Interview With Prof. Glenn Cohen[1]

SPIL, Mumbai : It prima facie appears that medical tourism reduces access to health care for the destination countries' poorer segment. Does the picture remain the same on a deeper analysis of the situation as well or is there a partial or total reversal of the same?

Prof. Cohen : I am not sure I agree that the prima facie case is so clear. I think it varies by locality to locality. As I have argued in my paper, Medical *Tourism, Access to Health Care, and Global Justice,* 52 Va J. Int'l L. 1 (2011):

Although… there have been a number of more anecdotal statements and analyses offered in favor of the empirical claim, there is very little in the way of statistical evidence supporting the empirical claim. As such, this is an area where more developmental economic work would be very helpful. That said, I think it useful to identify six triggering conditions, which, when combined with substantial amounts of medical tourism, may lead to reduced populations and thus satisfy the empirical claim:

(1) The health care services consumed by medical tourists come from those that would otherwise have been available to the destination country poor. When medical tourists seek travel abroad for cardiac care, hip replacements, and other forms of surgery used by the destination country poor, the siphoning effect is straightforward. By contrast, the destination country poor are already unlikely to be able to access some boutique forms of treatment, such as cosmetic surgery and stem cell and fertility therapies. Thus, while medical tourism by American patients for these services would diminish access by, for example, Indian patients, it would not necessarily diminish access for poor Indian patients (which would remain steady at virtually none). Instead, it would cut into access by upper-class patients. Thus, one triggering condition focuses on whether medical tourism is for services currently accessed by destination country poor. That said, as discussed below, over time, the salience of the distinction is likely to break down, and even medical tourism for services currently inaccessible to destination country poor may siphon resources away from the poor because increased demand for services like cosmetic surgery may redirect the professional choices of graduating or practicing physicians who currently provide health care to India's poor into these niche markets. Whether that dynamic obtains would depend in part on the extent to which the destination country regulates specialty choice versus the extent to which health care workers can pursue the specialties most desirable to them

(2) Health care providers are "captured" by the medical tourist patient population, rather than serving some tourist clientele and some of the existing population. Absent regulation, the introduction of a higher-paying market will likely cause health care providers to shift away from treating patients in the lower-paying market. Thus, for example, Hopkins and her co-authors argue that this dynamic has taken place in Thailand, where "almost 6000 positions for medical practitioners in Thailand's public system remained unfilled in 2005, as an increasing number of

[1]Assistant Professor of Law, Harvard Law School

physicians followed the higher wages and more attractive settings available in private care," and that due to medical tourism, "the addition of internal 'brain drain' from public to private health care may be especially damaging" for "countries such as Ghana, Pakistan, and South Africa, which lose approximately half of their medical graduates every year to external migration."This has also been the dynamic when private options are introduced into public systems, even in the developed world, although a number of jurisdictions, such as Canada and France, have tried by regulation to prevent flight to the private system. Regulations that require providers to spend time in both systems are also more likely to produce positive externalities from the private to public health care systems; for example, a physician who receives extra training as part of her duties in the medical tourism sector may be able to carry that training over to her time spent treating poor patients, if regulation forces her facility to treat poor patients. I discuss such possible regulation more in depth in Part IV, but it is worth noting that in medical tourism havens like India, even when such regulations are in place, many observers have been skeptical that they have been or will be enforced.

(3) The supply of health care professionals, facilities, and technologies in the destination country is inelastic. Theoretically, if medical tourism causes increased demand for health care providers and facilities in the destination country, the country could meet such demand by increasing the supply of these things. In reality, however, even Western nations have had difficulty increasing this supply when necessary. As discussed, the need to match increased demand for the right specialties poses additional problems. In any event, investments in building capacity always entail an adjustment period. Thus, even countries that are unusually successful in increasing the size of their health care workforce to meet the demands of medical tourism will face interim shortages.

(4) The positive effects of medical tourism in counteracting the "brain drain" of health care practitioners to foreign countries are outweighed by the negative effects of medical tourism on the availability of health care resources. Medical migration, or "brain drain," represents a significant threat to health care access abroad. For example, 61% of all graduates from the Ghana Medical School between 1986 and 1995 left Ghana for employment (of those, 54.9% worked in the United Kingdom and 35.4% worked in the United States), and a 2005 study found that 25% of doctors in the United States are graduates of foreign medical schools. A recent study of nurses in five countries found that 41% reported dissatisfaction with their jobs and one-third of those under age thirty planned on leaving to work elsewhere. As Larry Gostin has put it, in the ordinary course of globalization, "health care workers are 'pushed' from developing countries by the impoverished conditions: low remuneration, lack of equipment and drugs, and poor infrastructure and management," and "they are 'pulled' to developed countries by the allure of a brighter future: better wages, working conditions, training, and career opportunities, as well as safer and more stable social and political environments." It is possible that for health care professionals tempted to leave their country of origin to practice in other markets, the availability of higher-paying jobs with better technology and more time with patients in the

medical tourist sector of their country of origin will counteract this incentive. Medical tourism may also enable the destination country to "recapture" some health care providers who left years earlier, or to change "brain drain" into "brain circulation," wherein home country providers leave for training abroad and return home ready to use and impart their skills to other providers in the home country. But while some countries that experience medical brain drain are also developing strong medical tourism industries, many are only sources of medical brain drain and not destinations for medical tourism. Thus, the creation of medical tourism hubs may actually exacerbate intra-regional medical migration.

