68] Over the last decade, however, the de facto autonomy of American patients has become increasingly limited by insurance

61. *See* Marjorie Maguire Shultz, *From Informed Consent to Patient Choice: A New Protected Interest*, 95 YALE L.J. 219, 219–20 (1985); *cf.* Cortez, *supra* note 49, at 695 (describing how a trend toward market-driven health care convergence will lead to greater patient autonomy and choice).

62. Shultz, *supra* note 61, at 220.

63. *Id.* at 222.

64. Edmund D. Pellegrino, *Patient and Physician Autonomy: Conflicting Rights and Obligations in the Physician-Patient Relationship*, 10 J. CONTEMP. HEALTH L. & POL'Y 47, 48–49 (1994).

65. *See* BENJAMIN HOROWITZ LEVI, RESPECTING PATIENT AUTONOMY 10 (1999) (arguing that "the presumption of personal autonomy is a principal underpinning of many of our moral and social institutions" and that "if we are to treat them as moral equals, whose ideas and values and aspirations we must take seriously, autonomous beings must be allowed to make their own decisions—even when they make decisions we consider to be bad or imprudent"); Shultz, *supra* note 61, at 220. *But see* Pellegrino, *supra* note 64, at 68 (arguing for limited patient autonomy when the treatment patients demand is harmful, morally reprehensible, or unnecessary).

66. Cortez, *supra* note 49, at 696.

67. *Id.* at 662; Shultz, *supra* note 61, at 220.

68. Cortez, *supra* note 49, at 662, 695–96.

company consolidation,[69] provider and facility mergers,[70] and decreased access to affordable care.[71] Medical tourism acts to combat these limitations by providing patients with access to a broader network of providers and facilities to meet many health care needs.[72] Furthermore, once patients have experienced high levels of patient autonomy, as has traditionally been the case in the United States, they are unlikely to settle for decreased decision making ability in the future.[73] Thus, medical tourism may provide an increasingly popular means for American patients to regain autonomy over their health care by voting with their feet for more affordable, autonomy-enhancing providers abroad.

In addition to providing patients with broader access to affordable medical care, medical tourism is able to increase patients' autonomy in several key ways. First, medical tourism provides patients an opportunity to access alternative or controversial medical procedures.[74] Patients often desire medical procedures that are not available in their region, due either to lack of approval by the Food and Drug Administration ("FDA"), or to a de facto ban on the procedure resulting from mores of local practitioners or economic considerations of health insurance companies.[75] This has historically been the case for controversial procedures such as laetrile treatment for cancer, stem cell therapy, and new forms of reproductive technology.[76] Such procedures are often available overseas at common medical tourism destinations.[77] While these procedures could present an increased health risk to patients, medical tourism

69. *See generally* AM. MED. ASS'N, COMPETITION IN HEALTH INSURANCE: A COMPREHENSIVE STUDY OF U.S. MARKETS, 2007 UPDATE (2007) (describing the continuing trends in insurer consolidation and the negative impact on competition and patient care).

70. *See* Allison Evans Cuellar & Paul J. Gertler, *How the Expansion of Hospital Systems Has Affected Consumers*, 24 HEALTH AFF. 213, 217 (2005) (describing the trend in hospital consolidations and arguing that "consumers were worse off" due to rises in "hospital market power").

71. *See supra* notes 1–3 and accompanying text.

72. Of course, medical tourism will only increase a patient's provider network for those procedures which reasonably can be provided through medical tourism: namely, non-urgent, non-routine medical procedures that a patient is able to schedule in advance.

73. *See* Cortez, *supra* note 49, at 662.

74. *E.g.*, Brady, *supra* note 16, at 1097 (stating that access to alternative or controversial procedures overseas is a motivation for medical tourists).

75. *See, e.g.*, BOOKMAN & BOOKMAN, *supra* note 7, at 52, 59; Cortez, *supra* note 14, at 78; Brady, *supra* note 16, at 1099.

76. *See* Cortez, *supra* note 14, at 77–78; Brady, *supra* note 16, at 1097–1100; Horowitz et al., *supra* note 7.

77. *E.g.*, WOODMAN, *supra* note 7, at 10 (describing hip resurfacing as one such not-yet-approved procedure).

facilities[78] are unlikely to conduct these procedures without empirical evidence of their effectiveness because the facilities' reputations would be harmed severely by increasing reports of adverse patient outcomes.[79] Furthermore, international jurisdictions are not without their own safety standards for medical devices and procedures.[80] Though these standards will undoubtedly differ in some respects from those imposed by the FDA, the FDA has at times been criticized for having an unduly burdensome and drawn-out approval process that impedes patients' ability to benefit from cutting-edge medical treatments.[81] This process can lead foreign patients to benefit from breakthrough treatments years before they are available in the United States.[82] Even if certain non-FDA approved procedures carry an increased risk, the need to promote patient autonomy suggests that the patient, presented with adequate information, should ultimately determine whether the potential benefits to be derived from such procedures are worth their inherent risks. Thus, within reason, medical tourism places this decision back into the hands of the medical tourist.

Medical tourism also increases patient autonomy by providing medical tourists with greater flexibility in scheduling procedures and avoiding significant delays in care. If they do not require immediate surgery, medical tourists are able to exercise significant control over

78. This Comment uses the term "medical tourism facilities" to describe international hospitals that cater to and specifically target medical tourists. Two such facilities are Bumrungrad International Hospital in Bangkok, Thailand, and Indraprastha Apollo Hospitals in New Delhi, India. *See* BUMRUNGRAD INT'L HOSP., http://www.bumrungrad.com (last visited Jan. 3, 2011); INDRAPRASTHA APOLLO HOSPS., http://www.apollohospdelhi.com (last visited Jan. 3, 2011). It is important to remember that many hospitals in developing countries lack the resources of these medical tourism "hot spots," even in countries where medical tourism has become an important industry. The quality of care and experience of patients would differ vastly at less developed hospitals. However, as of yet, medical tourists have not begun receiving care in such facilities, and this Comment presumes that those facilities would not have the ability to attract foreign patients or sustain a medical tourism clientele.

79. *See* BOOKMAN & BOOKMAN, *supra* note 7, at 60. The impact of reputation on medical tourism facilities is considered in greater detail *infra* Part III.A.1.

80. The FDA has compiled a list of foreign governmental agencies that serve FDA-like roles in preserving quality of health care. *International Organizations and Foreign Government Agencies*, U.S. FOOD & DRUG ADMIN., http://www.fda.gov/InternationalPrograms/Agreements/ucm131179.htm (last updated Nov. 12, 2010).

81. *See, e.g.*, Cortez, *supra* note 14, at 77–78. For example, proponents of medical tourism often point to the widespread and successful use of hip resurfacing procedures in Asia and Europe for many years before the FDA approved the procedure. WOODMAN, *supra* note 7, at 10.

82. WOODMAN, *supra* note 7, at 10; Cortez, *supra* note 14, at 77–78.

when their treatment will occur.[83] This flexibility allows medical tourists, to the extent their health will not be adversely impacted, to arrange their surgeries around their lives, rather than their lives around their surgeries. Increased flexibility also allows medical tourists to avoid substantial waiting periods in their home countries for certain crucial procedures.[84] Such flexibility provides particularly strong motivation for medical tourists traveling from countries practicing socialized medicine, where delays for even life-saving procedures can be significant.[85] Though surgical procedures are more accessible in the United States than in many other countries, the waiting period for medical care in the United States is increasingly onerous,[86] and shorter waiting periods may provide substantial motivation for American medical tourists facing delays.[87]

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83. *Cf. Medical Tourism Hearing*, *supra* note 17, at 5–6 (statement of Maggi Ann Grace, patient advocate) (describing one patient's effort to schedule his heart surgery in India after running into obstacles to the surgery at home).

84. *See id.* at 4 (stating that for her husband to obtain insurance in the United States covering his surgery, he would have had to wait a year); WOODMAN, *supra* note 7, at 11.

85. *See* WOODMAN, *supra* note 7, at 11; Cortez, *supra* note 14, at 79.

86. *See, e.g.*, MERRITT HAWKINS & ASSOCS., 2009 SURVEY OF PHYSICIAN APPOINTMENT WAIT TIMES 14 (2009), http://www.merritthawkins.com/pdf/mha2009waittimesurvey.pdf (finding an average waiting period of more than twenty days for new patient appointments over five specialties). It may be helpful to note that, though this study revealed decreased waiting times since 2004, the study was conducted during the height of the most recent economic downturn when medical visits had reportedly decreased overall. *Id.* at 13–14.

87. American tourists may be particularly motivated to participate in organ transplantation overseas. *See* BOOKMAN & BOOKMAN, *supra* note 7, at 90; McLean, *supra* note 33, at 597; *see also Waiting Time by Blood Type*, ORGAN PROCUREMENT & TRANSPLANTATION NETWORK, http://optn.transplant.hrsa.gov/ (follow "Data" hyperlink; then follow "National Data" hyperlink; then select "Median Waiting Time" category and "All" Organ category; then follow "Waiting Time by Blood Type" hyperlink) (last visited Jan. 3, 2011) (suggesting that the majority of patients requiring organ transplantation remain on the waiting list for a year or more). "Transplant tourism" has recently attracted criticism because a black market for organs exists in countries such as South Africa, India, and China, through which organs may be purchased illegally from members of vulnerable populations, such as the poor, who are willing to sell their organs. BOOKMAN & BOOKMAN, *supra* note 7, at 90, 122; Yosuke Shimazono, *The State of the International Organ Trade: A Provisional Picture Based on Integration of Available Information*, 85 BULL. WORLD HEALTH ORG. 955, 956 (2007). At least in theory, such concerns should be addressed through the standardization and quality assurance procedures already in place; there appears to be no empirical evidence that high-quality medical tourist destinations frequented by American medical tourists are availing themselves of this black market. Though such considerations raise significant concern regarding the impact of medical tourism on local populations, *see generally*, Shimazono, *supra*, these considerations are best addressed by policies and laws in the destination country and are beyond the scope of this Comment.

3. The "Luxury" Factor

Medical tourism also provides a "luxury experience" for patients, which is relatively unheard of in the U.S. health care industry.[88] Medical tourists are often astonished by the quality of service they receive and the personal attention with which it is rendered.[89] Compared to many American hospitals, in which understaffing may result in reduced attentiveness to patients,[90] many medical tourism destinations are staffed to provide personal attention from both doctors and nursing staff.[91] In some locales, private nursing care is offered twenty-four hours a day.[92]

Beyond the quality of their medical staff, medical tourism destinations also provide additional luxury amenities and services to patients. Hospitals frequented by medical tourists often are designed to provide patients with the look and feel of a five-star hotel.[93] For example, Apollo Hospitals in New Delhi, India, allows patients to reserve suites with a separate lounge and bathroom for a patient's attendants and a dining area with microwave, refrigerator, and several LCD televisions.[94] Bumrungrad International Hospital in Bangkok, Thailand, offers a "Great Chefs program" for its patients, for which some of Thailand's premier chefs have designed patient menus showcasing local Thai cuisine.[95] Further, medical tourism destinations offer patients the opportunity to experience local attractions. Each of the most common medical tourism destinations

88. *See* Howard D. Bye, *Shopping Abroad for Medical Care: The Next Step in Controlling the Escalating Health Care Costs of American Group Health Plans?*, HEALTH LAW., Apr. 2007, at 30, 31.

89. *See, e.g.*, Boyle, *supra* note 41, at 44; Klaus, *supra* note 8, at 226; Rebecca Leung, *Vacation, Adventure and Surgery?: Elective Surgeries by World-Class Doctors at Third-World Prices*, 60 MINUTES (Sept. 4, 2005), http://www.cbsnews.com/stories/2005/60minutes/main689998.shtml. For a first-hand account of one medical tourist's experience, see *Medical Tourism Hearing*, *supra* note 17, at 2–8; Maggi Ann Grace, HOWARD'S HEART, http://maggigrace.com/howardsheart (last visited Jan. 3, 2011) (stating that both the patient and his companion, the author of the blog, were treated "like royalty" during their hospital stay in India). Testimonials of high attentiveness and quality of care have continued to be reported by more recent medical tourists. *See, e.g.*, Boyle, *supra* note 41, at 42–43; Klaus, *supra* note 8, at 226.

90. *See Medical Tourism Hearing*, *supra* note 17, at 5; Boyle, *supra* note 41, at 44.

91. *See Medical Tourism Hearing*, *supra* note 17, at 6; Boyle, *supra* note 41, at 44; Leung, *supra* note 89.

92. Boyle, *supra* note 41, at 44; Parsiyar, *supra* note 13, at 387.

93. *See* Leung, *supra* note 89.

94. *Category of Rooms Apollo Hospitals New Delhi*, APOLLO HOSPS., http://www.apollohospitals.com/category_delhi.php (last visited Jan. 3, 2011).

95. *Bumrungrad Launches 2009 Great Chefs Program*, BUMRUNGRAD INT'L HOSP., http://www.bumrungrad.com/hospital-news.aspx#GreatChef (last visited Jan. 3, 2011).

offers Americans natural beauty, popular tourist attractions, and the opportunity to experience an "exotic" culture.[96] After surgery, patients may convalesce at relaxing locales such as beaches or in spa resorts.[97] To capitalize on these attractions, medical tourism brokers frequently offer packages which, in addition to medical care, provide sightseeing tours of local attractions.[98] Such experiences are available to all medical tourists, including those individuals who would not have been motivated to travel to these destinations without the medical component of their trip. Taken as a whole, these benefits to medical tourists provide extra motivation for receiving care overseas.

4. Benefits to American Patients Generally

In addition to the various benefits for individuals, medical tourism may provide benefits for the American patient population as a whole, including improved quality of care and decreased health care costs. The American health care industry is currently facing critical shortages in medical staff.[99] Physician shortages have been noted throughout the nation, including in various specializations, and are expected to increase.[100] Nurses are in particularly short supply; in 2000, demand for registered nurses exceeded supply by more than 100,000, and by 2020 this shortage is expected to increase more than two hundred percent.[101] As the population continues to age rapidly

96. *See, e.g.*, BOOKMAN & BOOKMAN, *supra* note 7, at 134–35; Klaus, *supra* note 8, at 228. Patients sometimes engage in sightseeing post-operatively; however, this practice is generally discouraged due to the increased risk of adverse health effects. *See* Boyle, *supra* note 41, at 45. *But see* Howze, *supra* note 23, at 1028 (suggesting that some facilities may fail to discourage post-surgical sightseeing).

97. *See* Boyle, *supra* note 41, at 44; Leung, *supra* note 89.

98. *See* Klaus, *supra* note 8, at 228.

99. *See, e.g.*, *Medical Tourism Hearing*, *supra* note 17, at 5 ("Highly skilled nurses in our hospitals are stretched beyond human limitations."); *see also* Terry, *supra* note 7, at 458 ("[D]eveloped countries have been unable to satisfy their demand for foreign-trained doctors, and more recently, for nurses.").

100. *See* Herbert Pardes, Opinion, *The Coming Shortage of Doctors*, WALL ST. J., Nov. 5, 2009, at A19, *available at* http://online.wsj.com/article/SB10001424052748703574604574499423536935290.html; Robert Pear, *Doctor Shortage Proves Obstacle to Obama Goals*, N.Y. TIMES, Apr. 27, 2009, at A1, *available at* http://www.nytimes.com/2009/04/27/health/policy/27care.html.

101. *Addressing the Nursing Shortage: Background Brief*, HENRY J. KAISER FAMILY FOUND., http://www.kaiseredu.org/topics_im.asp?imID=1&parentID=61&id=138 (last visited Jan. 3, 2011); *see also* Robert J. Rosseter, *Nursing Shortage Fact Sheet*, AM. ASS'N OF COLLS. OF NURSING 1–2, http://www.aacn.nche.edu/media/pdf/NrsgShortageFS.pdf (last updated Sept. 20, 2010) (citing several recent studies that indicate the demand for registered nurses will increase over the next ten to twenty years while the supply of registered nurses will decrease).

and the need for medical care increases, these shortages are likely to grow and may create grave deficiencies in medical care.[102]

Medical tourism provides an effective remedy for these concerns. As medical tourism becomes a more prevalent practice, it will likely help ease the burden on American health care providers by removing some of the current patient load to providers overseas. By reducing the strain on the American health care system, medical tourism should allow American providers to supply a more uniform and patient-oriented standard of care, which in turn should lead to improved patient outcomes.[103] Moreover, medical tourism may also help reduce American health care costs. Recent political discourse regarding health insurance has brought to light the cost benefits of increased competition in the health insurance industry.[104] Medical tourism may provide an effective means of introducing beneficial competition into the health care market. Theoretically, this effect could occur in two ways. First, medical tourism may provide direct competition for American health care providers, forcing them to lower the costs of many procedures in order to compete with overseas facilities.[105] This effect has already been observed to a limited extent; for example, one South Dakota surgery facility has reduced the cost of its joint replacement surgeries to less than half the average U.S. cost in order to compete with overseas providers.[106] Such cost

102. *See* Pardes, *supra* note 100; Pear, *supra* note 100; Rosseter, *supra* note 101, at 1–2. Such trends may increase with the influx of newly-insured individuals after the PPACA takes effect. *See, e.g.*, Kevin B. O'Reilly, *Health Reform's Next Challenge: Who Will Care for the Newly Insured?*, AM. MED. NEWS (Apr. 12, 2010), http://www.ama-assn.org/amednews/2010/04/12/prl10412.htm.

103. *See generally* ROBERT L. KANE ET AL., AGENCY FOR HEALTHCARE RESEARCH AND QUALITY, NURSE STAFFING AND QUALITY OF PATIENT CARE (2007), http://www.ahrq.gov/downloads/pub/evidence/pdf/nursestaff/nursestaff.pdf (correlating nursing shortages to adverse patient outcomes, including mortality rates, increased lengths of stay, and hospital-acquired illness and infection). *But see generally* David C. Goodman & Kevin Grumbach, *Does Having More Physicians Lead to Better Health System Performance?*, 299 JAMA 335 (2008) (arguing that an increased physician pool per capita does not necessarily translate to increased quality of care, particularly when increases occur in oversaturated areas or specialties).

104. *See* Michael E. Chernow et al., *Geographic Correlation Between Large-Firm Commercial Spending and Medicare Spending*, 16 AM. J. MANAGED CARE 131, 131, 135 (2010) (concluding that more effort promoting competitive pricing for health care services is needed if private health care markets are to reduce costs); *Barack Obama and Joe Biden's Plan to Lower Health Care Costs and Ensure Affordable, Accessible Health Coverage for All*, BARACKOBAMA.COM, http://www.barackobama.com/pdf/issues/HealthCareFullPlan.pdf (last visited Jan. 3, 2011) (proposing increased competition in private insurance and drug markets as a partial solution to soaring health care costs).

105. *See* Parsiyar, *supra* note 13, at 387; Horowitz et al., *supra* note 7.

106. Van Dusen, *supra* note 11.

reduction could become more widespread across both facilities and procedures as medical tourism continues to grow.

Second, medical tourism could provide a more viable alternative to current insurance plans, allowing greater numbers of patients to bypass the American insurance industry when receiving medical care. This could reduce premiums as insurance companies are forced to market their plans more effectively to prospective patients and preserve their business.[107] In a similar vein, insurance companies may be forced to incorporate foreign providers into their plans, providing affordable options for those remaining uninsured.[108] The availability of lower-cost plans to individuals and small businesses should, in turn, reduce the number of underinsured individuals.

Though falling prices could lead health care providers to reduce the quality of care or insurance companies to reduce the quality of coverage, they would be unwise to do so when high-quality foreign facilities and providers are still available at comparable prices. The addition of medical tourism facilities, and thus a substantial number of additional providers less attuned to the American health care market, will tend to break down the effectiveness of any oligopolistic tendencies among American providers.[109] At a minimum, both price and quality would have to be comparable before American patients otherwise open to medical tourism could be persuaded to forego medical tourism's significant benefits. Thus, medical tourism is likely to continue to effect positive change on the domestic health care industry, even as it grows in popularity among American consumers.

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107. Though the passage of the PPACA and its individual mandate to retain health insurance may limit the incentive for some patients to bypass the insurance industry in this way, millions of Americans are still expected to choose to remain uninsured by paying the required fine. *See supra* notes 55–56 and accompanying text. Thus, insurers may still be forced to price their plans competitively to remain attractive to these individuals.

108. Klaus, *supra* note 8, at 235; *see also* Cortez, *supra* note 14, at 121 (providing examples of private insurers that utilize foreign health care providers).

109. *See* Mattoo & Rathindran, *supra* note 39, at 365–66 (describing the health insurance industry as oligopolistic and predicting that it "will gravitate toward an equilibrium where each firm chooses the strategy of not offering consumers the possibility of cheaper care . . . as long as other firms behave the same way"). An oligopoly is a market form in which only a few sellers dominate the market, creating an incentive to retain high prices to preserve the profit margin for each seller. BLACK'S LAW DICTIONARY 1120 (8th ed. 2004). Though the PPACA will provide subsidies to low-income families to obtain insurance through public exchanges, these exchanges—as well as the legislation as a whole—rely upon existing private insurers to provide health insurance. *See Focus on Health Reform*, *supra* note 6, at 4–5. Thus, the legislation will not ensure that additional sellers enter the market and, absent price ceilings on insurance coverage, may be ineffectual to alter the oligopolistic tendencies already inherent in the industry.

