

Medical Tourism, Access to Health Care, and Global Justice

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Medical tourism – the travel of patients from one (the “home”) country to another (the “destination”) country for medical treatment – represents a growing business. A number of authors have raised the concern that medical tourism reduces access to health care for the destination country’s poor and suggested that home country governments or international bodies have obligations to curb medical tourism or mitigate its negative effects when they occur.

This article is the first to comprehensively examine both the question of whether this negative effect on access to health care occurs for the destination country’s poor, and the normative question of the home country and international bodies’ obligations if it does occur. I draw on the work of leading theorists from the Statist, Cosmopolitan, and Intermediate camps on Global Justice and apply it to medical tourism. I also show how the application of these theories to medical tourism highlights areas in which these theories are underspecified and suggests diverging paths for filling in lacunae. Finally, I discuss the kinds of home country, destination country, and multilateral forms of regulation this analysis would support and reject.

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- I. PREFACE
 - II. INTRODUCTION
 - III. KINDS OF MEDICAL TOURISM, KINDS OF ETHICAL CONCERNS
 - IV. THE EMPIRICAL CLAIM
 - V. THE NORMATIVE QUESTION
 - A. Self-Interest
 - B. Cosmopolitan Theories
 - C. Statist Theories
 - D. Intermediate Theories
 - 1. Cohen, Sabel & Daniels
 - 2. Pogge
 - VI. CONVERGENCE, DIVERGENCE & POLICY PRESCRIPTIONS
 - VII. CONCLUSION: FROM MEDICAL TOURISM TO HEALTH CARE GLOBALIZATION
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I. Preface

When the editors of the *Canadian Journal of Comparative and Contemporary Law* approached me about republishing my article *Medical Tourism, Access to Health Care, and Global Justice* to share with a Canadian audience, I welcomed the opportunity to add this short preface that would allow me to focus on developments since I published the original text.

Turner, and Mark Wu for comments on earlier drafts. For their comments, I also thank participants at the Harvard Law School/Program on Ethics and Health Population-Level Bioethics Reading Group on January 6, 2011, the International Conference on Ethical Issues in Medical Tourism at Simon Fraser University on June 25, 2010, and at the Health Law Scholars Workshop of the American Society for Law, Medicine & Ethics and the St. Louis University School of Law Center for Health Law Studies on September 12, 2009. Excellent research assistance was provided by Russell Kornblith, Katherine Kraschel, and Teel Lidow. Originally published in the *Virginia Journal of International Law*: Glenn Cohen, "Medical Tourism, Access to Health Care, and Global Justice" (2011) 52:1 *Va J Int'l L* 1. Reproduced with permission. Copyright © 2011 Virginia Journal of International Law Association; I Glenn Cohen.

The first development is conceptual, and relates to dialogue about my work led by excellent colleagues in Canada. I will focus on three.

First, in their thoughtful paper in the *Journal of Law, Medicine, and Ethics*, commenting on my own prior work on this subject, YY Brandon Chen and Colleen Flood (of the University of Toronto) suggest that in this paper, I have been wrong in the questions that I focus on:

[W]e argue that there is an *a priori* bias embedded in how Cohen (and other commentators) has framed the problématique of medical tourism ... [In Cohen and other commentators' writing,] the burden appears to rest on opponents of medical tourism to prove its negative consequences on LMICs' [low- and middle-income countries'] health care access before regulatory actions may be considered. In contrast, we argue in this paper that the evidentiary burden should be reversed. We contend that even when access to health care in LMICs is not adversely affected by medical tourism, there are still equity-related concerns that in and of themselves render medical tourism normatively problematic. As we discuss further below, this inequity can (and often does) arise, for example, when access to primary and preventive health services for the general LMIC populations maintains the inadequate *status quo* while medical tourists from well-resourced developed countries are afforded cutting-edge secondary and tertiary care. If equity is considered a relevant goal for health care systems and one accepts our conclusion that medical tourism in LMICs will likely have deleterious equity impacts, then the burden should be borne by medical tourism's proponents to demonstrate its benefits on health care access and to justify why some degree of government regulation is inappropriate.¹

Though I am not sure I completely agree with their read of my work, Flood and Chen usefully press me to be clearer that there are three distinct versions of the empirical question that will tie into various potential approaches to global justice: (1) Are there disparities in access to health care for the general population between destination countries in the developing world and home countries in the developed world (call this the *equity* question)?; (2) Do we have evidence that medical tourism causes deficits or worsens inequities, or, at the very least, is it associated with deficits or worsening inequities in access by home country citizens to health care (call this the *causation* question)?; (3) Irrespective of what

1. YY Brandon Chen & Colleen M Flood, "Medical Tourism's Impact on Health Care Equity and Access in Low-and Middle-Income Countries: Making the Case for Regulation" (2013) 41:1 *JL Med & Ethics* 286 at 287-88.

caused the deficits, would regulation of medical tourism reduce these deficits or inequities (call this the *redressability* question)?