(5) Medical tourism prompts destination country governments to redirect resources away from basic health care services in a way that outweighs positive health care spillovers. In order to compete for patients on quality and price against both the patient's home country and other medical tourism hubs, destination countries will need to invest in their nascent medical tourism industry through, for example, direct funding, tax subsidies, and land grants. Unfortunately, such funding often comes from money devoted to other health programs, including basic health care and social services, and those effects are likely to be felt most strongly by the destination country poor. In other words, we need some sense of whether governments actually invest in health care services accessible by the poor (or at least do not take them away) in a counterfactual world where medical tourism is restricted. We also need to examine this dynamic as against a potential countervailing dynamic wherein medical tourism leads to a diffusion of Western medical technology or standards of practice or other health care spillovers that are beneficial to the entire patient population. Which dynamic wins out can only be answered on a country-by-country basis, but in India, for example, some commentators have suggested that the product of these countervailing forces has ultimately been a net negative for the destination country poor.

(6) Profits from the medical tourism industry are unlikely to "trickle down." Successful medical tourism industries promise an infusion of wealth into the destination country, and the possibility that all boats will rise. In practice, however, that possibility may not be realized. The reason for this might be something insidious like rampant corruption, or it may be something more benign, such as a tax system that is not particularly redistributive, or a largely foreign-owned medical sector. Thus, the fact that a destination country gains economically from medical tourism (for example, in GDP terms) does not necessarily mean that those gains are shared in a way that promotes health care access (or health) among the destination poor.

Still, to address your question more directly, I think some of these vectors are more temporary and others more long-term. For example the production of new physicians and increasing physician or nurse work force is a potential long-term solution to shortages caused by internal brain drain from public to private. Also over the long term, regulation of things like how many hours individual practitioners can spend in the medical tourism versus public system could also be a potential salve.

SPIL, Mumbai : What role does litigation, both Municipal and International, have to play in dealing with medical tourism? Has it succeeded in the same?

Prof. Cohen : We have seen very little international litigation; instead almost all of it has been domestic, either in the home country or the destination country. The main place where litigation has been discussed is as to medical malpractice. As I have argued in Protecting Patients with Passports: Medical Tourism, Medical Tourism and the Patient-Protective Argument, 95 Iowa L. Rev. 1467 (2010) , there are substantial obstacles in place that prevent U.S. patients from recovering in litigation against foreign hospitals or providers:

While the analysis in actual cases will be fact specific, it seems reasonable to conclude that several doctrines of American civil procedure work in conjunction to substantially reduce the likelihood and amount of recovery in med-mal when medical error from care causes injury abroad as opposed to when care is delivered within the United States. In particular, I focus on four obstacles: personal jurisdiction, forum non conveniens, choice of law, and the enforcement of judgments.

A. Personal Jurisdiction

A U.S. court must have personal jurisdiction over the foreign hospital and/or healthcare provider for the plaintiff to maintain suit. Limits in states' long-arm statutes and constitutional limitations may make this hard to achieve.

The long-arm statutes of particular states may not reach foreign healthcare providers or hospitals because their long-arm has been read as limited to tortuous conduct by act or omission committed within the forum state, which would exclude med-mal committed abroad. Other state long-arm statutes cover tortuous conduct by act or omission outside of the state which causes injury within the state, but only if the defendant "regularly does or solicits business, engages in any other persistent course of conduct in the State or derives substantial revenue from services, or things used or consumed in the State." Many foreign hospitals and providers are unlikely to satisfy this requirement (although foreign providers who receive patients from insurer-prompted medical tourism are more likely to do so). Still other states allow long-arm jurisdiction only over corporations or partnerships and not natural persons, which might permit jurisdiction over foreign hospitals but not individual foreign providers.

Even if a long-arm statute purports to reach the medical injurious act committed abroad, for example because it claims to be coextensive with the outer limits of what is permitted under the Due Process Clause, the exercise of personal jurisdiction over these defendants may not be permissible under the Due Process Clause. The Due Process Clause requires that the defendant have minimum contacts with the state where the suit is brought; but establishing that jurisdiction in these cases, through either "general" or "specific" jurisdiction may be difficult.

Although the inquiry is fact intensive, in most cases we would expect a foreign doctor or even a foreign hospital to lack the systematic and continuous contacts with the plaintiff's home state

required to establish general jurisdiction. This is true even in cases of insurer-prompted medical tourism where the provider may have contracts guaranteeing patient and reimbursement rates with a U.S. insurer.

Plaintiffs will also have difficulty establishing specific personal jurisdiction against foreign doctors, who do not usually purposefully avail themselves of the benefits and protections of the laws of U.S. jurisdictions.