B. *Medical Tourism's Regulatory Pitfalls*

The substantial benefits of medical tourism may also expose patients to a number of risks. Medical tourism has been criticized largely because procedures obtained abroad circumvent the complex regulatory framework designed to protect American patients.[110] This section will discuss three regulatory pitfalls medical tourists may encounter as patients abroad, which analysts have noted in their attempt to criticize the practice: (1) uncertain quality of care, (2) absence of an effective legal remedy for patients claiming injury from medical malpractice, and (3) conflict with the ERISA fiduciary duties. This section will argue that these pitfalls are likely to be less prevalent than many risk-averse critics have argued. Consequently, this analysis will demonstrate that the risks described below are outweighed by the benefits to both individuals and American patients as a population. Medical tourism, as a net positive practice, should be embraced as a viable alternative for American patients.

1. Quality of Care

The primary concern of critics of medical tourism is the safety of American patients.[111] When medical tourism first emerged as a widespread phenomenon in the United States, many worried that the quality of care provided in medical tourism facilities would be far below the quality of care available in the United States.[112] Such criticisms carry substantial weight. Despite medical tourism's salient benefits, both financial and otherwise, high-quality patient care is needed to justify medical tourism. The practice could not readily be condoned or represent a valid trade-off for consumers if it posed a significantly greater risk to the health and safety of patients than the care available to them domestically.[113]

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110. *See, e.g.*, Cortez, *supra* note 14, at 73 ("[P]atients are opting out of our health care system and the delicate equilibrium of policy choices that it represents."). *See generally* Brady, *supra* note 16 (criticizing medical outsourcing as a violation of ERISA); Mirrer-Singer, *supra* note 16 (arguing for increased regulation of medical tourism because overseas jurisdictions lack adequate means of legal redress for malpractice).

111. *See, e.g.*, Cortez, *supra* note 14, at 72–73; Brady, *supra* note 16, at 1096–97; Howze, *supra* note 23, at 1026–29.

112. *See, e.g.*, *Medical Tourism Hearing*, *supra* note 17, at 45; Klaus, *supra* note 8, at 234.

113. The critical necessity of high-quality health care is not lost on the average consumer; a recent report suggests that quality remains a strong motivating factor in a patient's choice of provider. *See* DELOITTE CTR. FOR HEALTH SOLUTIONS, *supra* note 2, at 5 (reporting that eighty-eight percent of consumers surveyed would consider seeking care outside of their community if the cost were the same but the outcomes were better than those available locally).

Fears of poor quality result in part from stereotypes regarding doctors and facilities in developing countries.[114] In reality, the quality of care available at common medical tourism destinations appears at least comparable to the care available to the average patient in the United States.[115] Furthermore, death rates and adverse outcome rates for patients undergoing cardiac procedures at hospitals in India and Thailand are comparable to and, in some instances, lower than those reported at American hospitals.[116] Such quantitative comparisons, however, are infrequent, and the general qualitative comparisons that are more common have tended not to parse out the component measures of quality of care, nor explain how the overall comparison is reached.[117] Thus, a closer analysis of quality is necessary to determine whether the medical care provided to medical tourists is truly comparable to care provided in the United States, thereby providing a favorable trade-off to consumers who elect medical tourism.

a. Measuring Quality of Care

Generally, "quality of care" is measured by the effectiveness and safety of health care services delivered to patient populations.[118] Beyond this broad definition, however, quality is notoriously difficult to measure or define.[119]

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114. *See* WOODMAN, *supra* note 7, at 21.

115. *See, e.g.*, Cortez, *supra* note 14, at 82–85; Klaus, *supra* note 8, at 225–26. *But see* Parsiyar, *supra* note 13, at 391 (suggesting there is insufficient statistical data to make such quality comparisons confidently, especially in light of conflicting qualitative observations from patients and analysts).

116. *See* Mattoo & Rathindran, *supra* note 39, at 360; Klaus, *supra* note 8, at 225.

117. *See, e.g.*, I. Glenn Cohen, *Protecting Patients with Passports: Medical Tourism and the Patient-Protection Argument*, 95 IOWA L. REV. 1467, 1492 (2010); Milstein & Smith *supra* note 34, at 1639; Klaus, *supra* note 8, at 225.

118. *See, e.g.*, AGENCY FOR HEALTHCARE RESEARCH & QUALITY, U.S. DEP'T OF HEALTH & HUMAN SERVS., NATIONAL HEALTHCARE QUALITY REPORT 2007, at iv–1 (2007), http://www.ahrq.gov/qual/nhqr07/nhqr07.pdf [hereinafter NATIONAL HEALTHCARE QUALITY REPORT 2007].

119. Cortez, *supra* note 14, at 102–03; *see also* NAT'L COMM. FOR QUALITY ASSURANCE, THE ESSENTIAL GUIDE TO HEALTH CARE QUALITY 6 (2007), http://www.ncqa.org/Portals/0/Publications/Resource%20Library/NCQA_Primer_web.pdf (describing how two government agencies define quality of health care). For example, the Joint Commission International, discussed in greater detail *infra* notes 149–54 and accompanying text, defines quality of care as "[t]he degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge." JOINT COMM'N INT'L, JOINT COMMISSION INTERNATIONAL ACCREDITATION STANDARDS FOR HOSPITALS 179 (2d ed. 2002). In contrast, the Institute of Medicine places additional requirements of quality on practitioners, defining health care quality based on whether treatment is "safe, effective, patient-centered, timely, efficient and equitable." NAT'L COMM. FOR QUALITY

Since 2000, significant energy has been focused on analyzing quality of care among U.S. health care facilities.[120] Despite an increasing availability of quality measurement data, comparing safety on a state or local level is practically impossible.[121] Federal policy makes reporting of adverse events voluntary for medical facilities, and few states require such events to be reported to the public.[122] Where reports are made, they may be incomplete when compared to the number and scope of errors that actually occur.[123] Substantial improvements in evaluation of care are unlikely, and facilities are even less likely to be evaluated individually in the near future.[124]

ASSURANCE, *supra*, at 6 (quoting INST. OF MED., CROSSING THE QUALITY CHASM: A NEW HEALTH SYSTEM FOR THE 21ST CENTURY, at xi (2001)).

120. *See, e.g.*, NATIONAL HEALTHCARE QUALITY REPORT 2007, *supra* note 118, at 6. For example, the Department of Health and Human Services ("DHHS"), through its Agency for Healthcare Research and Quality ("AHRQ") arm, has collected over 50,000 data points since 2000 by surveying dozens of state and private entities to assess quality of health care in the United States. *See id.* at 1, 10, 23–24; AGENCY FOR HEALTHCARE RESEARCH & QUALITY, U.S. DEP'T OF HEALTH & HUMAN SERVS., WHAT IS AHRQ? 4–7 (2002), http://archive.ahrq.gov/about/whatis.pdf. The increased focus on quality measurement was spurred by the publication in 2000 of a landmark study, INST. OF MED., TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM (Linda T. Kohn et al. eds., 2000), which revealed significant failings in the quality of American health care. *See* NATIONAL HEALTHCARE QUALITY REPORT 2007, *supra* note 118, at iv, 6. This study and the corresponding changes in American health care quality are discussed *infra* Part I.B.I.c.

121. NATIONAL HEALTHCARE QUALITY REPORT 2007, *supra* note 118, at 7.

122. Cathleen F. Crowley & Eric Nalder, *Within Health Care Hides Massive, Avoidable Death Toll*, HEARST NEWSPAPERS: DEAD BY MISTAKE (Aug. 10, 2009), http://www.chron.com/disp/story.mpl/deadbymistake/6555095.html. Only twenty states and the District of Columbia require mandatory reporting of surgical outcomes and medical errors. *Id.* Of those twenty states, only five currently provide hospital-specific data to the public. *See State Reporting: Reporting Snapshot*, HEARST NEWSPAPERS: DEAD BY MISTAKE, http://www.chron.com/deadbymistake/hospitals/ (last visited Jan. 3, 2011). For an example of health care information available to the public through a state agency, see Cal. Office of the Patient Advocate, *Are You Getting Quality Health Care?*, CA.GOV, http://www.opa.ca.gov/report_card/ (last visited Jan. 3, 2011). Even where these laws are in place, the legislation may lack either funding or adequate enforcement measures, or both. *See* Eric Nalder, *Washington Law Lacks Both Money and Teeth*, HEARST NEWSPAPERS: DEAD BY MISTAKE (July 30, 2009), http://www.chron.com/disp/story.mpl/deadbymistake/6555205.html.

123. Crowley & Nalder, *supra* note 122.

124. Efforts to implement more universal and exacting reporting standards have been met with resistance. *See* DEAN M. HARRIS, CONTEMPORARY ISSUES IN HEALTHCARE LAW AND ETHICS 71 (2nd ed. 2003). This resistance is due in part to substantial concern from health care providers that outcome reporting could be used against them in malpractice suits. *See id.* The PPACA has prioritized quality of care initiatives, including the creation of a "national strategy for quality improvement in health care" and an interagency working group to address national quality of care issues. Patient Protection and Affordable Care Act, Pub. L. No. 111-48, §§ 3011-3012, 124 Stat. 119, 378–81 (2010) (to be codified at 42 U.S.C. § 280j). The law also requires triennial evaluation of quality assessment measures and the creation of new quality assessment measures as deemed

When data are made available by American facilities, such information is rarely accessible to consumers to assist them in making health care decisions.[125] Even where information on individual American facilities is provided to consumers, it is generally presented in a highly technical fashion, which is difficult for laypersons to understand or use effectively.[126] As a result, few patients appear to use quality indicators when choosing a health care provider.[127]

Like their U.S. counterparts, little evidentiary data are available on medical tourism facilities, even among those facilities that have received international accreditation and high marks from independent evaluative sources.[128] Critics have decried the safety of medical tourism facilities as uncertain due to the dearth of statistical quality comparisons between American and international providers.[129] Such comparisons between American providers are similarly unavailable, however, given the lack of nationwide and

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necessary to more accurately assess the quality of American health care. Patient Protection and Affordable Care Act, § 3013 (to be codified at 42 U.S.C. § 1395aaaa-1). However, the law provides no substantive guidelines for these assessments or the likely impact of these mandates, and their effect on health care quality remains unclear.

125. Though several states provide publicly-available "report cards" on health care providers that compare facilities across various quality measures, *see, e.g.*, Cal. Office of the Patient Advocate, *supra* note 122, the vast majority of states do not make even mandatory quality reports from individual facilities available to the public. Crowley & Nalder, *supra* note 122. A primary exception to this general rule is the information provided by the Joint Commission through their online "Quality Check." *See* The Joint Comm'n, *Quality Check*, QUALITYCHECK.ORG, http://www.qualitycheck.org/consumer/searchQCR.aspx (last visited Jan. 3, 2011). Quality reports are available for specific facilities throughout the United States and are presented in a relatively user-friendly manner. *See id.* However, quality is only indicated to consumers via qualitative reports relative to an unidentified national average, rather than through quantitative data. *See id.* In enacting the Patient Safety and Quality Improvement Act of 2005, Pub. L. No. 109-41, 119 Stat. 424 (codified at 42 U.S.C. §§ 299b-21 to -26 (2006)), intended to increase voluntary error reporting among hospitals and other care facilities, Congress has also expressed a federal policy deeming patient safety information identifiable to individual health care facilities to be confidential from members of the public and privileged against law enforcement and civil discovery processes. *See* Patient Safety and Quality Improvement Act § 299b-22; William E. Fassett, *Patient Safety and Quality Improvement Act of 2005*, 40 ANNALS PHARMACOTHERAPY 917, 917–19 (2006), *available at* http://www.theannals.com/cgi/reprint/40/5/917. Thus, much of the data which might be used by consumers to make informed choices regarding their health providers remains shielded from their access.

126. *See* NAT'L COMM. FOR QUALITY ASSURANCE, *supra* note 119, at 15–16.

127. *Id.* at 15 (stating that, in 2004, approximately six percent of American patients used quality indicators when selecting a doctor, and only eight percent of American patients used this information to select a hospital).

128. *See* Terry, *supra* note 7, at 464. A more in-depth discussion of accreditation can be found *infra* Part I.B.1.b.

129. *See* Terry, *supra* note 7, at 464; Brady, *supra* note 16, at 1096.

facility-specific mandatory reporting.[130] Though additional empirical data regarding the quality of specific medical tourism facilities would lend greater credibility to claims of high quality care, the lack of consistent data on American facilities indicates that missing data on medical tourism facilities are not necessarily indicative of sub-par quality among those facilities. Given that direct quantitative comparison is difficult, it is necessary to look at additional quality indicators to understand fully the quality of care provided by medical tourism facilities.

b. Shared Quality Assurance Measures

Despite the absence of adequate evidentiary measures to assess quality, either at home or abroad, several quality assurance measures indicate high quality among common medical tourism facilities. International facilities do not share many of the same requirements as U.S. health care facilities because of disparate—although not per se inferior—regulatory requirements in other countries.[131] The presence of these quality assurance mechanisms indicates that concerns over quality of care in medical tourism facilities are misplaced.

Despite these inherent differences, patients in industrialized nations have come to demand the relatively high quality of care to which they are accustomed in their home facilities.[132] In order to attract patients and cater to the increasing demand for high-quality medical care overseas, medical tourism destinations have broadened their quality assurance mechanisms to conform to standards of industrialized care.[133] The United States, for example, shares two primary quality assurance mechanisms with common medical tourism facilities: facility accreditation and physician licensure and training.[134] American hospitals and other health care facilities are primarily regulated through a form of voluntary industry self-regulation known

130. *See* HARRIS, *supra* note 124, at 71; Brady, *supra* note 16, at 1096.

131. *See* BOOKMAN & BOOKMAN, *supra* note 7, at 145–47 (describing unique regulatory standards for medical procedures, devices, and pharmaceuticals). These standards will differ depending on the political, economic, and social ideologies of the nation and its people. *See, e.g.*, *id.* at 66–82 (describing the varying degrees of public-private health care sector interaction in medical tourism destinations and the effect on medical tourism regulation in these countries). However, health care regulatory standards appear to be converging toward more internationally recognized standards of care, particularly in those countries attempting to attract an international patient market. *See id.* at 139–51; Cortez, *supra* note 49, at 664–87.

132. *See* BOOKMAN & BOOKMAN, *supra* note 7, at 145.

133. *See id.*

134. *See id.* at 147–51.

as "accreditation."[135] This process is carried out in the United States by the Joint Commission,[136] a private nonprofit organization which conducts on-site surveys of participating care facilities to assess compliance with a broad range of detailed quality standards.[137] Accreditation does not provide a means of direct regulation, but tends to signal that the facility holds itself to certain high standards of quality.[138] The American medical insurance industry has placed significant weight on Joint Commission accreditation, as many insurance companies require health care facilities to carry this accreditation before third-party payment is authorized.[139] Moreover, the Joint Commission carries a "quasi-governmental status" within the United States due to its statutory authority to certify Medicaid and Medicare eligibility and its status as the primary private certification mechanism for health care facilities to receive such eligibility.[140] Thus, though not legally required for operation in the United States, Joint Commission accreditation indicates that the accredited organization meets at least minimum acceptable standards of care as recognized by the federal government and most states. Because of its value in helping facilities avoid duplicative credentialing surveys,[141] the Joint Commission is responsible for over ninety percent of hospital accreditation in the United States.[142]

On the other hand, no binding international standard for hospital quality currently exists.[143] Hospital quality may vary significantly between countries, in part based on disparate access to resources and adequately trained staff.[144] Quality is a vital consideration for medical

135. ROBERT I. FIELD, HEALTH CARE REGULATION IN AMERICA: COMPLEXITY, CONFRONTATION, AND COMPROMISE 43 (2007).

136. *See* HARRIS, *supra* note 124, at 71.

137. *See* FIELD, *supra* note 135, at 43; HARRIS, *supra* note 124, at 75; Klaus, *supra* note 8, at 236. Through auditors, the Joint Commission surveys facilities for quality standards compliance and grants or denies accreditation; if granted, accreditation then must be renewed every three years. *See* FIELD, *supra* note 135, at 43–44.

138. Cortez, *supra* note 49, at 670.

139. *Id.* at 670–71.

140. *Id.*; *see also* Social Security Amendments of 1965, Pub. L. No 89-97, 79 Stat. 286, 326–27 (codified as amended at 42 U.S.C. § 1395bb (2006 & Supp. II 2009)) (authorizing the Joint Commission on Accreditation of Hospitals to certify facilities for Medicare eligibility); David Gourley, *Competitor to the Joint Commission Approved by CMS*, FOCUS: J. RESPIRATORY CARE & SLEEP MED., July–Aug. 2009, at 12, 12 (describing the Joint Commission's status as the means of Medicare and Medicaid certification and its primacy among certification methods).

141. *See* FIELD, *supra* note 135, at 43; HARRIS, *supra* note 124, at 75–76.

142. Gourley, *supra* note 140, at 12.

143. *See* BOOKMAN & BOOKMAN, *supra* note 7, at 145–47.

144. *See* Cortez, *supra* note 49, at 702–03.

tourism facilities, however, as providing high-quality care is a functional requirement for inducing medical tourists to engage in health care overseas.[145] Because fears about sub-standard quality of care have remained a primary barrier to medical tourism's expansion,[146] despite evidence that such fears are largely unfounded,[147] medical tourism facilities have attempted to assuage potential patients' fears by submitting to voluntary accreditation procedures akin to those standard in the United States.[148] One of the leading sources of international accreditation is the Joint Commission International ("JCI"), the international arm of the Joint Commission.[149] Though JCI accreditation is a separate process from Joint Commission accreditation for facilities in the United States, the method of assessment used by both organizations is the same, and accreditation of both organizations is established based on compliance with very similar standards.[150] Because of its close relationship to the Joint Commission—as well as the Joint Commission's governing trade organizations, such as the American Medical Association and the American College of Physicians—accreditation by the JCI carries significant clout in the international community,[151] particularly among Americans looking to ensure that medical tourism facilities are held to a quality comparable to that of American facilities.[152] Most nations perceive JCI accreditation as an indication that a facility meets high standards of quality and is dedicated to continued quality improvement.[153] Furthermore, unlike the Joint Commission's role in the United States, the JCI does not confine its primary purpose to accreditation; in addition to its significant role in accrediting facilities, the JCI has also begun to establish itself as a leader in promulgating international health care

145. *See* BOOKMAN & BOOKMAN, *supra* note 7, at 145. The implications of poor quality on the success of medical tourism facilities are discussed *infra* Part III.A.1.

146. *See* BOOKMAN & BOOKMAN, *supra* note 7, at 145 ("To the extent that the supplying physician, institution, or country cannot provide satisfactory demonstration of quality, [medical tourists] will take their business elsewhere.").

147. DELOITTE CTR. FOR HEALTH SOLUTIONS, *supra* note 2, at 8.

148. *See id.* at 8–9.

149. JOINT COMM'N INT'L, *supra* note 119, at 1; *see also* BOOKMAN & BOOKMAN, *supra* note 7, at 148; DELOITTE CTR. FOR HEALTH SOLUTIONS, *supra* note 2, at 8.

150. *Compare* JOINT COMM'N INT'L, *supra* note 119, at 171–72 (providing a comprehensive description of the JCI accreditation procedures), *with* JOINT COMM'N, COMPREHENSIVE ACCREDITATION MANUAL FOR HOSPITALS: THE OFFICIAL HANDBOOK ACC 1–ACC 62 (2007) (providing a comprehensive description of the Joint Commission accreditation assessment).

151. Cortez, *supra* note 49, at 671.

152. *See* DELOITTE CTR. FOR HEALTH SOLUTIONS, *supra* note 2, at 9.

153. *See* Cortez, *supra* note 49, at 671.

quality standards and educating health care providers worldwide about best practices.[154] This international focus on improvement of health care safety and quality suggests that the JCI has a legitimate interest and increasing experience in promoting high quality health care on an international scale.

A second principal indicator of quality of care shared by U.S. and medical tourism facilities is the physician credentialing and licensing process. In the United States, physicians are required to pass several hurdles before being allowed to practice medicine. American doctors must first graduate from a certified medical school, which offers standardized training for its students, and they must pass a rigorous, standardized board examination, the United States Medical Licensing Examination.[155] Licensure is required by state statutes, which authorize licensing boards to act under the state's police power to protect the public welfare.[156] In addition to these baseline requirements, physicians who hope to practice in a particular specialty often submit to private board certification within that specialty, requiring the physician to pass another rigorous examination to demonstrate competency in that area of expertise.[157] Together, these requirements ensure that American physicians have the knowledge the American medical community deems necessary to practice medicine.

The boundaries of the states' police powers stretch only so far, however, and American medical boards have no jurisdiction to impose licensure requirements on practitioners who operate on American citizens in foreign nations.[158] Doctors practicing at medical

154. *See id.* Improving the quality of care internationally through education and standards-based assessment has been an active goal of the JCI since its inception. *See* JOINT COMM'N INT'L, *supra* note 119, at 1. The Joint Commission does not conduct educational programs directly, but does engage in education and more direct standards promulgation activities, including within the United States, through another international affiliate, the Joint Commission Resources. *See Facts About the Joint Commission*, JOINT COMM'N (Mar. 15, 2010), http://www.jointcommission.org/facts_about_the_joint_commission/ (follow "Download" hyperlink).