Chen and Flood assert that “even when access to health care in LMICs is not adversely affected by medical tourism, there are still equity-related concerns that in and of themselves render medical tourism normatively problematic,”² suggesting a focus on only the equity question. But later, they say: “[i]f equity is considered a relevant goal for health care systems and one accepts our conclusion that medical tourism in LMICs *will likely have deleterious equity impacts*.”³ Those last words suggest that the causation question, or at least the redressability question, is what matters to them after all.

In any event, Chen and Flood helpfully press me to say what I think the empirical evidence, they and others have produced, can and cannot do. The *equity* question, as such, is *not* my concern in this article or my larger project. The empirical answer to that question is easy: it is beyond cavil that there are deep disparities in health care access between developed and developing countries, as there are to accessing many good things that make a life go well. For those whom the existence of such disparity, whatever its cause and whether or not regulating medical tourism will ameliorate matters, is enough to motivate an obligation to render aid, empirical evidence is largely beside the point.

By contrast, I am interested in the *causation* question. To the extent medical tourism causes (or at least is associated with) these diminutions in health care access and thus worsens inequities, then it is easier to build a moral case for intervention.⁴ And, even if medical tourism does not

2. Chen & Flood, *ibid* at 287.

3. *Ibid* at 288 [emphasis added].

4. What if medical tourism did not worsen the health care for the destination country poor, or in fact improved it, but also increased disparities since the wealthy benefitted even more? That is, both the worse and best off are made better off, but not equivalently. For true pure egalitarians, who believe inequality is bad, that would be a problem, but of course that view has some well-accepted problems relating to leveling down. For prioritarians, the pertinent question is whether the worse-off are made better off, and whether they are made as better-off as they might be compared to other feasible regulatory re-arrangements. I am more drawn to the latter view, and so I focus on whether medical tourism “causes deficits” or “fails to improve” the health care of the destination

cause the negative effects, for some theories of global justice, it may still be important that regulations of the industry can *redress* health inequities. Thus, in this article, I review empirical data suggesting that medical tourism causes (or is at least associated with) diminutions in health care access, as well as data suggesting regulation of the sector might ameliorate health inequities. I do not focus on the existence of general health inequities that are unconnected to medical tourism.

The second development is just to note that there has been additional empirical evidence offered about some of the negative effects of medical tourism.⁵ I discuss some of this new evidence in greater depth in my new book *Patients With Passports: Medical Tourism, Law, and Ethics*.⁶ That said, as I suggest in my article, the evidence is still patchy and any assessment can only be made country-by-country and indeed practice-by-practice.

The third thing I want to add is to emphasize some aspects of the Canadian context in the analysis. In Canada we have two separate potential pools of medical tourists – those who are traveling out of country with the support of the Canadian health care system, and those paying out-of-pocket to go. The latter group is well covered in the original article. The former group is worth further attention. In accord with the *Canada Health Act*,⁷ each of the Canadian provincial and territorial health care

country poor, not on whether it worsens inequality per se. For those who are more attracted to purer egalitarian views, much of what I say in this chapter can be re-analyzed under that standard.

5. See Chen & Flood, *supra* note 1; Matthias Helble, “The Movements of Patients Across Borders: Challenges and Opportunities for Public Health” (2011) 89:1 Bulletin of the World Health Organization 68, online: World Health Organization <<http://www.who.int/bulletin/volumes/89/1/10-076612/en/>>; Jeremy Snyder et al, “Caring for Non-Residents in Barbados: Examining the Implications of Inbound Transnational Medical Care for Public and Private Health Care” in David Boterrill, Guido Pennings & Tomas Mainil, eds, *Medical Tourism and Transnational Health Care* (Hampshire: Palgrave Macmillan, 2013) 48 at 51; Jeremy Snyder et al, “Beyond Sun, Sand, and Stitches: Assigning Responsibility for the Harms of Medical Tourism” (2013) 27:5 Bioethics 233 at 234; Zahra Meghani, “A Robust, Particularist Ethical Assessment of Medical Tourism” (2011) 11:1 Developing World Bioethics 16 at 28.
6. I Glenn Cohen, *Patients With Passports: Medical Tourism, Law, and Ethics* (New York: Oxford University Press, 2014).
7. RSC 1985, c C-6.

plans must reimburse for out-of-country care in emergency situations.⁸ Strictly speaking, this is not medical tourism as I defined it, but medical care coincident with tourism or other travel. However, the Canadian provinces *also* all fund patients who travel abroad for health care and are *sent* there by the provincial health plans.