When the foreign hospital is a defendant, the case for specific in personam personal jurisdiction would depend in part on how patients were solicited, and, for online contacts, the nature of the foreign hospital's web presence. For example, personal jurisdiction would be easier to establish if a foreign hospital solicited a particular patient via a website and/or specifically targeted U.S. patients. To examine one real example, Wockhardt hospital in India advertises "International Patient Services" on its website and lists two specific toll free numbers, one for the United Kingdom and one for the United States and Canada. This seems like a pretty thin reed on which to hang personal jurisdiction. It does not evince the "targeting" of the U.S. market that some courts have deemed necessary to support jurisdiction, but only the "passive advertisement" that courts have found insufficient. Even if courts found this form of Internet contact sufficient, it would be very easy for Wockhardt and others to adjust their web presence to avoid personal jurisdiction. Plaintiffs might be able to establish personal jurisdiction more easily by showing that the hospital adopted practices to target U.S. consumers, for example, by adjusting billing practices or based on referral relationships with in-state providers. For similar reasons, a court is more likely (though perhaps still not very likely) to assert personal jurisdiction over foreign providers in cases of insurer-prompted medical tourism.

The case for personal jurisdiction is somewhat better for medical-tourist intermediaries located abroad. As our discussion of one such intermediary (MedRetreat) suggests, medical-tourist intermediaries are more likely to purposefully avail themselves of the forum state's laws by actually recruiting patients there. Additionally, these intermediaries are more likely to establish a business presence in the markets from which they recruit.

The problem is that intermediaries are likely to be judged under a set of substantive med-mal doctrines that are less plaintiff friendly than those for hospitals or physicians. I am unaware of any case on how to treat medical intermediaries for med-mal purposes, but one plausible analogy would be to treat them like independent-practice-association-type health-maintenance organizations ("HMOs"), that are HMOs with large contractual networks of physicians who see patients with many types of insurance. HMOs have occasionally been subjected to direct liability when their doctors commit medical malpractice, but only when the HMO directly employs the doctor, or under a theory of apparent or implied authority when the doctor is an independent contractor. Neither seems a good fit for intermediary liability here: foreign doctors are in no way employees of the intermediary, and apparent or implied authority is a considerable stretch. A different HMO-liability theory evaluates HMOs for negligence in reviewing the credentials

and competency of the doctors to whom it refers patients--that is, breach of the "duty to select and retain only competent physicians." In "a managed care program the patient has chosen the particular program not the physicians who are provided. The patient must use the physicians on the panel. . . . Thus the program's obligation for the patient's total care is more comprehensive than in the hospital setting."

While this seems like a better fit for the intermediary context, under current law it is unlikely to provide much med-mal traction against the intermediary because the intermediary can satisfy this duty quite easily. A leading treatise suggests that, in the domestic context, the kinds of things that would violate this duty are selecting "a panel physician or dentist who has evidenced incompetence in her practice, or has dementia from AIDS." If held to this standard, intermediaries might satisfy the duty merely by pointing to the JCI accreditation of the hospital to which it referred the patient or to the board certifications of the foreign physicians it selected.

What if the intermediary is a U.S. insurance company, as with the insurer-prompted medical tourism I will discuss in Part IV? In that case, a plaintiff faces the same liability-theory difficulties just discussed and two additional obstacles: first, some states have made HMOs immune from negligent-treatment suits and second, for those whose health insurance is employer sponsored, some courts have found that, in some cases, liability based on negligent selection of physicians "relates to" an Employee Retirement Income Security Act ("ERISA") plan and is therefore preempted by ERISA, although the exact preemptive scope is still very much in flux. Of course, the flipside of ERISA preemption is that the HMO is now open to liability for breach of fiduciary duty under ERISA. But the remedies available through that statute pale in comparison to common law med-mal, and it is not clear whether an HMO's use of medical tourism would actually violate its fiduciary duty under ERISA.

In sum, while this is a fact-specific inquiry, both long-arm statutes and constitutional limits on personal jurisdiction will make it difficult to hale foreign physicians and hospitals into U.S. court to defend a medical-malpractice claim, and intermediary liability will be a poor substitute.

B. Forum Non Conveniens

Even when personal jurisdiction is satisfied, a med-mal suit of this kind brought in a U.S. court would still be subject to a challenge under the doctrine of forum non conveniens. That doctrine gives the U.S. courts discretion to dismiss the case when (1) jurisdiction is proper in an alternative forum and (2) the alternative forum is preferred under a multifactor balancing test that weighs the burdens to plaintiff and defendant against the public's interest.

The first requirement will likely be satisfied in many medical tourism cases, since the legal system of the destination country will often entertain a med-mal suit by a U.S. citizen treated in that country. The Court has made clear that the fact that "the substantive law that would be applied in the alternative forum may be less favorable to the plaintiffs than that of the present forum . . . should ordinarily not be given conclusive or even substantial weight" in the analysis. Indeed,