155. FIELD, *supra* note 135, at 21–22; *About USMLE*, U.S. MED. LICENSING EXAMINATION, http://www.usmle.org/general_information/general_information_about.html (last visited Jan. 3, 2011).

156. HARRIS, *supra* note 124, at 71–72.

157. FIELD, *supra* note 135, at 26–27.

158. The Supreme Court has recognized a broad right of states to impose licensure requirements on professionals "as part of their power to protect the public health, safety, and other valid interests," but this right is justified only insofar as it regulates practitioners "within their boundaries." *See* Goldfarb v. Va. State Bar, 421 U.S. 773, 792 (2004). As a practical matter, even if the Constitution purported to provide jurisdiction to regulate any providers operating on a state citizen, regardless of their location or citizenship, imposing

tourism facilities must be licensed according to the laws of the facility's country of origin, and U.S. requirements are consequently inapplicable.[159] Medical tourism facilities, however, appear to understand the value of licensing and credentialing familiar to medical tourists. In an attempt to attract medical tourists and prove a commitment to quality care, medical tourism facilities have tended to hire physicians educated at highly reputable teaching facilities in the United States and other industrialized nations.[160] Many of these physicians also carry certification in their practice specialty.[161] Furthermore, many medical tourism facilities allow patients to review the credentials of their physicians online before being referred to a particular provider, allowing medical tourists with specific licensing and/or credentialing preferences to select providers who meet these criteria.[162]

Because there is currently no international medical licensure or credentialing system available, requirements for achieving a medical degree and receiving licensure in foreign countries will differ from the requirements imposed within the United States.[163] However, the simple fact that a provider has received medical training outside the United States is by no means an indicator of inferior quality of care. Even patients in American hospitals are not guaranteed to receive care from American-trained providers, as approximately twenty-five percent of all practicing physicians and fourteen percent of all practicing nurses in the United States received training overseas.[164]

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such regulations on foreign nationals practicing outside the United States is a practical impossibility.

159. BOOKMAN & BOOKMAN, *supra* note 7, at 149–50.

160. *See* Klaus, *supra* note 8, at 225–26; DELOITTE CTR. FOR HEALTH SOLUTIONS, *supra* note 2, at 8; *see also Meet Our Doctors*, BUMRUNGRAD INT'L HOSP., http://www.bumrungrad.com/overseas-medical-care/medical-services/meet-our-doctors.aspx (last visited Jan. 3, 2011).

161. *See* BOOKMAN & BOOKMAN, *supra* note 7, at 150–51; Klaus, *supra* note 8, at 226. For example, over 200 physicians employed at Bumrungrad International Hospital were board certified in the United States, signaling that they have passed the same rigorous equivalency exams required of U.S. physicians. BUMRUNGRAD INT'L HOSP., http://www.bumrungrad.com (last visited Jan. 3, 2011).

162. *See, e.g.*, *Plan Your Visit*, APOLLO HOSPS., http://influx.co.in/apollo/apollonew/international_patient_services_plan.php (last visited Jan. 3, 2011); *FAQ's*, BUMRUNGRAD INT'L HOSP., http://www.bumrungrad.com/overseas-medical-care/faq-s.aspx (last visited Jan. 3, 2011).

163. *See* BOOKMAN & BOOKMAN, *supra* note 7, at 150–51; Klaus, *supra* note 8, at 227–28.

164. Cortez, *supra* note 49, at 665; Mattoo & Rathindran, *supra* note 39, at 359–60; Boyle, *supra* note 41, at 44. Foreign-educated physicians also comprise approximately twenty percent of American medical school faculty. Cortez, *supra* note 49, at 665; Mattoo & Rathindran, *supra* note 39, at 359.

Developing countries such as India, the Philippines, and Iran represent the eight largest suppliers of foreign physicians to the United States.[165] Practitioners trained in developing countries are able to provide high-quality care because medical curricula have become increasingly standardized from country to country. Organizations such as the Institute for International Medical Education and the World Federation for Medical Education promulgate international medical education standards, and developing countries increasingly adapt their curricula to incorporate more traditional Western medical curricula and modern bioscience research.[166] Because physicians employed by medical tourism facilities are likely to have training and educational experience equal to many American physicians, they are likely capable of providing similarly safe and high-quality treatment as that received in the United States.

These two elemental markers of health care quality—facility accreditation and physician licensure and training—suggest that patient safety and quality of care are, at the very least, likely to be comparable between U.S. and medical tourism facilities. As one analyst has suggested, "[s]urgical care provided in a Joint Commission Accredited hospital in India by a member of the Royal College of Surgeons is unlikely to be inferior to the same care provided in an American hospital with Joint Commission Accreditation by a member of the American College of Surgeons."[167]

c. Qualitative Comparison with United States Care

Despite the quality assurance mechanisms in place to protect medical tourists,[168] critics of medical tourism have suggested (or, more often, implied) that medical tourism is inherently inferior in quality to care provided in American facilities.[169] According to such reasoning, this inherent lack of quality, whether based on challenges unique to the medical tourism context or assumptions of sub-par care available in developing countries, makes medical tourism an invalid or inherently dangerous option when compared to care received in the United States.[170]

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165. Cortez, *supra* note 49, at 665; Mattoo & Rathindran, *supra* note 39, at 359.

166. Cortez, *supra* note 49, at 666–68.

167. McLean, *supra* note 33, at 601.

168. For discussion, see *supra* Part I.B.1.b.

169. *See, e.g.*, Boyle, *supra* note 41, at 45–46; Howze, *supra* note 23, at 1026–29.

170. *See, e.g.*, Boyle, *supra* note 41, at 49 ("If the United States were to ignore the issue of medical tourism, only injury, physically and financially, will result."); Howze, *supra* note 23, at 1050–52 ("Medical tourism is a symptom of a system that is broken and in need of repair. It is not a cure.").

Critical analysts have identified and focused on several quality of care issues unique to medical tourism. These issues include a medical tourist's difficulty in obtaining proper pre-operative[171] or post-operative care,[172] increased risk of adverse surgical outcomes due to risky post-operative behavior,[173] more difficult recovery due to prolonged separation from family, friends, and familiar physicians,[174] and engagement in "thoughtless surgery."[175]

Though these considerations may create additional risks for medical tourists, these concerns are not as compelling as critics assert. For example, the contention that taking a medical tourist away from his family physician creates additional risks for him ignores the simple reality that many Americans lack a primary care physician at all,[176] and even those who have a long-standing physician relationship typically are not treated surgically by that physician.[177] Other concerns may be addressed by medical tourism providers or third-party brokers hired to book medical tourist itineraries. Such brokers are often instrumental in ensuring that a patient's medical tourism facility is provided with all necessary medical history prior to surgery and facilitating phone or email communication between the medical tourist and her surgeon in order to ensure greater continuity of care.[178] In addition, medical tourism facilities have attempted to

171. Cortez, *supra* note 14, at 103–04.

172. *See, e.g.*, Howze, *supra* note 23, at 1029; Klaus, *supra* note 8, at 226–27. According to this reasoning, American physicians may be reluctant to step in to remedy care provided by another doctor and thereby risk being held liable for the malpractice of the overseas physician. Howze, *supra* note 23, at 1028. Such follow-up care may also add unexpected costs to medical tourists' total fees, since insurance is unlikely to pay for these procedures. *See, e.g.*, Cortez, *supra* note 14, at 104; Howze, *supra* note 23, at 1029.

173. *See, e.g.*, Boyle, *supra* note 41, at 45; Howze, *supra* note 23, at 1028–29. These critics worry that such risky behavior may be encouraged to a certain extent by the medical tourism brokers who arrange trips or by the websites medical tourists use to learn about and schedule their overseas care. *E.g.*, Boyle, *supra* note 41, at 45–46.

174. *See* Boyle, *supra* note 41, at 46; Howze, *supra* note 23, at 1026; Parsiyar, *supra* note 13, at 389.

175. Howze, *supra* note 23, at 1027–28; Klaus, *supra* note 8, at 240–42. "Thoughtless surgery" refers to elective procedures chosen by a patient for their reduced cost and package deals with an exotic vacation, before the patient has adequately considered their inherent risks. *See* Klaus, *supra* note 8, at 240.

176. *See generally* NAT'L ASS'N OF CMTY. HEALTH CTRS. & THE ROBERT GRAHAM CTR., ACCESS DENIED: A LOOK AT AMERICA'S MEDICALLY DISENFRANCHISED (2007) (providing statistics on the shortage of primary care physicians in the United States).

177. *See* Bureau of Labor Statistics, *Occupational Outlook Handbook, 2010–11 Edition: Physicians and Surgeons*, U.S. DEP'T. OF LABOR, 1–2, http://www.bls.gov/oco/pdf/ocos074.pdf (last visited Jan. 3, 2011) (describing the distinct roles of primary care physicians and surgeons).

178. *See* WOODMAN, *supra* note 7, at 46–48; Klaus, *supra* note 8, at 228.

address many common patient concerns, for example, by improving the access of patients to their family and friends during their treatment periods.[179]

Furthermore, many of these considerations are distinguishable from more traditional quality of care concerns because they are much more easily controlled by the patient himself. By taking additional precautions in preparing for his medical tourism experience, the patient can largely mitigate the risks underlying these concerns.[180] Though medical tourism may require patients to take a slightly more hands-on approach to fully safeguard their health following surgery, patients who are adequately informed about these issues before they engage in medical tourism will be much less vulnerable to its limitations than critics assert.

Perhaps more importantly, many critics of medical tourism assume an American-centered view of quality health care, retaining underlying assumptions about the quality of the U.S. health care system and basing their comparisons of medical tourism's quality on a hypothetical "gold standard."[181] Such assumptions, however, have been called into question in recent years through increasingly in-depth investigation of American health care quality. According to a World Health Organization report, the United States ranks first among nations in medical expenditures, but only thirty-seventh overall in the quality of care delivered by its domestic health care system.[182] Moreover, a report published in 2000 by the Institute of Medicine reported that as many as 98,000 Americans are killed by

179. For example, facilities typically will provide living arrangements for the patient's caretaker, which allow the caretaker to remain in the hospital with the patient during her stay. *See, e.g.*, *International Patient Services: Category of Rooms Apollo Hospitals New Delhi*, APOLLO HOSPS., http://www.apollohospitals.com/category_delhi.php (last visited Jan. 3, 2011). Bumrungrad International Hospital also provides a "virtual patient visit" website which allows the patient and her network of family and friends to exchange messages and pictures during the patient's stay. Klaus, *supra* note 8, at 228. Thus, receiving care abroad does not necessarily remove a medical tourist from the comforts of her family and friends.

180. For example, patients can control their post-operative itinerary and flight schedule in order to reduce the risk of adverse post-operative effects. Even delaying their return by a few days or weeks, for example, might significantly reduce the risk of surgical complications, and most medical tourists choose to extend their stay by this length of time. Boyle, *supra* note 41, at 45; Klaus, *supra* note 8, at 227. Similarly, medical tourists may be less likely to engage in thoughtless surgery if more fully and forcefully informed of the risks inherent in any surgical procedure.

181. *See, e.g.*, Brady, *supra* note 16, at 1096–97 (describing the lack of empirical comparability between U.S. and foreign providers and casting inherent surgical risk as "a dark pall over medical standards abroad," but not domestically).

182. WORLD HEALTH ORG., THE WORLD HEALTH REPORT 155, 200 (2000).

medical errors each year, making medical error the eighth leading cause of death at that time.[183] Since this report was published, the federal government has increased efforts to protect patient safety and reduce medial errors.[184] Despite efforts of the Agency for Healthcare Research & Quality ("AHRQ") and others to collect data on health care quality and enhance patient care,[185] quality improvements since 2000 have been slow,[186] and quality of care has continued to vary substantially across state lines.[187] Further improvements in the U.S. health care system, particularly in reducing medical errors, have been hampered in part by the nature of its compliance system. The federal government and most states neither require reporting by hospitals of adverse patient events nor mandate that the Joint Commission release information it collects to the public.[188] As previously

183. INST. OF MED., *supra* note 120, at 26. More than two-thirds of the errors analyzed in this report were believed to be preventable, and many of these may have been attributable to negligence. *Id.* at 36.

184. *See* Lucian L. Leape & Donald M. Berwick, *Five Years After to Err is Human: What Have We Learned?*, 293 JAMA 2384, 2385 (2005) (recognizing that Congress appropriated $50 million annually to patient safety research and named the Agency for Healthcare Research and Quality as the lead research organization for federal patient safety research).

185. For discussion, see *supra* notes 119–22.

186. NATIONAL HEALTHCARE QUALITY REPORT 2007, *supra* note 118, at iv, 2 (revealing annual improvement of only 1.5% between 2000 and 2005). This modest change was calculated based on a subset of "core measures" intended to represent the most important and well-supported measures in the study; these include such varied indicators as breast cancer incidence, childhood vaccinations, and surgical post-operative complications. *See id.* at 11, 13–16.

187. *Id.* at iv, 3, 5.

188. *See* FIELD, *supra* note 135, at 47; JOINT COMM'N, *supra* note 150, at ACC-54, SE-1, PI-9. Medical errors are addressed in the United States primarily through voluntary reporting mechanisms authorized by the Patient Safety and Quality Improvement Act, 42 U.S.C. §§ 299b-21 to -26 (2006). Though some states have mandatory reporting requirements for adverse events and medical errors, this is far from the general rule, as many states allow hospitals to choose the extent to which they will report such events. *See supra* notes 122–27 and accompanying text. To assuage providers' fears of legal reprisal for their errors, the Patient Safety and Quality Improvement Act places significant limitations on how this information may be used or disclosed, including comprehensive confidentiality and government privilege for voluntarily reported patient safety data. 42 U.S.C. § 299b-22; FIELD, *supra* note 135, at 47. No facility under the federal regime is required to report on any adverse events that occur within their facilities, FIELD, *supra* note 135, at 47, and continuing fear of litigation may prevent providers from making these data available. *See id.*; NATIONAL HEALTHCARE QUALITY REPORT 2007, *supra* note 118, at 8. Though the Joint Commission accreditation assesses hospitals on the quality of their adverse event records and encourages reporting of particularly harmful "sentinel events," these behaviors are not required for accreditation, and the Joint Commission generally does not release any information collected to the public or government. *See* JOINT COMM'N, *supra* note 150, at ACC-54, SE-1, PI-9. A "sentinel event" is defined as "an unexpected

discussed, limited data exist with which to compare American and international medical care qualitatively.[189] However, several general observations are appropriate for common medical tourism destinations. First, medical tourists' reports of the quality of their care are vastly positive in nature.[190] Though specific instances of poor quality have been noted, with painful results for the unfortunate recipients of this care,[191] such instances appear to stem primarily from the use of "unaccredited hospitals and unlicensed providers."[192] Of course, all medical procedures carry certain inherent risk,[193] and even careful doctors are fallible people. However, because medical tourism represents a more substantial break from the "status quo" of American medical care, medical tourists may be more likely to choose practitioners based on negative reports against a particular international provider than the average American patient receiving care from local practitioners.[194] The medical tourism industry therefore provides a stronger incentive to provide high-quality care than most American facilities. Furthermore, the JCI may provide additional means of keeping medical tourism facilities in check, beyond the role played by the Joint Commission in regulating American medical care. In determining whether to grant accreditation, the JCI evaluates the adequacy of a facility's quality of care data collection and analysis, as well as steps taken to ensure continuous quality and safety improvement.[195] In addition, the JCI has expressed a commitment to publicizing standard-specific scores for the facilities it accredits.[196] Though only a rough proxy for actual error reporting, publicizing scores on these safety measures would give medical tourists a better understanding of the safety measures in

occurrence involving death or serious physical or psychological injury, or the risk thereof." *Id.* at SE-1.

189. *See supra* Part I.B.1.a.

190. Howze, *supra* note 23, at 1030; *see supra* notes 115–17 and accompanying text.

191. *E.g.*, Terry, *supra* note 7, at 464 (quoting *Medical Tourism Hearing*, *supra* note 17, at 45 (statement of Bruce Cunningham, M.D., President, American Society of Plastic Surgeons)).

192. *Id.*

193. Brady, *supra* note 16, at 1097.

194. *See* BOOKMAN & BOOKMAN, *supra* note 7, at 60, 145. The effects of reputation on medical tourism facilities are discussed in greater detail *infra* Part III.A.1.

195. JOINT COMM'N INT'L, *supra* note 119, at 102–09.

196. *Id.* at 8. The JCI will provide this information "[w]hen a sufficient database of accredited organizations is available for a comparative report . . . ." *Id.* Ensuring that the JCI adheres to this commitment may be an important part of ensuring transparency in the medical tourism market and thereby protecting American medical tourists. *See infra* Part III.B.

place and provide additional incentive for facilities to implement and follow these safety procedures.

Given the most comprehensive comparison of American and medical tourism facilities currently possible, medical tourists appear, at the very least, to be no worse off than American patients in the quality and safety of care they receive abroad. Though this section has focused largely on the limitations and regulatory pitfalls in the United States, it should not be construed to suggest that increased regulation of the American health care system would not be preferable if effective in ensuring better patient outcomes. If the United States were to establish more effective standards to ensure quality of care that far surpassed the effectiveness of measures available overseas, increased regulation of medical tourism might be warranted. Until the United States is able to regulate its own medical quality more uniformly and effectively, however, restricting access to overseas medical treatment based on quality of care issues is unduly protectionist and hypocritical.

2. Access to Legal Remedy

Another criticism leveled against medical tourism is the lack of legal remedy for patients claiming injury from medical malpractice.[197] Some errors are inevitable in any health care system; no matter how scientifically advanced or carefully administered the treatment, health care professionals are ultimately human, and even good doctors make mistakes.[198] When medical tourists become the victims of medical malpractice, they will likely face high recovery costs on their return to the United States, as even insured individuals will be unlikely to obtain coverage for injuries incurred through out-of-network procedures.[199] Analysts universally agree that injured American medical tourists lack any viable means of legal recourse remotely akin to the U.S. civil court system.[200] As one popular medical tourism facility has conceded, "[t]here is presently no international legal

197. *E.g.*, Howze, *supra* note 23, at 1029–38; Mirrer-Singer, *supra* note 16, at 212–27; Parsiyar, *supra* note 13, at 393–96.

198. *See* JACK HASSON & RAZI SHARAFIEH, WHY EVEN GOOD DOCTORS MAKE MISTAKES: AN ANECDOTAL INTRODUCTION TO MEDICINE 8 (2005) (describing the imperfection of medicine and the varied types of mistakes that even vigilant doctors make).

199. Boyle, *supra* note 41, at 45; Howze, *supra* note 23, at 1029 (citing *Medical Tourism Hearing*, *supra* note 17, at 46 (statement of Bruce Cunningham, M.D., President, American Society of Plastic Surgeons)).

200. *See, e.g.*, Boyle, *supra* note 41, at 46; Brady, *supra* note 16, at 1100–02; Howze, *supra* note 23, at 1029–38; Parsiyar, *supra* note 13, at 395–96.

regulation of medical tourism.... The issue of legal recourse for unsatisfactory treatment across international boundaries is a legally undefined issue at present."[201]

Medical tourists' lack of legal recourse stems from several sources. As a threshold matter, medical tourism facilities may require patients to take steps to limit their legal remedy against the provider.[202] Medical tourists must generally sign away any rights to sue for malpractice when they seek medical care in Asian facilities.[203] In refusing to recognize such waivers as valid,[204] American courts have tended to base their decisions on the dual grounds that health care providers supply services in the "public interest," and that patients lack the ability to bargain on equal terms with health care providers.[205] In contrast, because most international jurisdictions do not adhere as strongly to similar rationales,[206] they may be more willing to recognize the validity of malpractice waivers.[207] Foreign judges may be further encouraged to uphold malpractice waivers as a protectionist measure to safeguard the foreign jurisdiction's domestic health care industry, particularly the fledgling medical tourism industry. Thus, such waivers may provide a strong disincentive for medical tourists to sue.

Second, the U.S. legal system is unlikely to provide an adequate means of legal redress against foreign providers.[208] Most patients would prefer to file a lawsuit close to home and in a familiar jurisdiction, and medical tourists may attempt to sue their foreign

201. Mirrer-Singer, *supra* note 16, at 212 (quoting *Medical Insurance India*, INDIAPROFILE.COM, http://www.indiaprofile.com/medical-tourism/medical-insurance-and-legal-aspects.html (last visited Jan. 3, 2011)).

202. *See* Brady, *supra* note 16, at 1100; Klaus, *supra* note 8, at 235.

203. Brady, *supra* note 16, at 1100; Klaus, *supra* note 8, at 235.

204. *See* Maxwell J. Mehlman, *Fiduciary Contracting: Limitations on Bargaining Between Patients and Health Care Providers*, 51 U. PITT. L. REV. 365, 401–04 (1990).