other courts have rejected an argument against forum non conveniens dismissals premised on the claim that the law of the alternative forum will yield much smaller damages such that the lawsuit would not be economically viable since the costs would exceed potential recovery. The Supreme Court indicated in Piper Aircraft Co. v. Reyno that in "rare circumstances, however, where the remedy offered by the other forum is clearly unsatisfactory, the other forum may not be an adequate alternative, and the initial requirement may not be satisfied," and gave as its example a case "where the alternative forum does not permit litigation of the subject matter of the dispute." However, as we will see in the next Subpart, these cases are not likely to meet this standard: while many of the destination countries for medical tourism have less capacious remedies for medical malpractice, and there exist significant practical difficulties in bringing these suits, such suits are not formally barred. The exception has proven rare indeed; the Wright and Miller treatise details the "ease with which a defendant can establish that an alternative forum is adequate" and suggests that the federal courts have "categorically reject[ed] generalized accusations of corruption, delay, and other inadequacies in foreign judicial systems, or imposing too high a level of proof" as being sufficient to fall within Piper's exception. That said, at least one court of appeals has found extensive delays (in the range of twenty years according to testimony in the district court) in the Calcutta High Court in India to make the alternative forum inadequate and thus to justify denying a motion to dismiss on forum non conveniens grounds. However, the court went to great length to emphasize the truly extraordinary nature of the delay in the case, the deferential abuse-of-discretion standard of review it was applying, the failure of the nonmoving party to put forth adequate evidence to meet its burden on the issue, and that this was not a more general determination as to the adequacy of Indian fora for litigation.

Turning to the second part of the analysis, while fact specific, many of the factors the Supreme Court listed seem to cut in a favor of a forum non conveniens dismissal in this context: "the relative ease of access to sources of proof; availability of compulsory process for attendance of unwilling, and the cost of obtaining attendance of willing, witnesses; possibility of view of premises," whether the plaintiff's "choice of an inconvenient forum, 'vexes,' 'harasses,' or 'oppresses' the defendant by inflicting upon him expense or trouble not necessary to his own right to pursue his remedy," the "administrative difficulties that follow for courts when litigation is piled up in congested centers instead of being handled at its origin," and the "local interest in having localized controversies decided at home."

Thus, forum non conveniens dismissals may pose a serious challenge to recovery in U.S. courts for medical tourists.

C. Choice of Law, the Enforcement of Judgments, and Suing Abroad

If these doctrines prevent a medical tourist from suing foreign hospitals and providers for med-mal in U.S. courts, the alternative is to sue in the foreign court system. Beyond the added expense and difficulty of suing abroad, this poses a further problem: in some cases it will be much more difficult to prevail in a med-mal claim under the destination country's substantive law and in its courts than it would be under U.S. law in U.S. courts.

Of course, some potential destination countries have a med-mal system closer to our own, and a full assessment would require detailed comparative med-mal work. Drawing on excellent work by others in this vein, though, it is safe to say that many of the destination countries to which today's patients are going have much less plaintiff-friendly med-mal systems. For example, in India "medical negligence claims are rare and multimillion dollar awards are nonexistent." One author claims that while medical malpractice relief is "technically available" in India, around 95% of cases are dismissed, and the substantial backlog of cases means "that the patient may face a lengthy delay before any adjudication," and given the minimal amount of damages likely to be recoverable, "the amount of litigation expenses may total more than any potential recovery, making the suit not economically viable." Another author suggests that it is extremely difficult to get Indian physicians to testify against other Indian physicians, although the same may be true to some extent in the United States. Thai laws "limit medical malpractice awards and do not compensate for pain and suffering." Some criticize Malaysian and Singaporean med-mal law as doctrinally too deferential to physicians "in determining the standard of care and whether that standard was breached in a each case," and one author has suggested that "Mexican courts do not provide any real recourse to victims of medical malpractice."

These divergences from U.S. substantive med-mal law will pose an obstacle for robust recovery not only for the patient who must sue in the foreign system, but also for the one who (notwithstanding the obstacles discussed) manages to maintain suit in a U.S. court: the application of choice-of-law principles will likely mean that the governing law will be that of the foreign country where medical care was provided. To oversimplify somewhat for our purposes, the most common approach is to resolve choice of law through state-interest analysis. Under the interest-based approach of the Restatement (Second) of Conflict of Laws, "in an action for a personal injury, the local law of the state where the injury occurred determines the rights and liabilities of the parties, unless, with respect to the particular issue, some other state has a more significant relationship," and courts are instructed to look at: "(a) the place where the injury occurred, (b) the place where the conduct causing the injury occurred, (c) the domicile, residence, nationality, place of incorporation and place of business of the parties, and (d) the place where the relationship, if any, between the parties is centered."

In the example of someone injured by medical care provided abroad, the default choice of law would be that of the foreign jurisdiction--the place where the injury occurred. The multifactor test is unlikely to lead to a divergence from the default since factors (a), (b), and (d) would likely point to the foreign country's substantive law, and factor (c) seems neutral. Things look slightly better for the American plaintiff in cases of insurer-prompted medical tourism with respect to factor (d) since more of the insurer-provider relationship may be centered in the United States. Still, he is likely to face trouble.

All in all, it seems likely that in med-mal cases that arise out of medical tourism, the law of the place of injury will usually apply. Several courts that have dealt with med-mal choice of law have reached this conclusion in choosing among U.S. state laws and in the very few med-mal cases

dealing with choice of law between a U.S. state's law and a foreign country's law.

Even if an American patient is allowed to maintain a suit in a U.S. court and wins, any judgment may be very difficult to enforce against a foreign physician or hospital without assets in the United States. Foreign courts are often "reluctant to enforce the decisions of U.S. courts," because "[M]any other countries find some of the grounds for jurisdiction in the United States exorbitant," and because "legal systems that do not include punitive damages may object to large U.S. awards." Pessimism as to whether one will ever be able to enforce the judgment will reduce the incentive to sue in the first place, especially given all of the other obstacles to recovery discussed above.

For all of these reasons, U.S. patients treated abroad who sue for medical malpractice seem considerably less likely to succeed, and their recovery substantially more limited if they do, compared to patients treated domestically.

SPIL, Mumbai : You seem to prefer regulating medical tourism, through the expansion of insurer vicarious liability or altering civil-procedural doctrines, instead of restricting it. Can you please elaborate further on this?

Prof. Cohen : For patients paying out of pocket, I have suggested that trying to restrict medical tourism is extremely difficult, costly, and unlikely to succeed. The question then is what to do? I favor regulation.

My preferred approach is actually what I call a "channeling regime." Home countries, intergovernmental organizations, or accreditation institutions like the Joint Commission International can create an "approved" list of medical tourism facilities, for which tax deductions and other benefits would flow to patients who use them. Insurers in the home country would be authorized to send patients only to such approved hospitals. By so doing we create a strong incentive for foreign hospitals to toe the line. If one is worried about lack of medical malpractice recovery – and I have expressed some ambivalence as to how big a worry this should be in my work – a home country could attempt more muscular "channeling" regimes that required foreign facilities to, for instance, engage in agreements to arbitrate, consent to jurisdiction, or offer medical malpractice insurance as a condition of accreditation by third-party accreditors like JCI, or to be on the "approved" list of national or international regulators. For insurers, this could be achieved by the usual home country mechanisms for regulating insurance products, and indeed the U.S. state of California has adopted a somewhat analogous system in licensing insurance products covering travel to Mexico for care.

I prefer this approach to either altering civil procedural rules or other interventions. I also think they are more likely to be politically feasible.

More radically, home countries could attempt to create victim's compensation funds (in analogy to the September 11 Victim's Compensation Fund or the Worker's Compensation system in the

U.S.) Such a scheme could be funded by levying a fee on facilities that wished to be part of the "approved" list in the channeling regime and using that revenue to pay for this system, or by charging facilitators who recruit in the U.S. Alternatively, funding could come from charging insurers using medical tourism of facilitators a per-patient fee and using that revenue to cross-subsidize the no-fault compensation system for uninsured patients.

A second possibility that Nathan Cortez has raised would be to make facilitators vicarious liable to medical tourism patients for any injury that results from the action of the foreign physician. This would allow the patient to recover as against the facilitator. The advantage to this approach would be to better align the incentives of patients, providers, and facilitators (thus overcoming an agency problem) since it would encourage facilitators to "more carefully, monitor quality, and perhaps purchase insurance to cover injuries," which is useful because "these companies are also in a better position to regulate, confront, and negotiate with foreign providers." However, as Cortez recognizes, there are also challenges with such an approach: it would require the government to develop something akin to the no-fault compensation schemes discussed above, and "most governments may be reluctant to devote the time and energy required to do so." Moreover, "such heavy-handed approaches might have the perverse effect of driving medical tourism intermediaries overseas to less regulated jurisdictions."

A different and less drastic variant of this approach that I have discussed elsewhere would retain the possibility of vicarious liability but require a showing of negligence, making facilitators vicariously liable for the negligent treatment of their providers. There is a parallel debate in domestic U.S. health care law about whether to make insurers vicariously liable for the torts of the doctors whose work for which they reimburse. On the one extreme, scholars like Bill Sage, Clark Havighurst, Jennifer Arlen, and Bentley Macleod, have argued that insurers should be fully liable (and in Sage's case exclusively so) for physician negligence; this recommendation is premised on the modern conception of systems as the major source of medical negligence and the assumption that managed-care organizations have the power to alter physician behavior. But they were writing in the domestic insurer context, and it seems facilitators may be less able to influence their foreign providers. The other pole, represented by Patricia Danzon and Richard Epstein, would wipe out insurer liability entirely; this view is premised on the idea that physicians are already on the line for liability, such that insurer liability merely adds redundant and unnecessary cost. But this is less true for medical tourism, where as discussed foreign physicians are not likely to be subject to U.S. med-mal liability. An intermediate view espoused by Gail Agrawal and Mark Hall would support full liability for insurers where doctors are essentially employees of the insurer but not other kinds of insurance designs. This view would suggest not expanding vicarious liability to facilitators in the absence of an employment-like level of control of foreign providers/facilities, which seems absent as to most facilitators currently operating in the market. Using the negligence variant of vicarious liability would also introduce a series of complications regarding proving the claim: including: would the U.S. patient have to prove the negligence of the foreign provider first, and can he do so from a U.S. court given that all the

evidence is abroad? Will the suit be adjudged under the U.S. or Indian standard of care? Will U.S. courts give preclusive effect to findings of negligence or lack thereof abroad?

My own sense is that the level of control currently exercised by facilitators and insurers would make allowing the assertion of vicarious liability against them, through negligence or strict liability, relatively ineffective as a solution to the problems identified. I also think that any talk of expanding liability in this way may prove less politically feasible. For these reasons I think the softer regulatory interventions are a surer bet, but for those who disagree I have outlined a way forward using compensation funds or expanded vicarious liability as well.