205. *See id.* at 401–03. These rationales draw heavily on the implied assumption that malpractice suits are necessary to protect the welfare of patients and to safeguard the public health, which is also used to justify the breadth and pervasiveness of medical malpractice litigation in the United States. *See* Klaus, *supra* note 8, at 235–39.

206. *See* Parsiyar, *supra* note 13, at 395 ("[O]ther countries are not as litigious as the United States.").

207. Theoretically, many developing countries have adopted policies protective of their emerging medical tourism industries in other contexts. *See* BOOKMAN & BOOKMAN, *supra* note 7, at 70–74 (describing the active role of the public sector in promoting medical tourism in destination countries).

208. For a comprehensive article addressing this topic, see Mirrer-Singer, *supra* note 16 (discussing many of the theories by which medical tourists attempt to bring claims in American courts against foreign health care providers).

provider in the U.S. court system.[209] However, an American court must have personal jurisdiction over the foreign provider before recognizing the suit, a burden which would be difficult for the medical tourist to meet.[210] American courts appear extremely reluctant to assert personal jurisdiction over nonresident doctors who do not practice in the forum state.[211] It could be difficult to establish minimum contacts sufficient to exercise personal jurisdiction, particularly over a physician who conducted a harmful procedure outside the forum state's borders.[212] In some instances, minimum contacts may be established when a plaintiff conducts business over the Internet.[213] However, American courts have been reluctant to find that the mere operation of a website is sufficient to meet the minimum contacts requirement, particularly in the few cases addressing medical websites.[214] Furthermore, courts are unlikely to recognize the alternative argument of "continuing tort," which would

209. *See, e.g.*, Howze, *supra* note 23, at 1032; Mirrer-Singer, *supra* note 16, at 212–13; Parsiyar, *supra* note 13, at 393.

210. Mirrer-Singer, *supra* note 16, at 212–13.

211. *Id.* at 213; *see, e.g.*, Harris v. Omelon, 985 A.2d 1103, 1107 (D.C. 2009) (finding no personal jurisdiction over a Virginia physician who merely phoned a prescription into the forum state); Bachman v. Med. Engineering Corp., 724 P.2d 858, 860–61 (Or. Ct. App. 1986) (recognizing no personal jurisdiction in Oregon over Washington physicians who allegedly practiced negligently on the defendant in Washington and whose contacts with Oregon included several Oregon patients and sporadic supervision of Oregon surgeons); Grove v. Maheswaran, 498 S.E.2d 485, 491 (W. Va. 1997) (failing to find sufficient minimum contacts to establish jurisdiction over a nonresident physician).

212. *See Harris*, 985 A.2d at 1106–07; *Bachman*, 724 P.2d at 860–61; Howze, *supra* note 23, at 1031–32; Mirrer-Singer, *supra* note 16, at 212–13.

213. *See, e.g.*, ALS Scan, Inc. v. Digital Serv. Consultants, Inc., 293 F.3d 707, 713–14 (4th Cir. 2002) (holding that, in Maryland courts, "specific jurisdiction in the Internet context may be based only on an out-of-state person's Internet activity directed at Maryland and causing injury that gives rise to a potential claim cognizable in Maryland"); Neogen Corp. v. Neo Gen Screening, Inc., 2002 FED App. 0080P at 10, 282 F.3d 883, 890–91 (6th Cir. 2002) (suggesting that "[s]everal aspects of the [defendant's] website ... support a finding of purposeful availment"—including granting passwords to forum state residents, soliciting forum state businesses, and posting study data held out as collected from forum state residents); Zippo Mfg. Co. v. Zippo Dot Com, Inc., 952 F. Supp. 1119, 1123–27 (W.D. Pa. 1997) (applying the widely adopted test for minimum Internet contacts).

214. *See, e.g.*, *Zippo*, 952 F. Supp. at 1124 ("A passive Web site that does little more than make information available to those who are interested in it is not grounds for the exercise of personal jurisdiction."); Zavala v. El Paso Cnty. Hosp. Dist., 2007-NMCA-149, ¶ 20, 143 N.M. 36, 172 P.3d 173 (finding that a hospital's "[e]stablishment of a passive website that can be viewed internationally is not sufficient to support general personal jurisdiction absent some showing that the website targeted" the forum state); Schexnayder v. Daniels, 187 S.W.3d 238, 249 (Tex. App. 2006) (finding no personal jurisdiction based on hospital website providing defendant-physician's credentials and email interaction); McLean, *supra* note 33, at 634–35.

allow the court to assert personal jurisdiction over a foreign physician merely because his tortuously-rendered care continues to harm the plaintiff within the forum state.[215]

Medical tourists who procured care through the use of a medical tourism broker might alternatively attempt to sue the broker, rather than the physician.[216] Brokerage firms incorporated in the United States may provide easier means of establishing personal jurisdiction, as they will always fall within the jurisdiction of their principal place of business and their state of incorporation.[217] However, this remedy would only aid those medical tourists who employed brokers to arrange their travel and medical plans and not those who arranged travel through other means. Even if personal jurisdiction is established over a broker, medical tourists are unlikely to prevail because the broker's relationship to any one provider is unlikely to justify a finding of actual or proximate causation or to establish vicarious liability for the provider's actions.[218]

In either case, conflict of laws issues will further reduce a medical tourist's likelihood of recovery in a malpractice suit.[219] If personal jurisdiction is established and a court recognizes a valid claim against the defendant, the defendant likely will be successful in challenging the suit's location through a *forum non conveniens* motion.[220] If an

215. *See, e.g.*, Cunningham v. Huffman, 609 N.E.2d 321, 324–35 (Ill. 1993); Mirrer-Singer, *supra* note 16, at 214. This is attributable in part to the policy implications of the theory's potential application to American physicians; a continuing tort theory has been rejected in the medical malpractice context in a number of American jurisdictions when it is based only on a continued harm to the plaintiff. *See, e.g.*, Canas v. Al-Jabi, 639 S.E.2d 494, 508–09 (Ga. Ct. App. 2006), *rev'd on other grounds*, Kaminer v. Canas, 653 S.E.2d 691, 691 (Ga. 2007); *In re* Moses, 2000-2643, p. 8 (La. 5/25/01); 788 So. 2d 1173, 1183; Stanbury v. Bacardi, 953 S.W.2d 671, 676–77 (Tenn. 1997); *see also* Aristide v. Jackson Mem'l. Hosp., 917 So. 2d 253, 255 (Fla. Dist. Ct. App. 2005) ("No Florida appellate court has applied the continuing tort doctrine to medical malpractice cases."). Some jurisdictions recognize an alternate "continuing treatment" theory, under which a patient may recover for injuries sustained through a course of treatments or a continued physician-patient relationship over time. *See, e.g.*, Beckel v. Gerber, 1998 SD 48, ¶ 10, 578 N.W.2d 574, 576. Even where this doctrine is recognized, however, it would be unlikely to apply to a medical tourist's injury, as the opportunity for continued treatment or continued relationship with the foreign physician is unlikely.

216. Mirrer-Singer, *supra* note 16, at 216.

217. *Id.*

218. *See id.* at 216–21.

219. *See id.* at 222–27.

220. Howze, *supra* note 23, at 1032; Mirrer-Singer, *supra* note 16, at 222, 224. The *forum non conveniens* doctrine allows a court to decline to exert jurisdiction when the plaintiff's chosen forum would pose an undue burden or hardship on the defendants, as is often the case when the defendant is a foreign national. *See* Gulf Oil Corp. v. Gilbert, 330 U.S. 501, 507–09 (1947). Removal may be denied if it would effectively prevent the defendant from receiving "reasonable access to some legal remed[y]." Mirrer-Singer,

American jurisdiction were to hear the medical tourist's lawsuit, most jurisdictions would apply the law of the country in which the malpractice occurred, which would decrease the likelihood of a finding of malpractice and reduce damage awards.[221] Finally, if a medical tourist is successful in winning a monetary judgment in her favor, obtaining enforcement of this judgment over a foreign provider is likely to be difficult.[222]

Even if relief is not barred by either waiver or lack of legal remedy, suing for malpractice in an international jurisdiction may not be economically prudent or feasible for medical tourists.[223] The United States is a more plaintiff-friendly jurisdiction than foreign countries, providing a civil court system, which is generally more efficient and produces larger damage awards and settlements than foreign jurisdictions.[224] Furthermore, malpractice law in other nations is not as protective of patients, or even as clearly defined, as U.S. medical malpractice law.[225] Foreign jurisdictions may be reluctant to

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supra note 16, at 223 (quoting Jeha v. Arabian Am. Oil Co., 751 F. Supp. 122, 125 (S.D. Tex. 1990)); *see* Piper Aircraft Co. v. Reyno, 454 U.S. 235, 254 (1981); Howze, *supra* note 23, at 1033–34. However, because American courts typically are unwilling to pass judgment on the adequacy of international tribunals, they are more likely to recognize the foreign jurisdiction in which the surgery took place as the appropriate forum for the suit. *See* Howze, *supra* note 23, at 1035–36; Mirrer-Singer, *supra* note 16, at 224. On the other hand, the U.S. Court of Appeals for the Third Circuit in *Bhatnagar v. Surrendra Overseas Ltd.*, 52 F.3d 1220 (3d Cir. 1995), refused to release a civil suit to the Indian courts on *forum non conveniens* grounds, citing the remote possibility of recovery and significant delay in that jurisdiction as evidence that the forum was inadequate. *Id.* at 1224; *see* Mirrer-Singer, *supra* note 16, at 224. This fact suggests that, should personal jurisdiction over a foreign provider be recognized, a medical tourist plaintiff may not be precluded from access to the traditional American malpractice recovery, particularly if the suit is brought within this circuit.

221. *E.g.*, Chadwick v. Arabian Am. Oil Co., 656 F. Supp. 857, 858 (D. Del. 1987) (dismissing malpractice action against oil company incorporated in Delaware, with its principal place of business in Saudi Arabia, where defendant was misdiagnosed in Saudi Arabia and Saudi law did not recognize liability); *see* Mirrer-Singer, *supra* note 16, at 226–27.

222. *See* ROBERT E. LUTZ, A LAWYER'S HANDBOOK FOR ENFORCING FOREIGN JUDGMENTS IN THE UNITED STATES AND ABROAD 415–37 (2007) (describing the difficulties encountered in enforcing American judgments in foreign nations).

223. *See, e.g.*, Boyle, *supra* note 41, at 46; Howze, *supra* note 23, at 1035–36.

224. *See* BOOKMAN & BOOKMAN, *supra* note 7, at 156; Boyle, *supra* note 41, at 46; Howze, *supra* note 23, at 1030, 1034–35; Parsiyar, *supra* note 13, at 395.

225. *See* Howze, *supra* note 23, at 1034–35; Klaus, *supra* note 8, at 236; Parsiyar, *supra* note 13, at 395. For example, approximately ninety-five percent of malpractice cases in India are dismissed, and those that survive dismissal must face substantial delays before the case is heard in court. Howze, *supra* note 23, at 1034–35. Similarly, most Asian countries lack consistent—and regularly enforced—malpractice standards. Klaus, *supra* note 8, at 236. Cuba does not allow patients to sue doctors for malpractice at all. Parsiyar, *supra* note 13, at 395.

recognize even valid malpractice claims by foreign patients against domestic providers because doing so would create unfavorable precedent encouraging similar suits and potentially harm their medical tourism industry. Thus, even assuming a medical tourist would be successful in having her malpractice suit heard in a foreign jurisdiction, the small and uncertain damage award, coupled with the significant expense of conducting a protracted trial overseas, makes any lawsuit financially infeasible.[226] When faced with the slim chance of success and strong possibility of losing money in pursuing a malpractice recovery, medical tourists lack incentive to pursue their claims abroad.

Despite the lack of an effective legal remedy for medical tourists, the fact that plaintiffs who have received negligent medical treatment abroad do not have access to remedies akin to those offered by the American malpractice system is unlikely to harm medical tourists as much as critics of the practice suggest.[227] According to prevailing American legal theory, medical malpractice is a beneficial component of the U.S. health care system justified by the advancement of three primary policy goals: (1) compensation for the costs of patients' injuries; (2) deterrence of future negligence; and (3) punishment of negligent practitioners.[228] However, even within the American tort system, these justifications do not appear to be served in practice.

Malpractice recoveries in the United States provide compensation not only for direct costs of the patient's injury, but also for its indirect costs, in an attempt to make the patient whole after his injury.[229] This form of redress tends to be much more extensive than in foreign nations, where damages may be limited to direct costs.[230] The American tort system, however, does not work consistently to provide redress for all, or even a majority of all patients harmed by provider negligence.[231] An estimated two percent of negligent medical

226. *See* Howze, *supra* note 23, at 1035.

227. *See, e.g.*, Mirrer-Singer, *supra* note 16, at 228–32; Parsiyar, *supra* note 13, at 395–96.

228. *See* David M. Studdert et al., *Medical Malpractice*, 350 NEW ENG. J. MED. 283, 283 (2004).

229. *See id.* ("[T]he party at fault for an injury should bear the associated costs, including lost earnings, medical bills, and 'pain and suffering.' ").

230. *See* BOOKMAN & BOOKMAN, *supra* note 7, at 156.

231. *See* A. Russell Localio et al., *Relation Between Malpractice Claims and Adverse Events Due to Negligence*, 325 NEW ENG. J. MED. 245, 249 (1991) ("[T]he number of patients in New York State who have serious, disabling injuries each year as a result of clearly negligent medical care but who do not file claims (5400) exceeds the number of patients making malpractice claims (3570).").

injuries result in a claim against the negligent provider.[232] Only a portion of these claims result in restitution for the injured plaintiff,[233] and only a limited portion of litigation expenditures actually benefit injured plaintiffs.[234] Some analysts also have argued that those who are able to recover tend to be overcompensated, for example through excessive recoveries for pain and suffering.[235] These additional expenses, coupled with the substantial administrative costs incurred by the system at large, are passed off to all patients in the form of higher costs for medical care.[236] Although the malpractice system is justified for its ability to compensate some injured patients for their injuries, it is ineffective in achieving this goal for the majority of injured patients and tends to impose additional costs and reduce access to care for all patients.

The deterrent effect of tort liability also remains questionable. In theory, practitioners who are forced to pay high damage awards and whose reputations are harmed by a malpractice claim will be less likely to provide poor care in the future.[237] Moreover, the medical community may look to those physicians as a reminder of the potential consequences of negligent care and be encouraged to act with greater care to avoid a similar fate.[238] There is little concrete evidence, however, that the threat of a medical malpractice action effectively deters practitioners from future negligence.[239] The threat

232. Studdert et al., *supra* note 228, at 285; *see* Localio et al., *supra* note 231, at 247, 249; *see also* H.H. Hiatt et al., *A Study of Medical Injury and Medical Malpractice: An Overview*, 321 NEW ENG. J. MED. 480, 480–81 (1989) (describing the methods of an empirical study of the compensation that patients with medically caused injuries receive, and the degree to which the threat of malpractice suits limits injuries).

233. *See* David M. Studdert et al., *Claims, Errors, and Compensation Payments in Medical Malpractice Litigation*, 354 NEW ENG. J. MED. 2024, 2031 (2006) (finding that approximately one-sixth of all legitimate claims of medical negligence which were fully litigated failed to result in a recovery for the plaintiff).

234. *Id.* (finding that approximately fifty to sixty percent of all money spent on medical malpractice is used to cover litigation expenses and not to compensate meritorious plaintiffs).

235. *See* HARRIS, *supra* note 124, at 252. *But see* Michael J. Saks, *Do We Really Know Anything About the Behavior of the Tort Litigation System—And Why Not?*, 140 U. PA. L. REV. 1147, 1271–80 (1992) (arguing that people with relatively small losses tend to be overcompensated, while those whose losses are large tend to be undercompensated).

236. *See* HARRIS, *supra* note 124, at 252; Klaus, *supra* note 8, at 235.

237. *See* Studdert et al., *supra* note 228, at 283; Klaus, *supra* note 8, at 236; *see also* GUIDO CALABRESI, THE COST OF ACCIDENTS: A LEGAL AND ECONOMIC ANALYSIS 26–28, 73–75 (1970) (exploring the deterrent effect of tort liability).

238. *See* Studdert et al., *supra* note 228, at 283; Brady, *supra* note 16, at 1100; Klaus, *supra* note 8, at 236.

239. Michelle M. Mello & Troyen A. Brennan, *Deterrence of Medical Errors: Theory and Evidence for Malpractice Reform*, 80 TEX. L. REV. 1595, 1607–08 (2002); Studdert et

of a lawsuit may actually result in adverse behaviors by practitioners, as they may be encouraged to engage in "defensive medicine" by ordering additional tests and procedures in order to ward off future malpractice claims.[240] In contrast, medical tourism providers may be effectively deterred from acting negligently without the need for malpractice liability, since the viability of a medical tourism facility is based in large part on its ability to maintain a reputation for quality, safe, and efficient service, which allows it to compete more effectively with other medical tourism destinations.[241]

The American medical malpractice system also fails to punish physicians effectively for negligent harm to patients. Malpractice suits impose certain "reputational and emotional harm[s]" on defendants,[242] as well as considerable hassle. However, due to the relative infrequency of malpractice suits,[243] coupled with the fact that practitioners tend not to experience major professional consequences unless they are sued routinely,[244] these harms may amount to a mere inconvenience, insufficiently persuasive to redress the plaintiff's harms or to deter future negligence.[245]

Monetary judgments against a provider are a potentially harsher punishment. However, payment mechanisms for these judgments produce an unintended removal of responsibility from physicians for their negligent acts. Expensive malpractice insurance has become a practical requirement for physicians practicing in the United States.[246] When a physician loses a malpractice suit, his insurance company will

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al., *supra* note 228, at 286; Brady, *supra* note 16, at 1100–01; Klaus, *supra* note 8, at 236. A number of studies examining the relationship between medical malpractice and reduced medical error have returned, at best, inconclusive evidence of deterrence. *See* Studdert et al., *supra* note 228, at 286; Klaus, *supra* note 8, at 236.

240. *See* HARRIS, *supra* note 124, at 252; Studdert et al., *supra* note 228, at 286. This practice is detrimental to patients: As increasing numbers of procedures become standard patient care, routine patient care is ratcheted up in the amount of time and cost each patient consumes, Studdert et al., *supra* note 228, at 286, increasing the burden on providers and reducing the quality of care delivered for all patients. Providing more treatment than is necessary may also result in adverse effects for the patient, resulting even more directly in reduced quality of care for the patients. *See* NAT'L COMM. FOR QUALITY ASSURANCE, *supra* note 119, at 9.

241. *See* Klaus, *supra* note 8, at 236–37. The effects of competition on medical tourism facilities' quality of care is discussed in greater detail *infra* Part III.A.1.

242. Klaus, *supra* note 8, at 239.

243. *See* Studdert et al., *supra* note 233, at 2025.

244. *See* Studdert et al., *supra* note 228, at 283–84; Klaus, *supra* note 8, at 238–39.

245. HARRIS, *supra* note 124, at 253; *see* Studdert et al., *supra* note 228, at 283. *But see* HARRIS, *supra* note 124, at 252 ("Even an unjustified claim can have an adverse effect on a physician's professional reputation.").

246. *See* Studdert et al., *supra* note 228, at 283

foot the bill while the cost of the insurance is passed on to all patients in the form of higher fees for medical services.[247] Thus, it is the insurance companies and (indirectly) the patients who are punished financially for a physician's malpractice. Such a perverse system may create moral hazard for some physicians, justifying inadequate measures to avoid liability as physicians are forced to pay the high costs of malpractice insurance regardless of these efforts.[248]

In contrast, physicians employed at medical tourism facilities are likely to be punished more substantially for their negligence. The reputations of these physicians are closely linked to their ability to attract patients because medical tourists are encouraged to use the reputation and history of a physician to enlist her services.[249] Furthermore, the ability of physicians overseas to avoid expensive malpractice insurance—and thereby avoid passing on the costs of this insurance to patients—may be a substantial factor in ensuring the reduced costs of medical tourists' procedures.[250]

Thus, the vast majority of American patients who choose to engage in medical tourism will not be harmed by giving up their right to sue, since the American malpractice system inadequately protects the interests of most injured patients and may produce incidental detriment to patient care. In contrast, the primary financial benefit of medical tourism, as well as other incidental benefits to quality of care, is likely to be promoted substantially by the absence of an American-style malpractice system and the increased administrative and insurance costs which such a system produces.

3. Conflict with ERISA

Poor quality of care and lack of medical malpractice remedy are the two strongest arguments leveled against medical tourism, as these

247. *See* Klaus, *supra* note 8, at 237. Medical malpractice insurance premiums generally are not "experience rated"; that is, they are not priced differently between individuals based on their malpractice history. MICHELLE M. MELLO, ROBERT WOOD JOHNSON FOUND., UNDERSTANDING MEDICAL MALPRACTICE INSURANCE: A PRIMER 1 (2006), http://www.rwjf.org/pr/synthesis/reports_and_briefs/pdf/no10_primer.pdf. Thus, a physician's malpractice insurance premium will not change, even if the insurance company is forced to pay out a large damage award on the physician's behalf.

248. *See* William M. Sage, *Medical Malpractice Insurance and the Emperor's Clothes*, 54 DEPAUL L. REV. 463, 475–76 (2005).

249. Cortez, *supra* note 14, at 107; Brady, *supra* note 16, at 1102; Klaus, *supra* note 8, at 239.

250. Klaus, *supra* note 8, at 238. In most cases, physicians abroad will carry some form of malpractice insurance, but because it may only be used to absorb the cost of a limited judgment against the physician, the costs of this insurance will be much less and not as impactful to the individual patient. *See* BOOKMAN & BOOKMAN, *supra* note 7, at 156.

have the potential to cause the most significant and lasting harm to patients. As a secondary concern, however, medical tourism has been challenged[251] on the grounds that it violates the fiduciary duty imposed by ERISA.[252] ERISA is a federal law that imposes a set of minimum standards on employee benefit plans, including health insurance plans, and is intended to protect employees by ensuring plans' basic fairness and financial stability.[253] As a central component of these standards, ERISA imposes fiduciary duties on those invested with discretionary control or authority in the plan's management or administrative decisions.[254] Pursuant to this duty, an ERISA fiduciary is held to a prudent person standard of care under which he is required to "discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries" and must act for two "exclusive purpose[s]": to provide benefits to the plan participants and to defray reasonably the plan's administrative expenses.[255]

It has been argued recently that the fiduciary duty imposed under ERISA is fundamentally inconsistent with the concept of medical tourism.[256] Specifically, this argument contends that health insurance plans, employers, and health maintenance organizations ("HMOs") cannot authorize and pay for participants to engage in medical tourism without violating their fiduciary duty of loyalty under ERISA.[257] Although the authorization of medical tourism does not result in a de jure violation of ERISA fiduciary requirements,[258] it is argued that the financial benefits of medical tourism, which inure primarily to the benefit of plan sponsors, are so great that they must necessarily overwhelm the sponsors' ability to evaluate the dangers

251. *See* Brady, *supra* note 16, at 1075.

252. Employee Retirement Income Security Act of 1974, 29 U.S.C. §§ 1001-1461 (2006).

253. § 1001(a).

254. § 1002(21)(A). This provision has been interpreted to preclude fiduciary duty for individuals who carry out "purely ministerial" duties for the plan, a determination which is highly fact-specific. Brady, *supra* note 16, at 1081.

255. § 1104(a)(1). The "prudent man standard" established under ERISA embodies the requirement that the fiduciary must act "with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims." § 1104(a)(1)(B). Some courts have held that this standard imposes a more stringent requirement on ERISA fiduciaries than is imposed on common law trust fiduciaries. Reich v. Valley Nat'l Bank of Ariz., 837 F. Supp. 1259, 1273 (S.D.N.Y. 1993); *see* Brady, *supra* note 16, at 1107.

256. *See* Brady, *supra* note 16, at 1075.

257. *Id.*

258. *Id.* at 1109.

inherent in medical tourism.[259] According to this argument, the very act of authorizing medical tourism in insurance plans necessarily produces a de facto violation of ERISA's fiduciary duties.[260] Further, medical tourism defeats ERISA's public policy justification of ensuring equity in the distribution of employee health benefits.[261]

This argument undervalues the full scope of ERISA's fiduciary requirements and underestimates the role of the employee in choosing to engage in medical tourism. Employers undoubtedly cannot force employees to obtain medical care overseas without breaching more substantial fiduciary requirements,[262] but merely authorizing plan participants to engage in medical tourism as one of many treatment options removes the ultimate decision from the plan sponsors. Because participants in ERISA plans are not fiduciaries themselves,[263] the patient's decision to choose an option offered under that plan cannot be the basis of a breach of fiduciary duty.[264] Although plan fiduciaries are required to act in the best interest of the plan participants, they are also required to defray administrative expenses wherever possible.[265] Allowing plan participants to choose

259. *See id.* at 1110–11.

260. *See id.* at 1111.

261. *See id.*

262. *See id.* at 1111–12.

263. *Id.* at 1109; *see* Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1002(21)(A) (2006). Section 1002(21)(A) recognizes as a fiduciary any person who

> exercises any discretionary authority or discretionary control respecting management of such plan or exercises any authority or control respecting management or disposition of its assets, . . . renders investment advice for a fee or other compensation, direct or indirect, with respect to any moneys or other property of such plan, or has any authority or responsibility to do so, or . . . has any discretionary authority or discretionary responsibility in the administration of such plan.

By definition, individuals acting in their capacity as plan participants do not carry the degree of managerial discretion necessary to be defined as fiduciaries under the statute.

264. Brady, *supra* note 16, at 1109; *see id.* at 1107 (recognizing that plan administrators are vested with substantial discretion despite their fiduciary duty, and conceding that "[a]s long as a plan administrator acted in the sole interest of the beneficiaries when deciding to utilize medical outsourcing in an employee benefit plan, such a decision apparently falls within the scope of ERISA's fiduciary duty"). Though the author suggests that merely offering medical tourism as an option violates the fiduciary duty, regardless of the patient's decision making responsibility, *id.* at 1111–12, he relies in large part on the substantial quality concerns and lack of legal remedy inherent in medical tourism in reaching this determination, *id.*, risks which this Comment argues are overestimated.

265. Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1104(a) (2006). ERISA imposes a duty not to misrepresent the plan and, in some jurisdictions, an affirmative duty of disclosure to plan participants. Brady, *supra* note 16, at 1085–87. If a plan administrator adheres to these duties in providing medical tourism options within

to engage in medical tourism will accomplish this latter duty, and the plan sponsor may be able to increase the benefit to plan participants by sharing the cost savings with them.[266] Moreover, reducing costs to plan sponsors may be the only means by which some employers can continue to afford to provide health care benefits to their employees.[267] Medical tourism thus may actually promote, rather than hamper, ERISA's goal of providing health care benefits more equitably. By relying too heavily on perceived failings in medical tourism's regulation and quality, this de facto violation argument fails to account for the fact that medical tourism has the potential to benefit *both* plan participants and plan sponsors and thereby meet both ERISA's legal requirements and the policy goals ERISA was created to promote.

C. *Recognizing the Trade-off*

Despite its substantial benefits to American patients,[268] particularly those placed in a vulnerable position by their lack of adequate medical insurance,[269] medical tourism presents patients with a set of value judgments to be weighed in reaching the decision to undertake medical care overseas.[270] While medical tourism involves some unique quality concerns, and overall quality may be difficult to assess, these quality concerns appear to be no greater overall than those already present in the U.S. health care system.[271] Though patients may assume more individual financial risk by obtaining care overseas due to the lack of comparable malpractice remedies in foreign jurisdictions, this risk may not be entirely different from the risk imposed by the limitations of the American malpractice system.[272]

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employee benefit packages, plan participants can make fully informed choices regarding the option to engage in medical tourism, and this decision does not give rise to a breach of fiduciary duty.

266. *See* McLean, *supra* note 33, at 600 (addressing the Blue Ridge Paper controversy, discussed *supra* notes 43–47 and accompanying text, which provides a salient example of both the draw of medical tourism for employers and the possibility of cost-sharing with employees).

267. *See* Boyle, *supra* note 41, at 43; Brady, *supra* note 16, at 1103; Klaus, *supra* note 8, at 243.

268. *See supra* Part I.A.

269. *See supra* Part I.A.1.

270. *See* Brady, *supra* note 16, at 1102 (describing the need for patients to "evaluate and weigh" the various risks and benefits of medical tourism before engaging in the practice).

271. *See supra* Part I.B.1.

272. *See supra* Part I.B.2.

Ultimately, the determination of whether to engage in medical tourism should be made by the individual patient based on his own value determination and risk assessment. Certainly, some risk-averse individuals will choose to operate within the current financial constraints of the American health care system despite the possibility for low-cost and high-quality care overseas. However, it is inaccurate—and harmful to American patients generally—to assume that the existence of any risks should preclude participation in the benefits of this emerging industry. Medical tourism provides a crucial opportunity for patients who require care and would otherwise be unable to obtain it, and it gives many more patients the opportunity to exercise additional autonomy and to save substantial sums while obtaining care. In the face of these vital benefits, concerns about quality of care and legal remedies appear less important and unconvincing. On the whole, the risk-benefit analysis of medical tourism weighs in favor of accepting it as a viable short-term alternative to the American health care system by providing care options to patients for whom the current system has failed.[273] As long as patients are adequately informed of the medical tourism industry's possible risks, they should be free to choose, without substantial interference, to take advantage of its benefits.

II. INEFFECTIVE REGULATORY FRAMEWORK AND PROPOSALS

In recognition of the risks inherent in medical tourism, a variety of reform proposals have been suggested to curb what some critics consider an inherently dangerous practice.[274] Most of these proposals build upon the existing regulatory framework used to police the U.S. health care system, cobbling together a solution to weaknesses in the domestic and international regulatory systems.[275] However, as this section will argue, neither the current structure of the U.S. health care regulatory system, nor proposed methods of limiting medical tourism among Americans, will be effective in reducing its risks or limiting its scope. Furthermore, imposing substantial regulatory limitations on medical tourism will likely lead to a reduction in its cost effectiveness, and therefore its primary benefit, for American patients.

273. *See Medical Tourism Hearing*, *supra* note 17, at 5. Some commentators, while recognizing the risks inherent in medical tourism, have reached similar conclusions. *See, e.g.*, Klaus, *supra* note 8, at 245–47; Parsiyar, *supra* note 13, at 403–04.

274. *See, e.g.*, Boyle, *supra* note 41, at 48–49; Brady, *supra* note 16, at 1112–14.

275. *See, e.g.*, Boyle, *supra* note 41, at 48–49; Brady, *supra* note 16, at 1112–14.

A. *Existing Regulatory Framework*

1. Forms of Domestic Government Regulation

The U.S. health care system is regulated by a combination of government agencies and non-governmental organizations, both public and private.[276] At the government level, both state and federal lawmakers are responsible for ensuring the safety and quality of domestic health care services.[277] The government has three primary means of regulating the domestic health care industry.[278] First, it may create laws that directly prohibit or mandate certain activities by health care providers.[279] Second, the government may recognize a civil cause of action for particular provider actions, allowing injured patients to sue providers for these breaches.[280] Medical malpractice suits for negligent care fall within this category. Third, the government may use its status as a significant purchaser of health care services through social programs such as Medicare and Medicaid as well as state employee health plans, to contract for additional protections and thereby impose requirements on providers who wish to supply services to government plan beneficiaries.[281]

These three regulatory methods are generally ineffective to police providers who operate on patients overseas. First, the United States has no jurisdiction to create laws that establish criminal liability for individuals who are not U.S. citizens and who are acting entirely on foreign soil.[282] Even if, in rare instances, a foreign doctor could be deemed to have engaged in the practice of medicine within the United States without a license, American officials likely cannot enforce domestic licensure requirements on foreign providers.[283]

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276. *See* FIELD, *supra* note 135, at 9–11; HARRIS, *supra* note 124, at 45–51.

277. HARRIS, *supra* note 124, at 67–68.

278. *Id.* at 4–5.

279. *Id.* at 4. For example, state governments mandate licensure of doctors before they are authorized to practice medicine within that state. FIELD, *supra* note 135, at 22–24; HARRIS, *supra* note 124, at 4–5.

280. HARRIS, *supra* note 124, at 5.

281. *Id.*

282. *See supra* note 158 and accompanying text.

283. To enforce domestic laws against foreign providers, the United States must effectively serve the provider with process in his or her home country, extradite the provider to the United States, and find personal jurisdiction over the provider in the U.S. court system. McLean, *supra* note 33, at 632. Minimum contacts are not necessary to establish personal jurisdiction if the state's criminal statute provides for extraterritorial jurisdiction. *Id.* at 635. Most States will authorize extraterritorial jurisdiction for those crimes "committed in whole or in part" within its territory, *id.* at 637 (quoting Hagseth v. Superior Court, 59 Cal. Rptr. 3d 385, 390 (Cal. Ct. App. 2007)) (internal quotation marks

Thus, direct legislation, including licensure, is not an effective means of regulating providers in the medical tourism context. Second, as this Comment has discussed, providing a cause of action against negligent foreign providers is generally not effective to redress medical tourists for the malpractice of these providers.[284] Whether such causes of action fail for lack of personal jurisdiction, *forum non conveniens*, or choice of law conflicts,[285] within the current judicial framework they are likely to be so ineffective that they fail to provide a useful means of regulating foreign providers.

Third, the government's status as a large-scale purchaser is equally unlikely to regulate medical tourism. Both federal and state governments have been reluctant to endorse medical tourism as a means of obtaining health care under government-sponsored plans. Federal programs such as Medicare and Medicaid refuse to pay for or reimburse health care obtained overseas.[286] Similarly, the states have neither taken advantage of medical tourism, nor attempted to regulate the practice as purchasers. Both the Colorado and West Virginia state legislatures recently proposed legislation providing incentives for state employees to elect overseas care in order to reduce the cost of insuring these public employees.[287] However, neither plan provided substantive guidelines for ensuring quality of care in the choice of overseas providers. The West Virginia bill required only that the provider be JCI accredited,[288] while the

omitted), a standard which likely could be met in the medical outsourcing context if a provider's actions created criminal harm within a particular state. McLean, *supra* note 33, at 635. Such was the outcome in *Hagseth*, in which a former Colorado doctor with no valid medical license was found guilty of practicing medicine without a license in California when he wrote a prescription through an online pharmacy which resulted in the patient's suicide. *Hagseth*, 59 Cal. Rptr. 3d at 385. Many countries are unlikely to extradite or to aid in serving process on their citizens unless a citizen is charged with a capital crime, due to the disruption extradition creates on domestic law and order and because extradition of medical tourism providers would be contrary to economic policy. McLean, *supra* note 33, at 632–33. Thus, licensure is not an effective means of regulation for medical tourism providers.

284. *See supra* Part I.B.2.

285. *See supra* Part I.B.2.

286. *E.g.*, Mattoo & Rathindran, *supra* note 39, at 360.

287. H.B. 07-1143, 66th Gen. Assemb., 1st Reg. Sess. (Colo. 2007), http://www.leg.state.co.us/CLICS/CLICS2007A/csl.nsf/fsbillcont3/DA1B1F6E36E70CD687257251007B7BAF?Open&file=1143_01.pdf; H.B. 2841, 2007 Leg., 2d Sess. (W. Va. 2007), http://www.legis.state.wv.us/Bill_Text_HTML/2007_SESSIONS/RS/Bills/hb2841%20intr.htm; *see also* Brady, *supra* note 16, at 1104 (West Virginia); DELOITTE CTR. FOR HEALTH SOLUTIONS, *supra* note 10, at 6 (Colorado and West Virginia).

288. H.B. 2841; *see* Brady, *supra* note 16, at 1104–05; DELOITTE CTR. FOR HEALTH SOLUTIONS, *supra* note 10, at 6.

Colorado bill lacked even this requirement.[289] Neither state successfully enacted the proposed legislation,[290] due in part to political resistance to government "outsourcing" of medical care to foreign providers rather than the domestic markets.[291] Thus, neither the federal nor state governments are employing their significant clout as health care purchasers to regulate medical tourism. In the rare instances in which they have considered purchasing medical tourism services, they have failed to place meaningful restrictions on authorized providers.[292] Because of the significant opposition to government endorsement of medical tourism, they also appear unlikely to do so in the near future.[293]

2. Additional Regulatory Methods for Foreign Providers

When addressing foreign actors, the federal government has several additional methods it can employ to protect domestic health care markets from international competition.[294] First, the United

289. H.B. 07-1143; *see* DELOITTE CTR. FOR HEALTH SOLUTIONS, *supra* note 10, at 6.

290. DELOITTE CTR. FOR HEALTH SOLUTIONS, *supra* note 10, at 6. The West Virginia bill died in committee; the committee considering the Colorado bill postponed the bill indefinitely. *See Bill Status - 2007 Regular Session*, W. VA. LEGISLATURE, http://www.legis.state.wv.us/Bill_Status/Bills_history.cfm?input=2841&year=2007&sessiontype=RS&btype=bill (last visited Jan. 3, 2011) (indicating the West Virginia bill died in committee); *Summarized History for Bill Number HB07-1143*, COLO. GEN. ASSEMBLY, http://www.leg.state.co.us/CLICS/CLICS2007A/csl.nsf/BillFoldersAll?OpenFrameSet (follow "House Bills 1101-1150" under "Select Bill Range"; then follow "History" hyperlink for HB07-1143) (last visited Jan. 3, 2011) (indicating the Colorado bill was postponed indefinitely).

291. Analysts have also suggested that the bills likely failed to pass due to their "aggressive . . . financial incentives for patients and employers." DELOITTE CTR. FOR HEALTH SOLUTIONS, *supra* note 10, at 6.

292. *See id.* at 6 (describing the contents of the two state bills, which included substantial incentives for potential medical tourists but—besides JCI accreditation in West Virginia—did not pose any restrictions on the overseas providers they were authorized to employ).

293. *See* Brady, *supra* note 16, at 1105. *But see* DELOITTE CTR. FOR HEALTH SOLUTIONS, *supra* note 10, at 6 (suggesting that the aggressive incentives in both bills were a primary reason for their failure, and the bills might pass if these incentives were watered down).

294. In contrast, state governments are ill-suited to regulate or influence foreign providers. The police power of the states enables them to regulate health care within their own borders but does not allow them to impose requirements on providers acting in other states or foreign countries. *See supra* note 158 and accompanying text. Furthermore, the power to regulate international trade and commerce is specifically reserved for the federal government under the U.S. Constitution. *See* U.S. CONST. art. I, § 8, cl. 1, 3, 10 ("The Congress shall have Power . . . To regulate Commerce with foreign Nations . . . [and] To define and punish . . . Offences against the Law of Nations . . . ."); U.S. CONST. art. II, § 2, cl. 2 ("[The President] shall have Power, by and with the Advice and Consent of the Senate, to make Treaties . . . ."). Were the federal government to delegate to the states the power to police particular aspects of medical tourism taking place within their individual

States may enter into multilateral agreements with other nations to ensure the quality of goods and services traded between those nations.[295] Trade agreements are often employed when two or more nations agree mutually to bind particular service sectors of their economies to meet specified provisions.[296] Theoretically, such agreements could set minimum quality standards for medical care for foreign nationals traveling either to the United States or to other nations for treatment.[297]

The federal government has not yet employed such agreements to ensure domestic health care quality;[298] furthermore, multilateral agreements are unlikely to be effective. The general purpose of international law, and specifically trade agreements, is to enhance, not impede, trade between nations.[299] Trade agreements that attempt

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borders, such as pre-operative or post-operative conferencing between medical tourists and their surgical teams, inconsistent regulation and international policy would result. Such action by the states, whether the result of congressional delegation or independent state action, also may be invalid due to a " 'dormant' foreign relations power" under the U.S. Constitution. *See State Laws Affecting Foreign Relations—Dormant Federal Power and Preemption*, JUSTIA.COM US SUPREME COURT CTR., http://supreme.justia.com/constitution/article-2/26-dormant-foreign-relations.html (last visited Jan. 3, 2011). Thus, the federal government is unlikely to make such a delegation to the individual states.

295. *Cf.* McLean, *supra* note 33, at 624–32 (discussing the General Agreement on Trade Services of the World Trade Organization and the implications this instrument has on nations that commit health care sectors to free trade, focusing primarily on the implications for telemedicine). For example, the quality of imported products is often regulated through the use of "technical barriers to trade," such as product standards and other mandated quality regulations, which establish the precise characteristics and quality assurance measures to which an imported product is required to adhere. OFFICE OF THE U.S. TRADE REPRESENTATIVE, 2010 REPORT ON TECHNICAL BARRIERS TO TRADE 5 (2010), http://www.ustr.gov/sites/default/files/REPORT%20ON%20TECHNICAL%20BARRIERS%20TO%20TRADE%20FINALTO%20PRINTER%2025Mar09.pdf. The technical barriers to trade of the United States are established through formal agreements—multilaterally through the World Trade Organization Agreement on Technical Barriers to Trade and bilaterally through free trade agreements with individual trading partners. *Id.* at 9. Similar agreements theoretically could be used to establish technical regulations on health care services traded between nations.

296. *See, e.g.*, Leah Belsky et al., *The General Agreement on Trade in Services: Implications for Health Policymakers*, HEALTH AFF., May–June 2004, at 137, 138 (describing promotion of free trade in services through the General Agreement on Trade Services).

297. *See* McLean, *supra* note 33, at 628.

298. *Cf.* Terry, *supra* note 7, at 467 ("International and regional trade agreements have had little impact on core U.S. health care delivery compared, for example, to impacts on environmental law and policy. In the long term this may change.").