SPIL, Mumbai : One of your articles (Protecting Patients with Passports: Medical Tourism and the Patient Protective-Argument), expresses your concern regarding the poorer quality of health facilities in the destination countries. What alternate remedy do you suggest to an un- or underinsured person seeking medical assistance while warning him against those poorer facilities?

Prof. Cohen : Again, I want to be clear that it is not the case that medical quality are poorer everywhere. The key point is actually opacity of information and heterogeneity of care quality.

One major question a hypothetical patient considering traveling to India for surgery will want to know is the quality of the care available at the Indian hospital he has in mind. It turns out, that this piece of information will be quite hard to acquire. Foreign countries by and large "do not require their hospitals to measure and report surgical outcomes or to participate in international-performance measurement systems."

While, as a World Bank economists Mattoo and Rathindran observe in in an article in Health Affairs, it is certainly true that "on average" the "quality of care available in developing countries is lower than in industrialized countries," the "relevant comparison is not with the standard of an average developing-country provider but with the standard of a provider likely to be used by the medical-tourist patient in their home country," and how they compare to the kind of care a particular patient could get domestically. That last point is worth amplifying: even if the medical tourist facilities offer the patient care quality below the average hospital in the patient's home country, the comparison that is relevant to the patient (and should be relevant to the policy-maker) is not to the average home country hospital care but to what care would realistically be accessible to the patient. For many uninsured or underinsured home country patients, that would be no non-emergency care at all.

Still, whatever the right baseline against which to evaluate the quality of foreign hospitals against, one still needs to know the quality of those foreign hospitals. That information is very hard to get. A few small-scale empirical studies of specific therapies and hospitals suggest high quality care. Arnold Milstein and Mark Smith (Milstein, A. and Smith, M. (2006), "America's New Refugees — Seeking Affordable Surgery Offshore," New England Journal of Medicine 355: 1637–1640) "doubt" that the average U.S. hospital can "offer better outcomes for common

complex operations such as coronary-artery bypass grafting, for which several JCI-accredited offshore hospitals report gross mortality rates of less than 1%." Aaditya Mattoo and Randeep Rathindran (Mattoo, A. and Rathindran, R. (2006) "How Health Insurance Inhibits Trade in Health Care," Health Affairs 25: 358–68) single out Bumrungrand Hospital in Bangkok, Apollo Hospital in New Delhi, and Crossroads Center in Antigua as "examples of reputable medical facilities in developing countries that are comparable to the best in industrial countries" and note that the Apollo hospital chain has maintained a 99% success rate in more than 50,000 cardiac surgeries performed, which is "on par with surgical success rates of the best U.S. cardiac surgery centers." However, Leigh Turner ("Patient Mortality in Medical Tourism: Examining News Media Reports of Deaths Following Travel for Cosmetic Surgery and Bariatric Surgery", in I. Glenn Cohen (ed.), The Globalization of Health Care: Legal and Ethical Challenges, Oxford: Oxford University Press, forthcoming 2012/2013)has recently compiled a list of several reports of death or serious injury connected to poor quality of care at destination hospitals, and it is hard to know if there are many more than have not been publicly discussed due to settlement agreements with confidentiality clauses or the difficulties one.

I have argued for systems of providing more information through home country regulation and improved demands for this information by accreditators. My own read of the existing literature leads me to doubt that mere information disclosure is enough. Instead I have argued in-depth elsewhere that we should adopt a more muscular form of the "channeling" approach, whereby to be "approved" (we require not the mere disclosure of information or something like the procedural-based JCI accreditation, but instead require that actual morbidity, mortality, avoidable error, and hospital-acquired infection rates be below a level set by regulators. More specifically as I have argued in my Iowa Law Review paper:

We could channel American patients towards medical tourism only for certain services. In their paper attempting to estimate the savings from medical tourism, Mattoo and Rathindran focused on only a subset of fifteen procedures that met the following criteria:

(1) The surgery constitutes treatment for a non acute condition; (2) the patient is able to travel without major pain or inconvenience; (3) the surgery is fairly simple and commonly performed with minimal rates of postoperative complications; (4) the surgery requires minimal follow-up treatment on site; (5) the surgery generates minimal laboratory and pathology reports; and (6) the surgery results in minimal post procedure immobility.

They then applied these criteria to "the 230 most commonly performed procedures . . . as published by the Agency for Healthcare Research and Quality." This reduced their list to fifteen procedures to study, including knee surgery, shoulder anthroplasty, tubal ligation, hernia repair, adult tonsillectomy, hysterectomy, cataract extraction, and glaucoma procedures. One could instead apply this list of criteria, or a variation thereof, not for the purpose of study design but to construct a list of "approved" surgeries. To the extent one is concerned by the quality-of-care disparities, the fact that a particular surgery is simple, is commonly performed with minimal

rates of postoperative care, and requires minimal on-site follow-up treatment may all be good proxies for types of care for which such disparities are less likely. This is not to say that Mattoo and Rathindran's own application of their criteria to generate fifteen procedures was perfect or that the criteria could not be usefully refined, but it does suggest that we may be able to sort procedures into high- and low-risk groups and channel patients only to low-risk ones.