299. *See* 149 CONG. REC. 19,429 (2003) (statement of Joseph E. Stiglitz, Professor of Economics & Finance, Columbia Univ.) ("The purpose of trade agreements is to facilitate trade, and to eliminate trade barriers among countries."); McLean, *supra* note 33, at 625.

to place restrictions on foreign providers are viewed unfavorably,[300] and the United States would be unlikely to persuade other nations to restrict their domestic health care market simply to meet American standards. Furthermore, utilizing the trade agreements that the United States has already entered into could limit the federal government's ability to regulate its domestic health care market. For example, as a member of the World Trade Organization, the United States is obligated, at least in part, to abide by the General Agreement on Trade in Services ("GATS") when trading services with other nations.[301] To the extent a nation has voluntarily dedicated a service sector to the GATS, this multilateral agreement serves to remove barriers to trade in that sector and to bind the committed nation to permit access to foreign service providers.[302] Because the language of the GATS has been liberally construed,[303] health care barriers could include overly burdensome physician licensure or special privileges for "public monopolies" such as the Department of Veterans Affairs.[304] Thus, the GATS could actually serve to limit the domestic regulations which the United States has already put in place to protect domestic patients. To date, the United States has not fully committed its health care sector to the GATS, although it has committed its health insurance sector.[305] Furthermore, because of the significant restructuring of the domestic health care market which

300. *Cf.* McLean, *supra* note 33, at 625 ("[I]nternational law views licensure schemes that attempt to circumscribe trade as an anathema.") (citation omitted).

301. *See, e.g.*, Nicholas Skala, *The Potential Impact of the World Trade Organization's General Agreement on Trade in Services on Health System Reform and Regulation in the United States*, 39 INT'L J. HEALTH SERVICES 363, 365 (2009) (describing generally member responsibilities after a nation's service sector has been voluntarily committed to GATS schedule).

302. *See* McLean, *supra* note 33, at 628–29. The only exception to this rule allows a state to erect barriers absolutely required to ensure the basic quality of service in a particular sector. *Id.*

303. *See* Skala, *supra* note 301, at 369–71 (describing both the liberal interpretation regarding commitment of activity to the GATS schedule of services and the impact of domestic regulations associated with committed service).

304. *See* McLean, *supra* note 33, at 626, 630.

305. *See* Belsky et al., *supra* note 296, at 144 (stating that "the United States has agreed to open the health insurance sector fully to foreign providers"); McLean, *supra* note 33, at 631 (stating that although some may believe that a fully committed health care sector is not possible for the United States, this view point may be overly optimistic). *But see* Skala, *supra* note 301, at 378–83 (suggesting the United States has dedicated portions of its health care sector, specifically hospital services and health care facilities, to the GATS beyond health insurance).

may be required to comply fully with the GATS requirements, the United States likely will be unwilling to do so in the future.[306]

The U.S. government also may employ trade barriers to shield the domestic health care market from foreign competition.[307] Present trade barriers specific to the health care industry include limitations on transferring funds from Medicare or Health Savings Accounts and expensive Health Insurance Portability and Accountability Act ("HIPAA") requirements on care providers.[308] No major U.S. government-sponsored health plan currently allows plan participants to use its funds for medical tourism procedures.[309] Trade barriers can also significantly impact the nation implementing them, as the nations they affect could react with increased trade restrictions of their own, in theory by impacting other markets as well as the industry in question.[310] Those nations investing heavily in a domestic medical tourism market may be likely to respond negatively to the imposition of trade barriers from the United States, in an attempt to protect their

306. *But see* McLean, *supra* note 33, at 631–32 (arguing that the United States may be influenced into committing its health care sector by the promise of cheaper health care overseas and the desire to benefit from expanding its capital markets to other nations).

307. *See id.* at 639. Such barriers typically operate by impeding either the import or export of particular goods or services. *Id.*

308. *Id.* at 639–40. Preventing the transfer of government insurance funds to medical tourists serves to raise the cost of foreign health care for patients who would otherwise take advantage of medical tourism—as these patients are now forced to choose between obtaining coverage under their health plans or paying for medical tourism out of pocket. This, in turn, disincentivizes the purchase of overseas care for these patients. Similarly, HIPAA compliance raises the cost of providing medical tourism options. *See id.* Presumably, the facility passes the cost on to the patient. In either case, the cost of obtaining medical tourism increases for patients, making patients less likely to engage in the practice and, on the whole, reducing the frequency with which overseas medical care is "imported" to American patients.

309. *See, e.g.*, BOOKMAN & BOOKMAN, *supra* note 7, at 152 ("Medicare and Medicaid forbid reimbursement for medical procedures that have been performed abroad.") (citation omitted). Note that there are limited exceptions under the Medicare program for emergency medical services performed while traveling abroad and for individuals living closer to a foreign hospital than a domestic hospital. *Id.* Neither of these exceptions would apply to medical tourism as it has been defined in this Comment.

310. *Cf.* Kishore Gawande, *A Test of a Theory of Strategically Retaliatory Trade Barriers*, 64 S. ECON. J. 425, 445 (1997) (recognizing that bilateral nontariff trade barriers have been shown to elicit retaliation, despite regulations promulgated both by the World Trade Organization and under the General Agreement on Tariffs and Trade which explicitly prohibit such retaliatory responses); Pascal Lamy, Dir.-Gen., World Trade Org., Address to the Peterson Institute for International Economics: Retreating from Market Opening Is Not a Solution to the Economic Crisis (April 24, 2009), http://www.wto.org/english/news_e/sppl_e/sppl122_e.htm (cautioning countries against trade barriers because "setting up new barriers to trade will be seen as protectionism and will risk retaliation from trade partners").

nascent industry.[311] Additionally, even effective trade barriers have only limited ability to influence markets over the long-term, as market forces typically operate to reduce the efficacy of such barriers within a short time of their implementation.[312] Thus, trade barriers are unlikely to work as an effective regulatory force to ensure quality within the medical tourism industry.

3. Impact of the Health Care Lobby

Though not part of the regulatory framework per se, the strength of the health care lobby in the United States is also worth noting. Recent contentious elections and debate over health care reform have brought to light substantial financial backing for the political activities, both election contributions and lobbying, of the health care industry in the United States.[313] Because health care is a valuable sector of the economy,[314] health care and health insurance lobbyists carry significant clout in both state and federal legislatures.[315]

Both health care providers and health insurance companies have strong incentives to protect the domestic health care industry from competition by foreign providers. Domestic health care providers lose significant revenue when patients elect to receive expensive surgeries overseas. A recent study by the Deloitte Center for Health Solutions estimates that 2008 medical tourism expenditures represent "$15.9 billion in lost revenue for U.S. health care providers," a number that is likely to increase significantly as the practice becomes more

311. *See* Howard Pack & Kamal Saggi, *Is There a Case for Industrial Policy? A Critical Survey*, 21 WORLD BANK RES. OBSERVER 268, 269 (2006) (describing the "infant industry" theory—which argues that trade barriers are required to protect a nascent industry from foreign competition so that it can develop—as "one of the oldest arguments for trade protection and perhaps the only such argument that is not dismissed out of hand by economists").

312. McLean, *supra* note 33, at 640–41.

313. *See, e.g.*, Robert Steinbrook, *Election 2008—Campaign Contributions, Lobbying, and the U.S. Health Sector*, 357 NEW ENG. J. MED. 736, 736–38 (2007) (describing election contributions and lobbying resources of the health care sector).

314. *See Health Care Costs: A Primer*, HENRY J. KAISER FAMILY FOUND., 1–2 (March 2009), http://www.kff.org/insurance/upload/7670_02.pdf (estimating that the health care sector accounts for approximately one-sixth of total the U.S. gross domestic product).

315. *See, e.g.*, Dan Eggen, *Health Sector Has Donated Millions to Lawmakers*, WASH. POST, Mar. 8, 2009, at A9, *available at* http://www.washingtonpost.com/wp-dyn/content/article/2009/03/07/AR2009030701748.html (recognizing that "[t]he health-care sector has long ranked with financial services and energy interests as one of the most powerful political forces in Washington, and it spent nearly $1 billion on lobbying in the past two years alone"); David D. Kirkpatrick, *At State Level, Health Lobby Fights Change*, N.Y. TIMES, Dec. 29, 2009, at A1 (detailing the efforts of health care industry lobbyists to affect health care reform at the state level).

widespread.[316] Health insurance companies also stand to lose substantial revenue as medical tourism becomes an increasingly viable option for Americans seeking to avoid insurance costs on the eve of the PPACA's implementation.[317]

Though insurance companies could preserve and even expand their customer bases were they to provide cheaper medical tourism options for those who could not otherwise afford their premiums,[318] the close relationship such companies must preserve with domestic providers will likely impede the feasibility of such plans. Any form of legislation attempting to regulate Americans' medical tourism consumption, short of complete protectionism of the domestic market, could be viewed as an endorsement of the practice and threatening to the domestic health care market. The health care and insurance lobbies likely would oppose such legislation strongly. At the very least, as the practice continues to grow in popularity among American consumers, these lobbyists are likely to push for restrictive measures to limit the ability of medical tourists to benefit from the practice and further inhibit the effectiveness of government regulatory efforts.

B. Other Proposals for Medical Tourism Reform

Proposals for medical tourism reform have relied primarily on the current health care regulatory framework to establish means of regulating and imposing substantial limitations on medical tourism.[319] Most proposals have suggested some form of state or federal legislation to provide monitoring of medical tourism activities and mandate restrictions on the industry through the action of state or federal agencies.[320] For example, one scholarly proposal would authorize employee health insurance plans to incorporate medical tourism options only on the condition that they set aside a specified percentage to be distributed to plan participants who are injured by

316. DELOITTE CTR. FOR HEALTH SOLUTIONS, *supra* note 2, at 14–15.

317. *See* Klaus, *supra* note 8, at 244 (describing potential for individuals to forgo purchasing "insurance and instead set aside cash in the event that a surgery is necessary").

318. *Id.*

319. *See, e.g.*, Cortez, *supra* note 14, at 123–27 (describing the potential oversight of medical tourism industry by the DHHS); Boyle, *supra* note 41, at 48–49 (describing the potential delegation by the federal government to states of the power to oversee medical tourism); Brady, *supra* note 16, at 1112–13 (describing the potential regulation of medical tourism through congressional action that regulates insurance providers and preserves their fiduciary responsibility in this context).

320. *See* sources cited *supra* note 317.

medical malpractice abroad.[321] Another proposal would provide the Department of Health and Human Services with authority to require licensure of domestic entities such as medical tourism brokerage firms, insurance companies, and travel agents who arrange for medical tourists' care overseas.[322]

These proposals are laudable for their attempt to ensure quality care, protect patients from the costs of medical malpractice, and ensure that the financial benefits of medical tourism inure directly to the patient. These legislative proposals each share a fundamental limitation, however, because domestic legislation has no ability to bind foreign providers.[323] As a result, these proposals must work indirectly through insurance companies or brokerage firms to ensure compliance with legislative standards.[324] Medical tourists retain the ability to arrange overseas medical care through the provider and without the use of such an intermediary.[325] The proposed regulation therefore is only effective to protect the smaller subset of the medical tourist population which enlists such third-party intermediaries. Imposing regulatory requirements on intermediaries also necessarily increases overhead costs for these third parties as they comply with additional requirements, and these costs will almost certainly be passed directly to the medical tourist. Thus, legislative proposals will not only fail to protect adequately all medical tourists, but will also reduce the cost incentives that comprise the primary benefit of medical tourism. Rather than providing protections for all medical tourists and ensuring uniform quality of care, these proposals may increase the disparities in access to quality care already present.

Another proposed reform involves mandating vicarious or strict liability on medical tourism brokers or health insurance companies that facilitate overseas care by negligent providers.[326] Because the scope of this proposal is again limited to third parties, rather than the

321. *See* Brady, *supra* note 16, at 1112–13.

322. *See* Cortez, *supra* note 14, at 124.

323. *See supra* notes 282–83 and accompanying text.

324. *See* sources cited *supra* note 317.

325. *See* BOOKMAN & BOOKMAN, *supra* note 7, at 61; *Using a Medical Tourism Facilitator*, HEALTH-TOURISM.COM, http://www.health-tourism.com/medical-tourism/using-facilitators/ (last visited Jan. 3, 2011) (describing the pros and cons of opting for a "medical tourism facilitator" or broker). Though medical tourism brokerage firms are common today, *see* Klaus, *supra* note 8, at 227–29, patients appear to be contracting directly with providers, since provider websites continue to provide this option and to market their services directly to individual patients. However, there are currently no statistics to suggest the proportion of medical tourists who arrange for travel using one method or the other.

326. *See* Cortez, *supra* note 14, at 122; Mirrer-Singer, *supra* note 16, at 231.

health care providers themselves, it creates the same increased costs and perverse policy outcomes as other legislative regulations.[327] These costs are likely to be even more substantial in the case of mandated liability. Damages would be awarded under the litigious U.S. system, reversing the cost benefits of avoiding malpractice liability. Vicarious liability in a civil context is applied only in limited circumstances, typically based on the theory of respondeat superior or on agency principles.[328] In either case, the party held vicariously liable is generally required to exercise (or appear to exercise, in the case of apparent agency theory) substantial control over the activities of the negligent party.[329] In the context of a medical tourism broker, however, the foreign provider is much more likely to be operating as an independent contractor of the brokerage firm, and will likely take steps to avoid the appearance of agency.[330] Thus, vicarious liability is not likely to be a good fit for the facts of the brokerage relationship, as mandating vicarious liability in such instances would require tort law to be stretched beyond its current boundaries.[331] Strict liability tends to be statutorily defined;[332] therefore, it may be a more feasible alternative which does not conflict with the present state of the law.[333] However, success on strict liability grounds would require a court to overcome significant practical obstacles and further drive up the expense of litigation.[334]

Analysts have also suggested that the federal government might impose limitations, either direct or functional, on medical tourists'

327. *But see* Mirrer-Singer, *supra* note 16, at 229–31 (arguing for the imposition of heightened liability standards on medical tourism brokers).

328. *See id.* at 219–20; *see, e.g.*, Burlington Indus., Inc. v. Ellerth, 524 U.S. 742, 754–55 (1998) (holding that vicarious liability under Title VII claims is constrained by common law agency principles); Lathrop v. Healthcare Partners Med. Grp., 8 Cal. Rptr. 3d 668, 674 (Cal. Ct. App. 2004) (recognizing that vicarious liability is defined by "the common law doctrine of respondeat superior").

329. *See* Mirrer-Singer, *supra* note 16, at 219–21 (discussing apparent agency theory in the context of medical tourism).

330. *See id.*

331. *See* Cortez, *supra* note 14, at 122 (finding vicarious liability for insurance companies authorizing medical tourism to be improper because "[c]urrently, employers and insurers in many circumstances are not liable to the employee/insured for a provider's negligence").

332. *See* Cortez, *supra* note 14, at 122; *see, e.g.*, FLA. STAT. ANN. § 376.313(3) (West 2010) (creating statutory strict liability for pollution damages to property of adjoining landowners).

333. *But see* Cortez, *supra* note 14, at 122 (suggesting that the practical difficulties and legal uncertainty of applying strict liability to medical tourism could render such a scheme "unworkable").

334. *Id.*

travel overseas.[335] However, this regulatory method likely would run afoul of constitutional protection of the right to travel.[336] Given the policy considerations of implementing such restrictions as a means of limiting access to medical care, restrictions on the right to travel internationally are likely to be struck down by the Supreme Court. Furthermore, even if these restrictions were to pass constitutional muster, the practical challenges and expense of monitoring citizens' overseas travel would substantially limit the effectiveness of these regulations. Finally, such restrictions are likely to face significant political opposition and are unlikely to garner sufficient support in Congress.

Though critics have proffered various regulatory proposals as a means of regulating medical tourism, these proposals will not be effective in producing more beneficial outcomes for medical tourists. While such proposals are commendable for their motives, they do not enhance—and in some cases may even reduce—the benefits of medical tourism for American patients. Whether imposing restrictions or requirements on third-party intermediaries or seeking to limit medical tourists' freedom to travel, these proposals are likely to cause more harm than good and should be avoided.

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335. *See id.* at 114. For example, the government could refuse to issue or validate passports for individuals intending to engage in medical tourism, or more directly regulate travel to medical tourism "target" countries. *See id.* at 117.

336. *See id.* at 115–18. The U.S. Supreme Court has identified a robust right to travel between states, which subjects limitations on interstate travel to a strict scrutiny standard. *Id.* at 115; *see, e.g.*, Att'y Gen. of N.Y. v. Soto-Lopez, 476 U.S. 898, 904 (1986); United States v. Guest, 383 U.S. 745, 757 (1966). The standard of review for restrictions on international travel is more ambiguous, but a series of cases has clearly established a right to international travel, and this right likely is vindicated through a mode of analysis more exacting than the rational basis test. *See* Califano v. Aznanorian, 439 U.S. 170, 176–78 (1978); Aptheker v. Sec'y. of State, 378 U.S. 500, 514 (1964); Kent v. Dulles, 357 U.S. 116, 125–28 (1958), *overruled on other grounds by* Regan v. Wald, 468 U.S. 222 (1984); Cortez, *supra* note 14, at 116–17 (maintaining that, based on case law, "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 basis test"); Thomas E. Laursen, Note, *Constiintional* [sic] *Protection of Foreign Travel*, 81 COLUM. L. REV. 902, 906–08 (1981) (conceding that the constitutional basis for the right to travel is "obscure," but recognizing the heightened standard of review initially applied). The Supreme Court has utilized a rational basis test to evaluate the constitutionality of restrictions which have a mere "incidental effect" on international travel. *Califano*, 439 U.S. at 177; Cortez, *supra* note 14, at 115. However, prior cases identifying a more direct effect on international travel have implied the need for a more exacting test. *See Aptheker*, 378 U.S. at 508, 514 (requiring more narrowly tailored federal restrictions on passport use and applications); *Kent*, 357 U.S. at 125–28 (describing the vital nature of interstate travel and the exigency previously required to restrict international travel); Cortez, *supra* note 14, at 116–17; Laursen, *supra*, at 908.

C. *Industry Self-Regulation*

Though it cannot be used as a complete regulatory "fix" for medical tourism, self-regulation provides a more promising alternative to other ineffective forms of regulation. Self-regulation plays a role in the regulation of the American health care industry, primarily through the action of non-governmental organizations.[337] Organizations such as the American Medical Association and the Joint Commission provide education and oversight to the providers they represent.[338] These organizations do not operate in a vacuum; rather, they work in tandem with government regulatory agencies by enhancing the regulatory framework the government has already put in place.[339] Government oversight is intended to provide a disinterested source of supervision by individuals unconnected to the industry who are unlikely to benefit directly from its increased profits.[340] In contrast, self-regulatory agencies—by definition—employ industry participants with greater knowledge of the industry and its inner workings,[341] knowledge which is used to inform regulatory choices and ensure maximal quality and efficiency among providers.[342] In theory, these regulatory methods provide a stronger means of regulation by ensuring both informed decision making and unbiased regulatory choices in the domestic health care market.

To date, voluntary industry self-regulation has been the principal regulatory mechanism employed to preserve the quality of the medical tourism market. This mechanism provides substantial regulatory benefit to the industry. Several regulatory organizations, most notably the JCI, provide the primary source of quality assurance outside the destination country's own regulatory framework, by providing accreditation to medical tourism facilities.[343] Though this may appear to be a weaker source of protection than the dual system

337. *See* HARRIS, *supra* note 124, at 69–70.

338. *See* FIELD, *supra* note 135, at 9–10, 70–72.

339. *See id.* at 44–45; HARRIS, *supra* note 124, at 69–70; *see also* ROBERT BALDWIN & MARTIN CAVE, UNDERSTANDING REGULATION: THEORY, STRATEGY, AND PRACTICE 136–37 (1999) ("Nearly all self-regulatory mechanisms of governmental significance are subject to some degree of external state influence . . . .").

340. *See* HARRIS, *supra* note 124, at 69–70.

341. *See id.*

342. *See* BALDWIN & CAVE, *supra* note 339, at 127.

343. *See, e.g.*, Brady, *supra* note 16, at 1096. Accreditation by the Joint Commission and JCI is discussed *supra* Part I.B.1.b. Accreditation and oversight are also provided by several other organizations, such as the International Society for Quality in Health Care and the European Society for Quality in Healthcare, but these organizations have not attained the same degree of recognition as the JCI, particularly within the United States. *See* DELOITTE CTR. FOR HEALTH SOLUTIONS, *supra* note 2, at 8.

adopted by the United States, the limitations of this system as applied to foreign providers are not as significant as they may appear. American lawmakers claiming to represent regulatory disinterested parties are not necessarily as disinterested as they purport to be. Nothing prohibits individual politicians from being personally invested, either financially or professionally,[344] in the health care industry, and the strong health care and health insurance industry lobbies provide further pressure and incentive to create pro-industry laws and policies.[345] Furthermore, unlike the true self-regulation of a domestic industry—as is provided by Joint Commission regulation in the United States[346]—JCI members provide oversight for health care providers in nations other than their own. Despite its international focus, the JCI maintains strong ties to the United States; specifically, its primary headquarters is located in the United States, and the vast majority of its officers and directors—as well as many of its managers and consultants—reside in the United States.[347]

Facilities do pay the JCI to establish and maintain accreditation,[348] providing some financial incentive for undue accreditation. This fact, coupled with a low rate of revocation among facilities previously granted accreditation, has comprised the primary source of criticism regarding the JCI.[349] Such criticisms may be overly reactionary, however, as the JCI has stronger motivations not to engage in lax accreditation tactics. The JCI's status as a world leader of hospital accreditation and its future utility may only be maintained through its continued ability to ensure the quality of international hospitals and safety of its patients. Lax accreditation would only serve to jeopardize the JCI's reputation and continued success. Because JCI accreditation has become a valued and relatively rare commodity

344. In fact, a number of federal and state legislators previously worked as physicians before being elected, and their medical knowledge—and potential professional biases—likely inform their political decision making. *See, e.g.*, Joel Roberts, *Doctors in Congress Criticized: Should Frist, Others Have Made Schiavo Diagnoses Based on Videos?*, CBS NEWS (Mar. 22, 2005), http://www.cbsnews.com/stories/2005/03/22/politics/main682208.shtml.