SPIL, Mumbai : Why do you see insurer prompted medical tourism as a deeper concern?

Prof. Cohen : As I have argued in my Iowa L. Rev. Article, "pre-theoretical intuitions about insurer-prompted medical tourism (relating to threats and pre commitments) fail to do much to make it more worrisome than tourism by the un- and underinsured, agency problems do give more cause for concern…" What is more of a concern is that (quoting that article):

One of the preconditions to the consumer-sovereignty-type argument is access to relevant information, and the absence of that access is a serious threat to a permissive approach. In discussing uninsured medical tourists in Part IV, I noted the problems caused by serious information deficits. At first blush, this might be an area where we have fewer qualms about insurer-prompted medical tourism. Because insurers can aggregate and evaluate data from the experience of multiple patients using medical-tourist providers, over time they may be better able to overcome information deficits as to care quality in a way that individual shoppers cannot.

There is, however, a divergence of incentives to use that information. One might think that insurers would have a great incentive to select high-quality foreign providers because they will bear the cost of continuity of care that result from medical error: to the extent that the expected costs of this continuing care (i.e., the increased chance that medical error will result through treatment abroad rather than domestically multiplied by the cost of this care) exceed the expected cost savings from using medical tourism as opposed to a U.S. provider, the insurer has an incentive not to use the foreign provider.

However, this incentive is distorted by the fact that U.S. patients switch insurers relatively frequently. Recent empirical work suggests that 16.6% of privately insured adults changed their insurer within a twelve-month period, most frequently (38.5% of the time) due to a change in the insured's own or spouse's employer. As a result, insurers have suboptimal incentives to invest in the future health of their covered populations, which in our setting provides reason to worry that insurers' incentives to select high quality care diverge from patients' incentives. While patients care about the costs imposed by poor quality of care throughout their lifetime, insurers care about the costs for the first year completely and then only at a reduced rate (because of expected switching) beyond that.

The agency problem is compounded by the fact that insurers do not completely internalize the negative effects on med-mal recovery either. Whether the patient can recover against his or her provider is not a matter of complete indifference for the insurer because successful med-mal recovery against the provider may diminish the risk that patients will go after the insurer as

defendant. However, as discussed above, because current substantive med-mal law is relatively insurer friendly in these suits, there should persist a divergence between the patient's and insurer's interests. Indeed, in a 2003 confidential interview study of experienced healthcare lawyers, Gail Agrawal and Mark Hall found "very little evidence . . . that health plans are motivated by the threat of liability to improve the quality of medical care delivered by their providers" in the domestic sphere, in part because of low estimates of the chance of success of such litigation.

One possible rejoinder to these problems more generally is that a patient could factor in these concerns when determining whether to opt for a plan … and that insurers would adjust their offerings and/or premiums accordingly. Further, patients could once again purchase med-mal insurance protection. However, the same information deficits and bounded-rationality limitations we encountered at the level of choosing a provider reappear at the level of choosing a health insurance plan and med-mal insurance. Indeed, as the research that Hall and Schneider have recently collected shows, in the domestic sphere, patients are particularly bad at choosing between health plans: they become overwhelmed at the large number of plans on the market, they are highly susceptible to framing effects, and they have trouble understanding even a single plan.

What is worse is that these problems stubbornly resist education. In one particularly pertinent pilot study, New York state engaged in heroic efforts to educate patients on plan choice (including individual enrollment meetings, brochures, videotapes, question-and-answer sessions and required educational seminars), yet when tested less than 30% of Brooklyn respondents understood that their plans covered out-of-area emergency care and less than 42% of all New Yorkers understood that their plans limited hospital choice. The introduction of more complex plans into the market will only exacerbate these problems by adding multiplicative layers of complexity--for every service the patient now has to evaluate the quality of physicians selected by the insurer, the effect on med-mal recovery, the size of the reward/punishment for foreign/domestic provider choice, etc.

One factor pushing the other way is that patients using insurer-prompted medical tourism may face somewhat lower civil-procedural hurdles in suits against the foreign providers when compared to uninsured medical tourists. This is because the requirements of some states' long arms and the Constitution for personal jurisdiction are more likely (though still far from certain) to be satisfied as against these providers due to their ongoing business relationships with insurers in the state. Nevertheless, many of the other procedural hurdles discussed will persist.

All that I have said so far establishes why insurer-prompted medical tourism is of great concern as to those who purchase health insurance in the individual market. But only a small portion of Americans--9.1% of the population, or nearly 27 million people according to 2005 estimates -actually get health-insurance coverage that way. Instead, most insurance choice by individuals is mediated through the employer. Employer-sponsored healthcare in the United States is popular in part because employers can take advantage of economies of scale in negotiating for

and administering health insurance and because of the favorable tax treatment--the employer can deduct the cost of health insurance it provides from its own income-tax base and payroll-tax obligations, and the benefits of the health insurance are excluded from the income of employees as well as from the employee's payroll-tax obligations for Social Security and Medicare contributions.

But employer-sponsored health insurance also puts the employer in control of many critical decisions, including whether to offer a plan at all, the scope of the plan's coverage, the healthcare provider networks to use, the level of premiums to be paid by employees, and the deductibles and co-payments that the plan will have. In our context, the decisions as to whether plans of various types are made available to the employees in the first place are predetermined by the employer. Thus, many patients may not be choosing a plan they would choose on their own (subject to all the information and bounded rationality constraints discussed above).

Thus, it would seem, even more so than as to health insurance purchased in the individual market, the consumer-sovereignty argument against choice-restricting regulation cannot be satisfied because its precondition that the consumer be the one choosing is not met. This would suggest that in the realm of insurer-prompted medical tourism, more stringent regulation of the employer-sponsored health-insurance market as compared to the individual market is in order.

Against that conclusion, one might offer two objections. First, the employee-employer agency relationship might somewhat mitigate the concerns discussed earlier about the insurer-insured agency problem and information overload from plan complexity. Employers are better positioned to evaluate these very complex plans in selecting what to offer their employees. Moreover, if employees stick with an employer longer than they do an insurer (only 38.5% of the 16.6% of yearly switching, or 6.3% of all insurance switching, also involves a change in employer), the employer may have an incentive to pick high quality providers because employers bear the cost of poor treatment choices in the form of prolonged absences or reduced productivity, although that conclusion is not certain. Further, even if employers do internalize to some extent the costs of poor care for their employees in this way, they will internalize the costs of poor care for the employee's family who is often covered by the same plan in a more attenuated fashion, if at all.

This response to the problem would be stronger if, as healthcare economists like Patricia Danzon have suggested, "economic theory and evidence indicate that, at least as a first approximation, employees ultimately bear the costs of employer-sponsored plans--including the costs of liability--through lower wages or higher premium contributions" such that "the implication is that the level and structure of health benefits reflect employee preferences" making employers "largely intermediaries." That is, given certain assumptions about competition in the labor market, employees will receive higher wages from employers with less desirable plans as compensation.

A second related rejoinder draws on the wide latitude offered to employers to predetermine which plans to offer in our status-quo system; that is, why worry about this comparably small decision

(where services are provided) given the large number of decisions the employer is empowered under current law to make in selecting the insurance it will provide? Except for in the very few states that currently have enacted "pay or play" legislation, employers can refuse to provide health insurance altogether. Further, except for the particular services covered by the mandated-benefit state laws discussed above, employers also retain the power to determine whether to offer plans that cover particular services or not. Given the greater power the law provides employers not to provide any health insurance or cover particular services, why should it not provide them the lesser power to determine where services will be offered?

These are powerful points, and there is something there, but they are not completely persuasive. One might respond that these broad employer powers are not justified and thus form a poor touchstone as normative guides, or that they are the result of historical contingencies behind our healthcare system, or that the new healthcare reform does away with some of that discretion. All this may be right, but for present purposes I want to emphasize a different response that unites the two rejoinders: while it is plausible that employees can adequately detect and assess the failure to provide coverage altogether (or perhaps even the failure to cover particular services) when assessing employers and the wages offered in a competitive market, it seems less plausible that they can adequately assess the benefits and costs of the medical-tourism piece of these plans, especially given the bounded-rationality problems discussed above.

SPIL, Mumbai : In your article- Circumvention Tourism, you distinguish between a person seeking say, an abortion from another seeking usage of some reproductive technology. What is the rationale behind such a distinction when it comes to applying criminal prohibitions of the home country?

Prof. Cohen : I argue that as a normative matter a home country is most justified in making extraterritorial its criminal prohibition when there is a "double coincidence of citizenship," when the "victim" and "perpetrator" are both domiciliary and citizens of the home country, and when the harm the government seeks to prohibit is serious bodily injury or death. These conditions, I suggest, are arguably met for abortion in that most home countries that criminalize abortion do so on the view that fetuses are persons or person-like and that the state has a justified role in preventing harms to them by criminalizing abortion. There is a debate about whether the fetus "victim" for a country that criminalizes abortion at home should be thought of as a citizen of that country, which is tricky since the fetus is not yet born, though I think the argument is still strong even if one does not think of the fetus as a citizen of its parent's home country but is instead treated as something more like a stateless individual.

In the Circumvention Tourism article I make clear that reproductive technology is quite different in this regard for two reasons:

First, by criminalizing a particular reproductive technology practice domestically--artificial insemination by donor, IVF, commercial surrogacy (gestational or traditional), noncommercial surrogacy (gestational or traditional), or many others--the home country might have multiple

divergent and sometimes over determined justifications. Second, we lack the double coincidence of citizenship in that, on some of these justifications, the "victim" is a citizen of the destination country. Together, these differences suggest that for some underlying justifications for the domestic prohibition, the home country does not have good reason to extra territorialize its prohibition to cover circumvention tourism.

SPIL, Mumbai : What poses a greater challenge to medical tourism: ethics or regulations?

Prof. Cohen : I do not think of these so much as challenges but as solutions to the problem. Currently the medical tourism industry is very unregulated. I see regulation as important to ensure that ethical and legal concerns we have with the industry are minimized, and allow the emergence and growth of the industry in a way that does not sacrifice ethics.