345. *See supra* Part II.A.3.

346. The Joint Commission is not only comprised and staffed by individual medical professionals, but it also has a "membership . . . composed of virtually every hospital in the country." FIELD, *supra* note 135, at 43.

347. *See 2010 JCI Board of Directors*, JOINT COMM'N INT'L, http://www.jointcommissioninternational.org/JCI-Board-of-Directors/ (last visited Jan. 3, 2011); *Contact Us*, JOINT COMM'N INT'L, http://www.jointcommissioninternational.org/Contact-Us/ (last visited Jan. 3, 2011).

348. *See* JOINT COMM'N INT'L, *supra* note 119, at 7; *see also* Brady, *supra* note 16, at 1096.

349. *See* Brady, *supra* note 16, at 1096.

among international hospitals,[350] the JCI would be unwise to saturate its potential market by providing more accreditation than is justified. The JCI is also a non-profit organization.[351] Though American non-profit law does not prohibit the JCI from earning a profit, any profit earned by the corporation cannot inure to private individuals affiliated with the organization for it to retain its non-profit status,[352] thus reducing the personal financial incentive for JCI officials to encourage undue accreditation. For these reasons, the JCI appears to be a relatively disinterested regulatory body despite its self-regulatory status. Because JCI accreditation is provided by a largely disinterested *and* knowledgeable regulatory body, additional regulatory mechanisms do not serve the same vital role under the American system or hold the same potential to persuade medical tourism facilities to provide quality care.

Together, these factors suggest that the JCI provides a significant degree of protection and quality control over medical tourism facilities, even greater than the protection provided by accreditation in the United States. Perhaps the only feasible regulatory proposal suggested by medical tourism critics has been to impose reporting requirements on the JCI.[353] The JCI could be required to provide to the federal government quality statistics on the medical tourism facilities it accredits. This would enable the federal government to provide medical tourists with this information and empower them to make more fully informed decisions regarding their care.[354] Furthermore, the Joint Commission is intimately connected with Medicare and Medicaid through its statutory authority and recognized prominence in U.S. hospital accreditation.[355] Because the Joint Commission would jeopardize its favored status if its

350. *See supra* notes 151–53 and accompanying text.

351. *Facts About Joint Commission International*, JOINT COMM'N, http://www.jointcommission.org/assets/1/18/Joint%20Commission%20International2.PDF (last visited Jan. 3, 2011).

352. *See* 26 U.S.C. § 501(c)(3) (2006).

353. *See* Cortez, *supra* note 14, at 125–26. The author also suggests broader oversight of the JCI in order to ensure accreditation adheres to proper safety and quality standards. *Id.* While such oversight is theoretically favorable, it may not be necessary given the fact that the JCI is largely comprised of American medical professionals supervising overseas providers, decreasing the incentive for JCI to over-accredit foreign competitors to their American peers. *See supra* notes 346–47 and accompanying text. Moreover, increased oversight (as opposed to mere reporting requirements) may result in greater opposition from foreign providers, as it may be viewed as an indirect attempt to impose protectionist trade barriers on foreign medical services.

354. The need for increased transparency is discussed *infra* Part III.B.

355. *See supra* Part I.B.1.b.

international arm failed to comply with governmental requirements, the JCI's status as a subsidiary of the Joint Commission incentivizes compliance with such mandated transparency.[356]

This proposal avoids some of the limitations inherent in other regulatory approaches. Although the heightened reporting requirements may increase the JCI's operating expenses to some degree—as well as those of the facilities it accredits—these additional expenses are not likely to be so burdensome that they will be passed on to individual patients in the form of substantially increased costs. Furthermore, though the JCI does not presently release data on individual facilities it accredits, the organization has stated its intention to release this information voluntarily when facilities have been accredited in a number sufficient to allow valid comparison.[357] Thus, JCI-accredited facilities cannot argue that they reasonably anticipated the JCI would maintain the confidentiality of their accreditation scores when the JCI eventually releases this information to the public. Though the JCI could encounter some opposition to its reporting directly to the U.S. government, which might be interpreted as protectionist or meddling in the affairs of other nations, this argument is not likely to stand given the relative openness of the JCI's long-term confidentiality plan. Moreover, medical tourism facilities likely would allow the information to be reported to the United States, given their desire to protect their attractiveness to American patients and to maintain internationally-recognized stature via JCI accreditation.

Although this regulatory proposal has merit, it cannot provide a complete solution to the regulatory pitfalls of medical tourism. Economic theorists have posited that industry self-regulation alone does not provide an effective regulatory scheme.[358] Outside sanctions are often important elements for effective industry self-regulation, as they provide industry regulators with incentive to ensure quality and

356. This rationale is further suggested by the federal government's recent attempts to grant other organizations statutory authority to conduct Medicare and Medicaid certifications, which could detract from the Joint Commission's prominence. *See* Gourley, *supra* note 140, at 12.

357. *See* JOINT COMM'N INT'L, *supra* note 119, at 8.

358. *See* BALDWIN & CAVE, *supra* note 339, at 126–33 (describing various criticisms of industry self-regulation and advocating that self-regulatory mechanisms promote fairness, foster accountability, and pursue proper objectives); John Braithwaite & Brent Fisse, *Self Regulation and the Control of Corporate Crime*, *in* 23 SAGE CRIMINAL JUSTICE SYSTEM ANNUALS: PRIVATE POLICING 221, 224 (Clifford D. Shearing & Philip C. Stenning eds., 1987).

regulated market actors with incentive to comply.[359] Medical tourism facilities are not required to follow JCI standards, as no regulatory body exists with jurisdiction to enforce these standards through sanctions or other forms of reprisal. If a medical tourism facility decides not to pursue accreditation, it is free to recruit medical tourists and provide medical care according to standards which the facility alone selects. In spite of the JCI's clout and relative disinterest, such self-regulation would be unlikely—without additional forces to further incentivize quality control—to be effective in mandating high-quality care. Thus, despite its benefits, JCI accreditation is a flawed regulatory mechanism which could not, by itself, provide complete oversight or remedy for medical tourism's regulatory pitfalls.

However, a much stronger and more effective regulatory mechanism does exist, which complements the incentives of JCI regulation and is uniquely suited to the medical tourism context: the driving force of the market itself.

III. MARKET-BASED SOLUTION TO MEDICAL TOURISM REGULATION

Although medical tourism represents a favorable trade-off for American patients to obtain inexpensive and comparably safe medical care, the practice does entail some risks to patients. At present, comprehensive regulation of medical tourism does not appear feasible given the state of the American health care regulatory system, and its desirability is questionable.[360] As this section will argue, however, substantial government regulation may not be necessary based on the inherent protections provided by a "modified" free-market approach.[361] By increasing transparency for medical

359. *See* IAN AYRES & JOHN BRAITHWAITE, RESPONSIVE REGULATION: TRANSCENDING THE DEREGULATION DEBATE 105–06, 125 (1992) (describing the inherent flaws in purely voluntary self-regulation); Avner Greif, *Microtheory and Recent Developments in the Study of Economic Institutions Through Economic History*, *in* 2 ADVANCES IN ECONOMICS AND ECONOMETRICS: THEORY AND APPLICATIONS 79, 88–89, 99–102 (David M. Kreps & Kenneth F. Wallis eds., 1997) (using historical examples of self-regulating Maghribi and Genoese traders to suggest that social and economic penalties are necessary to prevent opportunistic behavior among individual economic actors); Andrew A. King & Michael J. Lenox, *Industry Self-Regulation Without Sanctions: The Chemical Industry's Responsible Care Program*, 43 ACAD. MGMT. J. 698, 713 (2000) (suggesting that explicit sanctions are required to prevent opportunism among self-regulating firms).

360. *See supra* Part II.

361. As is argued *infra* Part III.B, increased transparency is not inconsistent with the concept of a free market; in fact, it may serve to enhance the effectiveness of a largely

tourists to allow them to make informed care decisions, U.S. officials can bolster the effects of market forces to protect American patients more effectively and to preserve medical tourism's benefits for those it will help the most.

A. Market-Driven Approach to Regulatory Pitfalls

1. Effects of the Market on Medical Tourism

The market for consumers' business within a particular industry produces powerful effects on the behavior of industry participants. Free market theory posits that the interaction between suppliers and consumers of a particular good or service will determine the economic behavior of both types of actors.[362] Each acts according to his own free will in a way that maximizes his own interest.[363] These actions, in turn, determine the prices at which goods and services are sold and, indirectly, the quality with which they are produced.[364] Through general economic principles of supply and demand, competition among providers in a particular industry will tend to lower costs and increase efficiency among these providers.[365]

At the same time, quality considerations require providers to be mindful of the value of the goods or services they are providing, particularly in industries such as medicine, in which consumers are unwilling to sacrifice quality for the sake of cost savings.[366] Though improved quality will often increase price,[367] the producer who is able to provide a maximal balance between quality and price will win consumers' business.[368] These forces are at work in the health care

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unregulated market. However, to distinguish from traditional notions of free-market economics, this Comment has termed this proposed system a "modified" free-market approach.

362. *See* IBRAHIM OZER ERTUNA, WEALTH, WELFARE, AND THE GLOBAL FREE MARKET 16 (2009).

363. *See id.*; ANDREW SCHOTTER, FREE MARKET ECONOMICS: A CRITICAL APPRAISAL 2 (Basil Blackwell 2d ed. 1990) (1985).

364. *See* ERTUNA, *supra* note 362, at 16.

365. *See id.* at 56; HARRIS, *supra* note 124, at 69.

366. *See* SHERMAN FOLLAND ET AL., THE ECONOMICS OF HEALTH AND HEALTH CARE 199 (4th ed. 2004) (recognizing that the "provision of quality information does influence consumers, particularly when the quality ratings are negative").

367. *See id.* at 196–200.

368. *See* James Gubb & Stephen Smith, *Will a Market Deliver Quality and Efficiency in Health Care Better Than Central Planning Ever Could? Yes*, 340 BRIT. MED. J. 568, 569 (2010); William B. Schwartz, *The Competitive Strategy: Will It Affect Quality of Care? Yes*, *in* MARKET REFORMS IN HEALTH CARE 15, 15–16 (Jack A. Meyer ed., 1983) (describing how competitive market forces will tend to weed out "wasteful" and "unnecessary" medical treatments and recognizing that "[t]he incentives provided by competition can be

industry as well.[369] When given the choice, purchasers (whether patients or managed care organizations) will spend their money obtaining the highest quality and lowest cost health care available, and other providers will be forced to adjust their practices accordingly or risk losing substantial profits and going out of business.[370] Because these forces operate to preserve the quality of health care provided to patients, proponents of a market-based regulatory approach suggest that these market forces are sufficient to protect the wellbeing and safety of patients without the need for substantial outside regulation.[371] In its most basic form, a market-based approach would preserve these beneficial market effects and ensure that the market is operating as efficiently as possible.

Medical tourism appears particularly well-suited to a market-based regulatory approach to health care regulation. This is true for several reasons. First, the quality of care provided to medical tourists will be preserved by distinctive features of the medical tourism market. As a general economic rule, a producer's reputation provides substantial incentive to constrain opportunistic behavior.[372] Because consumers choose producers based on a price-quality analysis,[373] a loss of reputation in either of these elements will necessarily result in a loss of profit in a competitive market. This is particularly true in the medical tourism context. American patients tend to be skeptical of

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expected to address this problem: Providers will be stimulated to offer service of a given quality at the lowest possible cost").

369. FOLLAND ET AL., *supra* note 366, at 200 (recognizing that "the provider's ability to raise prices above those charged by others and to sell low-quality services at high-quality prices is significantly constrained"); Gubb & Smith, *supra* note 368, at 569; Schwartz, *supra* note 368, at 15–16. However, these market forces are somewhat attenuated for the health care industry due to "market failure" factors. *See infra* Part III.A.2.

370. *See* HARRIS, *supra* note 124, at 69 ("In America's free market economy, competition ordinarily improves the quality and reduces the price of goods and services for the benefit of the consumer . . . in the health care industry, competition may be able to promote quality and reduce costs as providers compete among themselves for managed care contracts.").

371. *See, e.g.*, John F. Cogan et al., *Healthy, Wealthy, and Wise*, HOOVER DIG., 2004, at 161, 163–65; Grace-Marie Turner, *Toward Free-Market Health Care*, HERITAGE FOUND., 2 (May 4, 2007), http://www.heritage.org/research/lecture/toward-free-market-health-care. It must be noted, however, that the effectiveness of free-market regulation of health care has been rejected by many scholars, at least in the domestic context. *See, e.g.*, FIELD, *supra* note 135, at 40, 202–04.

372. Gerald P. O'Driscoll Jr. & Lee Hoskins, *The Case for Market-Based Regulation*, 26 CATO J. 469, 474 (2006); *see* Daniel B. Klein, *Trust for Hire: Voluntary Remedies for Quality and Safety*, *in* REPUTATION: STUDIES IN THE VOLUNTARY ELICITATION OF GOOD CONDUCT 97, 105 (Daniel B. Klein ed. 1997).

373. *See* BALDWIN & CAVE, *supra* note 339, at 210–11; FIELD, *supra* note 135, at 16.

overseas medical care; reports have suggested that concerns about the quality of care in developing countries is one of the primary factors limiting increased participation in medical tourism.[374] Patients are highly unlikely to travel to a particular medical tourism facility if they believe they may experience adverse medical outcomes.[375] Without the ability to lure medical tourists to obtain services through the reports of its high-quality care, a facility will be unable to survive competition with other, higher-quality facilities. Thus, the ability of a medical tourism provider to maintain a positive reputation is crucial to its continued viability in the medical tourism market.

At the same time, medical tourists retain the ability to influence the reputation of individual providers. Because most medical tourists have used web-based resources to arrange their medical services, they could easily use these same resources to alert future patients of poor quality care they receive; such information is likely to spread quickly to the medical tourism community and to affect the behavior of future medical tourists.[376] In order to attract patients and maintain a viable patient base, medical tourism facilities therefore must ensure that the quality of care they provide remains high.

Second, a market-based regulatory method avoids imposing barriers to access on potential medical tourists. Medical tourism is ultimately designed to supplement, rather than supplant, the American domestic health care system. It functions to provide additional options to those who otherwise have difficulty obtaining health care.[377] The value of this system is derived primarily from its competitive cost advantage, which allows American patients to obtain high-quality health care at a low price. In order to maintain the value of this system for American patients, this competitive cost advantage must be preserved. As medical tourism facilities are able to compete directly to provide the services to a relatively limited number of foreign patients, the competitive forces acting on these providers will continue to preserve the cost advantage for future medical tourists.[378]

Further, additional regulation imposes added costs to producers, which are often passed on to the consumer in the form of increased

374. *See, e.g.*, BOOKMAN & BOOKMAN, *supra* note 7, at 60, 145; *see also* Mattoo & Rathindran, *supra* note 39, at 364 (suggesting that concerns about quality of care is one of the major factors preventing insurance companies from covering medical tourism).

375. *See* BOOKMAN & BOOKMAN, *supra* note 7, at 60, 145.

376. Klaus, *supra* note 8, at 236.

377. *See supra* Parts I.A.1, I.A.4.

378. *See* BALDWIN & CAVE, *supra* note 339, at 210–11.

prices.[379] For this reason, the imposition of additional regulatory mechanisms on the medical tourism industry will tend to impede the very benefit which drives the medical tourism market and provides benefits to its participants. In the context of a system which provides a service vital to many American patients, a patient's choice to participate in the practice should be paramount. Yet a more substantial regulatory scheme would limit the cost savings available to medical tourists and directly inhibit patients' choices. A market-based approach is most appropriate precisely because it is the only approach ultimately able to preserve the value of the practice for patients—by maintaining the net positive balance of cost and quality which makes its service so valuable.

2. Attenuated Market Failure in the Medical Tourism Market

In addition to these inherent benefits of a market-based regulatory approach, such an approach provides the most appropriate form of regulation because more stringent regulatory methods are unjustified in the medical tourism context. Common American beliefs regarding the value of capitalistic market forces have characterized the U.S. policy approach to health care, particularly within the last few decades.[380] Debate continues to rage over the ability of market forces to protect the interests of patients.[381] Prior to the enactment of the PPACA, the American health care system had been more strongly market-based than those of other industrialized nations, which rely heavily upon public industries through national health care systems and which utilize private insurance in a much more limited manner.[382] Some scholars point to the inability of American regulators to stem the rising tide of health care costs and unequal access to care as indicative of the inevitable failure of a market-based

379. *See, e.g.*, FED. TRADE COMM'N & DEP'T OF JUSTICE, IMPROVING HEALTH CARE: A DOSE OF COMPETITION 5 (2004), http://www.justice.gov/atr/public/health_care/204694.pdf (recognizing in the domestic health care context that "[e]mpirical studies have found that licensing regulation increases costs for consumers").

380. *See* CARL F. AMERINGER, THE HEALTH CARE REVOLUTION: FROM MEDICAL MONOPOLY TO MARKET COMPETITION 1–2 (2008); Cortez, *supra* note 49, at 662 ("Most health care systems have incorporated at least some market based tools to increase competition and efficiency, which tends to invite more private sector participation. It is no coincidence that the United States' health care system relies most heavily on these market principles among developed countries and also invites the most private sector participation.").

381. *See, e.g.*, FIELD, *supra* note 135, at 40, 202–04.

382. *Id.* at 203–04; *see* Cortez, *supra* note 49, at 662.

approach.[383] However, most analysts recognize that full market forces are unable to operate in the American health care system due to the unique nature of this industry.[384]

Current regulation of the American health care system has been justified largely based on these inherent limitations of a market-only approach to ensuring quality. Specifically, two primary issues have been identified as the sources of health care market failure: limited competition and absence of sufficient information to choose better-quality providers.[385] Competition is limited in the U.S. health care system in two primary ways. First, managed care providers and third-party payors operate through an oligopolistic competition structure and exert significant control over both consumers' access to providers and their ability to choose providers and terms of care.[386] These pressures directly limit consumer choice and also distort the connection between consumer choice, quality, and cost-effectiveness considerations. In addition, the law of supply and demand often is attenuated for health care services due to "inelasticity of demand,"[387] which results from patients' pressing need for services and their inability to take advantage of quality and cost comparisons when choosing a provider.[388] Even where quality and cost comparison data are available, empirical studies have shown that American patients often fail to use this type of information when purchasing care,[389] further emphasizing the inelasticity effects.

Furthermore, analysts highlight the technical nature of health care services and the difficulty and inaccuracy with which patients are able to measure and compare quality.[390] These factors create an

383. *See, e.g.*, Cortez, *supra* note 49, at 682; Len M. Nichols et al., *Are Market Forces Strong Enough to Deliver Efficient Health Care Systems? Confidence Is Waning*, HEALTH AFF., Mar.–Apr. 2004, at 8, 8–15.

384. *See, e.g.*, ABA SECTION OF ANTITRUST LAW, COMPETITION AS PUBLIC POLICY 120 (2010); FIELD, *supra* note 135, at 202–04; Nichols et al., *supra* note 383, at 11–15.

385. *See* FIELD, *supra* note 135, at 202; HARRIS, *supra* note 124, at 69.

386. *See* Mattoo & Rathindran, *supra* note 39, at 365–66; Nichols et al., *supra* note 383, at 14 (describing the "[i]nsufficient health plan competition" and barriers to entry within the health insurance market).

387. "Inelasticity of demand" occurs when changes to the price of a good or service do not affect—or affect in only a limited manner—demand for that service. *See* FIELD, *supra* note 135, at 202.

388. ABA SECTION OF ANTITRUST LAW, *supra* note 384, at 13; *Id.*

389. *See* NAT'L COMM. FOR QUALITY ASSURANCE, *supra* note 119, at 13, 15; HENRY J. KAISER FAMILY FOUND. & AGENCY FOR HEALTH CARE RESEARCH & QUALITY, NATIONAL SURVEY ON AMERICANS AS HEALTH CARE CONSUMERS: AN UPDATE ON THE ROLE OF QUALITY INFORMATION (2000), http://www.ahrq.gov/downloads/pub/kffchartbk00.pdf; Cohen, *supra* note 117, at 1508–10.

390. FIELD, *supra* note 135, at 16.

"asymmetry of information" between patients and providers.[391] These limitations tend to inhibit the ability of medical consumers to make fully informed choices when deciding between the limited pool of available providers,[392] thereby preventing consumer choice from fully preserving quality of care. Such concerns are considered even more critical than in other industries because the consequences of poor consumer choice are dire and may not be discovered until a fatal error already has been made.[393]

However, due to the nature of the medical tourism industry, both forms of market failure are substantially attenuated in that context. The inelasticity of demand which typically characterizes the American health care system is more severe than that currently observed in the medical tourism industry. Medical tourism cannot be used to provide all types of patient care, but only those nonroutine procedures which allow for a delay in treatment sufficient to permit medical tourists to arrange travel. This delay permits medical tourists the opportunity to comparison shop between potential providers and to choose a provider with high quality and low prices. Medical tourists' increased incentives to conduct such comparison shopping[394] will also tend to enhance this effect. Additionally, medical tourism is much less convenient than selecting a provider in the patient's hometown and requires a significant investment of time and resources;[395] thus, patients may be more likely to investigate the option—as well as its various providers—before choosing to obtain medical services in this manner. Additionally, current medical tourists typically pay for their medical care out of pocket and are not impeded in their decision making by the interference of third-party payors.[396] Notwithstanding the obvious benefits third-party payors could derive from engaging in medical tourism, it is uncertain whether this trend is likely to change in the near future.[397] These factors, taken together, suggest that demand is likely to be substantially more elastic in the

391. *Id.* at 202. "Asymmetry of information" refers to a circumstance in which either the buyer or seller of a good or service has access to material information not available to the other party. *See id.*

392. *Id.* at 16, 202.

393. *Id.*

394. *See supra* notes 374–76 and accompanying text.

395. *See Medical Tourism Hearing*, *supra* note 17, at 2, 4, 7 (describing one patient's experience with medical tourism, which included a month-long stay in the destination country, substantial Internet research to find providers, and visa approval from the destination country).

396. *See supra* notes 34–40 and accompanying text.

397. *See supra* notes 41–60 and accompanying text.

medical tourism context than in the domestic health care market. They further suggest that the low costs and high quality of medical care provided by medical tourism facilities will better influence patient purchasing decisions and will result in more efficient and effective care at similar facilities than is currently observed in the United States.[398]

Medical tourism is also likely to avoid many of the informational asymmetries inherent to the domestic health care market. In the United States, informational asymmetries are attributable to several causes. Patients generally lack education or technical expertise in the medical field and seek out medical providers "for the explicit purpose of obtaining health information" which they would not otherwise have.[399] American patients are historically unmotivated (or unable) to compare potential domestic providers for quality and price before selecting a provider.[400] They are also less able to rely on prior experience in discriminating between high and low quality care—unlike providers, whose experience in trading medical services is informed by day-to-day experience.[401] Even where patients are cognitively capable of obtaining quality information and willing to do so, the high "search-information cost" of obtaining this information is likely to act as a functional bar to obtaining it.[402] Together, these factors establish American patients' inability to make informed cost and quality comparisons when choosing providers.

In contrast, these obstacles are attenuated in the medical tourism context. The apathy of American patients in differentiating between providers may stem from a variety of cognitive barriers, including an overly optimistic appraisal of domestic health care providers[403] and a

398. *See* Terry, *supra* note 7, at 469 ("In the absence of negative evidence ... it is arguable that foreign-sourced, low-cost, high-quality care will stimulate global health care and reduce the market failures seen in Western systems.").

399. Frank A. Sloan, *Arrow's Concept of the Health Care Consumer: A Forty-Year Retrospective*, *in* UNCERTAIN TIMES: KENNETH ARROW AND THE CHANGING ECONOMICS OF HEALTH CARE 49, 49 (Peter J. Hammer et al. eds., 2003).

400. *See supra* note 389 and accompanying text.

401. *See* Sloan, *supra* note 399, at 50.

402. *See id.* at 52–53. "Search information costs," also referred to as "search costs," are defined as the costs to the consumer of acquiring information relevant to purchasing decisions. *See* Gerald E. Smith et al., *Diagnosing the Search Cost Effect: Waiting Time and the Moderating Impact of Prior Category Knowledge*, 20 J. ECON. PSYCHOL. 285, 286 (1999). These costs include monetary resources, such as the sums expended in searching for information and opportunity costs of engaging in search, as well as the cognitive efforts necessary to process information and make decisions. *Id.*

403. *See* Cohen, *supra* note 117, at 1510; Arnold Milstein & Nancy E. Adler, *Out of Sight, Out of Mind: Why Doesn't Widespread Clinical Quality Failure Command Our Attention?*, HEALTH AFF., Mar.–Apr. 2003, at 119, 122.

tendency to conflate familiarity with trustworthiness.[404] However, medical tourism departs from the traditional method of procuring care within the United States—choosing local providers recommended by other individuals or insurance companies[405]—and obtaining overseas care requires a substantial investment of time and resources. The initial reaction of many Americans to the concept of medical tourism is apprehensive at best,[406] providing potential medical tourists with incentive to second guess the practice and investigate the quality of medical tourism facilities before selecting a provider. These factors are likely to reduce the inherent optimism patients carry for domestic providers and may signal to patients the need to investigate quality and cost further before engaging in medical tourism.[407] For these reasons, medical tourists appear substantially more likely to employ quality comparison information when choosing between providers.

Additionally, the effects of search costs are reduced in the medical tourism context. The medical tourism market is dominated by a relatively limited number of providers, particularly in comparison to the domestic health care market.[408] Patients, therefore, are required to process much less information in the medical tourism context before making an informed provider decision. The medical tourism industry also has developed a business model requiring widespread dissemination of quality information over the Internet for its very survival.[409] Patients seeking information about medical tourism facilities find online resources more central to their decision

404. Milstein & Adler, *supra* note 403 at 122.

405. *See* FOLLAND ET AL., *supra* note 366, at 196 (describing health care as a "reputation good," defined as "a good for which consumers rely on the information provided by friends, neighbors, and others to select from the various services available in the market").

406. *See* Klaus, *supra* note 8, at 233–34.

407. *See* Cohen, *supra* note 117, at 1482–85 (discussing how medical tourists choose where to obtain treatment); *id.* at 1539–41 (discussing critics' concerns about medical tourists receiving substandard care and what can be done to address the problem).

408. *Compare About Joint Commission International: International Accreditation and Certification*, JOINT COMM'N INT'L, http://www.jointcommissioninternational.org/about-jci/ (last visited Jan. 3, 2011) (recognizing the number of JCI accredited international facilities at "more than 300"), *with Fast Facts on US Hospitals*, AM. HOSP. ASS'N, http://www.aha.org/aha/resource-center/Statistics-and-Studies/fast-facts.html (last updated Dec. 6, 2010) (reporting that as of 2008, approximately 5,815 "registered" hospitals were operating within the United States).

409. *See* BOOKMAN & BOOKMAN, *supra* note 7, at 61–62; Neil Lunt et al., *Nip, Tuck & Click: Medical Tourism and the Emergence of Web-Based Health Information*, 4 OPEN MED. INFORMATICS J. 1, 1 (2010) (recognizing that "[a] key driver in the Medical Tourism phenomenon is the platform provided by the internet for gaining access to healthcare information and advertising").

making than those patients seeking domestic medical services.[410] This fact, in turn, ensures that the tools for selecting a provider are accessible to medical tourists at the touch of a button, which is not necessarily true of domestic patients. For these reasons, the "search-information costs" of investigating medical tourism are likely to be substantially reduced for potential medical tourists. This, in turn, should enable medical tourists to utilize information more effectively to evaluate provider quality than in the domestic context.

For these various reasons, factors unique to the medical tourism market will overcome the market failures intrinsic to the domestic health care industry. By inhibiting the effects of both asymmetric information and inelasticity of demand, these factors serve to reduce limitations on market forces which, in turn, reduce the efficiency of the market and its effectiveness as a regulatory force.[411] Because medical tourism lacks the substantial market failures experienced in the domestic health care context, these factors cannot be used as a justification for restrictive regulations similar to those imposed in the domestic health care industry.

B. Enhancing the Market Through Increased Transparency

Notwithstanding these substantial attenuations of market failure in the medical tourism context, the nature of medical tourism cannot fully eliminate the informational asymmetries between patients and providers. Medical tourists will still lack expertise in the medical field relative to their providers,[412] and information regarding quality of medical tourism facilities may not be entirely accurate or sufficient to promote fully informed patient choice.[413] Rather than using this

410. *Compare* BOOKMAN & BOOKMAN, *supra* note 7, at 61–62 (describing the importance of web-based medical tourism resources for consumers), *and* Lunt et al., *supra* note 409, at 1–3 (explaining the vital importance of web-based information to medical tourism providers), *with* Ha T. Tu & Johanna R. Lauer, *Word of Mouth and Physician Referrals Still Drive Health Care Provider Choice*, CTR. FOR STUDYING HEALTH SYS. CHANGE, 2–3 (Dec. 2008), http://www.hschange.com/CONTENT/1028/1028.pdf (recognizing that patients primarily choose primary care providers through word of mouth recommendations and health plan information rather than web-based resources).

411. *See* FIELD, *supra* note 135, at 202–04; *see also* FOLLAND ET AL., *supra* note 366, at 188–94 (discussing inefficiencies and information asymmetries in the health care market that create the possibility of adverse provider selection).

412. *See* FIELD, *supra* note 135, at 202 ("Physicians know much more about their patients' medical needs than the patients themselves, so it is extremely difficult for the consumers of health care to decide on their own what services they should purchase.").

413. *See* Lunt et al., *supra* note 409, at 5; *see also* Cohen, *supra* note 117, at 1506–11 (discussing problems with the availability and quality of information both within the United States and abroad).

residual market failure as a justification for heavy regulation of the practice of medical tourism, however, policymakers can attempt to improve patients' access to relevant information, thereby enhancing the informed nature and overall quality of medical tourists' decision making. By taking steps to make the medical tourism industry more transparent to American consumers, regulators may both protect the benefits of medical tourism and help to protect patients from its hidden risks.

Efforts to enhance transparency of the medical tourism industry may provide a more appropriate avenue through which regulators can appropriately protect patient safety and ensure quality of care overseas. Heavy regulation in the name of protecting patients from inadequate information or bad decision making may wax unduly paternalistic, as it is based in part on assumptions that the typical patient is neither sufficiently informed nor sufficiently self-efficacious to investigate her own care. In the modern technological context, these assumptions also may be inaccurate.[414] The Internet has made available to curious consumers data on quality of patient care, provider credentials, international medical and legal standards, and other considerations equally relevant to medical tourism; information also has been promulgated in print medical tourism guides.[415] Web resources such as Healism.com provide message boards through which past medical tourists can leave both positive and negative feedback for future medical tourists.[416] Resources intended to assist a potential medical tourist's decision making abound.

However, the type of transparency necessary to remedy market failure requires more than these available resources. Some Internet sources may provide unreliable or biased information,[417] and consumers looking for a balanced assessment of the practice may have to sift through the many testimonial pages run by medical tourism brokers who benefit financially from providing positively-skewed statements to potential consumers. More fundamentally, even the most truthful testimonials have only limited benefit to consumers.

414. *See* FIELD, *supra* note 135, at 40 (recognizing the availability of physician data and suggesting that "[p]erhaps patients finally have the tools to begin to take greater responsibility for assessing the quality of their own care").

415. BOOKMAN & BOOKMAN, *supra* note 7, at 60–64. *See generally* WOODMAN, *supra* note 7 (providing an example of a print medical tourism guide).

416. *See Testimonials*, HEALISM.COM, http://www.healism.com/forum/listcat/testimonials/ (last visited Jan. 3, 2011); *see also* Parsiyar, *supra* note 13, at 384 (describing available Internet communities).

417. Lunt et al., *supra* note 409, at 5 ("There is evidence that the quality of online information continues to vary widely.").

Medical tourists face substantial information costs in both time and money when trying to obtain information about potential providers.[418] Where it is available, comparative data on health care quality and cost are usually highly technical in nature and difficult for laypersons to follow.[419] To better enable medical tourists to make informed decisions about the providers they choose—or, ultimately, whether to choose to engage in medical tourism at all—large compilations of reliable and easily-accessible data on quality and cost are necessary.

To accomplish this task, American regulators can rely on a familiar entity: the Joint Commission.[420] Through its international affiliate, the JCI, the Joint Commission collects large amounts of data from international health care facilities on a regular basis for the purpose of providing and maintaining accreditation.[421] This data includes detailed ratings of virtually all aspects of a facility's operations, from patient safety, disease prevention, and continuity of care practices to staff credentialing and hospital governance standards.[422] The United States should take advantage of this data collection as a regulatory tool by ensuring that the Joint Commission adheres to its promise to make this information publically available. The government should further synthesize the data in a way that is more readily available to laypersons (for example, by providing the data for free online) and easier to apply to medical tourism decision making. For example, the government might choose to provide a facility-by-facility comparison of all relevant quality factors evaluated by the JCI. The analysis should also include an easily understood explanation of each of the reported factors and their significance to

418. Terry, *supra* note 7, at 465–66.

419. *See* FIELD, *supra* note 135, at 16; *see also* NAT'L COMM. FOR QUALITY ASSURANCE, *supra* note 119, at 16 ("Health care is often a confusing world of technical language not easily understood by most people. Poor understanding between heath care providers and patients leads to poor quality care.").

420. *See supra* Part I.B.1.b.

421. *See* JOINT COMM'N INT'L, *supra* note 119, at 5–10. The JCI obtains data from each facility it surveys during the initial accreditation process and every three years after accreditation is granted, as well as periodically between these standard surveys on an as-needed basis. *See id.* Currently, more than 300 health care facilities have been accredited by the JCI. *About Joint Commission International: International Accreditation and Certification*, JOINT COMM'N INT'L, http://www.jointcommissioninternational.org/about-jci/ (last visited Jan. 3, 2011).

422. *See generally* JOINT COMM'N INT'L, *supra* note 119 (collecting detailed data on international accreditation standards for hospitals). The JCI has publicly committed to publishing these ratings of individual facilities once a sufficient amount of data has been obtained to enable quality comparisons. *See id.* at 8.

overall care, to facilitate patients in making meaningful, informed choices between providers.[423]

Although the JCI is not a government entity, it is likely to comply with disclosure requirements due to its close affiliation with the Joint Commission and its favored quasi-governmental status in the United States.[424] Because the Joint Commission already collects this data during the accreditation process, no additional compliance costs should be passed on to consumers in the form of higher prices for medical services.[425] Furthermore, enhancing transparency may also help to protect American medical tourists from being party to a "race to the bottom" among medical tourism facilities.[426] Such a plan would enable patients to better assess changes in quality over time and avoid purchasing services from a particular facility if the quality were to decrease significantly, before such decreases in quality became standard throughout the industry. Thus, increasing transparency through the JCI would help to remedy some of the dangers of the practice while thoroughly preserving its benefits for American patients.

Government-mandated transparency does not conflict fundamentally with a market-based approach. In the wake of market failures such as the Enron scandal of 2001 and the global financial crisis of 2009, economists and political analysts alike have generally recognized an underlying fallacy in the concept of an economic system entirely free of governmental control.[427] As one author has recently noted, even "[t]he most absolutist of free-market advocates now recognize that the state must be a guarantor of rules," due to the informational asymmetries inherent in a market system.[428] Transparency may be enhanced by private intermediaries designed to dispense information to individual consumers, and the credibility of these intermediaries ensures at least some degree of accuracy, as it

423. The importance of these factors in measuring the quality of care is discussed *supra* Part I.B.1.

424. *See supra* Part I.B.1.b.

425. *See supra* Part I.B.1.b.

426. *See* Cortez, *supra* note 14, at 105.

427. For a small sampling of such arguments, see MARK A. MARTINEZ, THE MYTH OF THE FREE MARKET: THE ROLE OF THE STATE IN A CAPITALIST ECONOMY, at xv (2009); CLYDE PRESTOWITZ, THE BETRAYAL OF AMERICAN PROSPERITY: FREE MARKET DELUSIONS, AMERICA'S DECLINE, AND HOW WE MUST COMPETE IN THE POST-DOLLAR ERA 159 (2010); JOSEPH E. STIGLITZ, THE ROARING NINETIES: A NEW HISTORY OF THE WORLD'S MOST PROSPEROUS DECADE 12–17 (2006).

428. GUY SORMAN, ECONOMICS DOES NOT LIE: A DEFENSE OF THE FREE MARKET IN A TIME OF CRISIS 8 (Alexis Cornel trans., 2009).

"stems from the fact that they risk their reputations and their money" on the accuracy of their information.[429] However,

> [t]here is no last resort in this context other than the state, the ultimate insurer when the market fails: The state also puts its reputation and its funds on the line, though this is not to say that it is absolutely trustworthy. Modern free-market theory thus recognizes the essential role of good public institutions in ensuring that transactions in national and international markets lead to lasting economic development.[430]

At the same time, markets are more likely to operate effectively when the costs of the state's guaranty is lowest, allowing economic actors to spend more on growth and less on adherence to state regulations.[431] When the methods of ensuring transparency are carried out by a third-party organization and only mandated by the government—as would be the case for the JCI—that organization bears the lion's share of costs associated with repairing those informational asymmetries. In this way, the medical tourism industry may be regulated so that neither consumers nor providers shoulder the ultimate cost of transparency.

Government regulation is particularly well-suited to a free market theory when its regulations enhance the efficiency of the market. In an efficient market, "prices reflect all available information about the fundamentals."[432] Where regulation is designed only to ensure that consumers are provided with all relevant information about a given market, such regulation should act to improve the efficient operation of that market.[433] These conditions of extreme transparency reflect the most basic assumptions on which free-market theory is based. Thus, enhanced transparency remains consistent with a modern understanding of free-market economics and may serve to remedy the flaws inherent in the health care market.

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429. *Id.* at 8–9.

430. *Id.* at 9.

431. *See id.* at 43–44.

432. STIGLITZ, *supra* note 427, at 61.

433. *See generally* Joseph Alba et al., *Interactive Home Shopping: Consumer, Retailer, and Manufacturer Incentives to Participate in Electronic Marketplaces*, 61 J. MARKETING 38 (1997) (analyzing the implications of electronic shopping to retailers who receive more complete information to aid them in their purchasing decisions); Yannis Bakos, *Reducing Buyer Search Costs: Implications for Electronic Marketplaces*, 43 MGMT. SCI. 1676 (1997) (studying the role of electronic marketplaces in lowering information costs and reducing market inefficiencies).

C. *Benefits to American Patients Generally*

Incidental to this Comment's proposed market-based approach to medical tourism, the U.S. health care system may experience systemic changes which are beneficial to American patients generally. As the practice grows and possibly expands beyond individuals who lack adequate insurance,[434] medical tourism facilities could create additional competition for domestic providers. If increased transparency of foreign providers is achieved, foreign providers likely will provide a cheaper, more accessible, and comparably safe alternative to many domestic providers. As domestic providers risk losing money to foreign providers, this competition could create incentives for domestic providers to reduce costs and to become more efficient in order to compete more effectively with medical tourism facilities for American patients.[435] It could also encourage domestic providers to become more transparent so as to provide similar quality assurances to domestic patients. Thus, these systemic changes may result in lower-cost, higher-quality, and more transparent care for all American patients, regardless of whether any individual patient engages in medical tourism. As one analyst has noted, medical tourism "has the potential of doing to the U.S. health-care system what the Japanese auto industry did to American carmakers."[436] If the medical tourism industry is able to maintain its competitive cost advantage and high quality care in the face of the recent health insurance reform, such effects are likely to occur, regardless of how these reforms eventually influence the domestic health care market.

CONCLUSION

Critics envision the rise of medical tourism as creating a virtual Scylla and Charybdis for American patients, "forcing [patients] to choose between domestic care, which may result in financial devastation, and under-regulated care abroad, which leaves patients without legal remedy . . . ."[437] There is some recognizable truth underlying this assessment, as both medical tourism and the current U.S. health care system are imperfect sources of health care.

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434. *See supra* notes 41–53 and accompanying text.

435. *See* Horowitz et al., *supra* note 7; *see, e.g.*, Klaus, *supra* note 8, at 245–46 ("The competition posed by [foreign] hospitals could inspire policymakers to develop innovative strategies for closing the gap between surgery costs in the United States and [abroad] . . . .").

436. Horowitz et al., *supra* note 7 (quoting Princeton University health care economist Uwe Reinhardt in Unmesh Kher, *Outsourcing Your Heart*, TIME, May 21, 2006, at 44, 44).

437. Brady, *supra* note 16, at 1111.

However, this Comment has argued that medical tourism, despite its inherent flaws, represents a favorable option for patients as compared to the U.S. health care system.

Medical tourism is not a solution to the various failings in the American health care market, and this Comment does not advocate any long-term plan which would impose overseas care on all underinsured individuals as a substitute for comprehensive health care and health insurance reform. Such a proposal would, as critics have suggested, be "irresponsible public policy."[438] It is equally irresponsible, however, to ignore the uncertain state of the American health care system as it currently exists, or the fact that medical tourism may represent the only means for some American patients to obtain the medical treatment they desire. Broad regulation of medical tourism is unnecessary, ineffective, and potentially harmful to both individual medical tourists and to patients generally, as it will inhibit the benefits which medical tourism provides American patients. Until American patients are assured of the benefits of equitable access to high-quality health care, medical tourism should remain a viable option, protected by efforts to promote transparency and otherwise allowed to thrive under the beneficial influence of the market.

HEATHER T. WILLIAMS

438. *See id.* at 1112.