As Runnels and Packer note:

Depending on the patient's specific situation and the province/territory, some or all of the costs of OOCC will be covered under provincial/territorial health insurance plans, determined by a process designed to ascertain that the patient meets the conditions for OOCC. These criteria for eligibility are generally similar in all provinces and territories, and are as follows:

- the treatment or care must be medically required;
- the medical or hospital service must be demonstrated to be unavailable in the province/territory and/or elsewhere in Canada; that is, "if all Canadian medical resources have been exhausted";
- the delay in the provision of medical care available in the province/territory or elsewhere in Canada must be considered to be immediately life threatening or may result in medically significant irreversible tissue damage;
- the treatment must fall under insured medical, oral surgeries and/or hospital services; and,
- the applicant must be a resident of the province/territory.⁹

There are also some variations between the provinces, for example, Manitoba will cover some transportation costs while most of the other

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8. See Vivien Runnels & Corinne Packer, "Travelling for Healthcare from Canada: An Overview of Out-of-Country Care Funded by Provincial/Territorial Health Insurance Plans" in Ronald Labonté et al, eds, *Travelling Well: Essays in Medical Tourism* (2013) 4:1 Transdisciplinary Studies in Population Health Series 133 at 135-37, online: University of Ottawa <<https://www.ruor.uottawa.ca/bitstream/10393/23788/1/Travelling%20Well-%20Essays%20in%20MedicalTourism.pdf>>; Canadian Institute for Health Information, *Have Health Card, Will Travel: Out-of-Province/-Territory Patients* (Canada: CIHI, 2010) online: Analysis in Brief <https://secure.cihi.ca/free_products/out_of_province_aib_201003_e.pdf>.
 9. Runnels & Packer, *ibid* at 136-37, citing Manitoba Health, *Out-of-Province Medical Referrals*, online: Province of Manitoba <<http://www.gov.mb.ca/health/mhsip/oop.html>>; British Columbia Medical Services Commission, *Out of Province and Out of Country Medical Care Guidelines* (Canada: Medical Services Commission, 2011) online: Government of British Columbia <http://www.health.gov.bc.ca/msp/infoben/ooc_funding_guidelines.pdf>.

provinces do not.¹⁰ Each of the provinces has a process for review of requests, approval or disapproval, and ultimately appeal. To take the example of Ontario:

[A] family physician (general practitioner) must take the first steps towards determining need with the patient. The family physician initiates the request for approval, and is required to refer a patient to a specialist physician or an assessment centre within Ontario for assessment. Only after the specialist physician has seen the patient and judged that the care needed cannot be obtained within the province does the specialist write an application for funding for out-of-country health services to the provincial health authority. The referring physician and a specialist must both complete and sign the application form, along with the patient or his/her representative who has power of attorney. The form must be accompanied by relevant documentation, such as clinical reports and lab test results ...

Information must be provided on the case and explanations given as to why OOCC is needed. The Ministry of Health reviews the application, and must approve it before treatment is obtained abroad, otherwise costs will not be reimbursed. In other words, not only must eligibility be established, but a patient must be pre-approved for OOCC by the provincial ministry of health if the costs of the healthcare are to be borne by the province. This process adds to the waiting time as the patient waits to be seen by a specialist who may refer the patient to yet another specialist within the province who is either able to offer the treatment or surgery or will recommend OOCC.

Health services and treatments which have been approved by out-of-country prior approval programs in different provinces and territories have included cancer treatment, diagnostic testing, high-risk bariatric surgery, residential treatment (such as for psychiatric disorders, eating disorders or substance abuse), neurosurgery, spinal surgery, and pregnancy complications.¹¹

When an application is denied, the patient may appeal that denial directly to the Ministry or to the province's Health Services Appeal and Review Board, a quasi-independent tribunal that holds public hearings as part of its adjudication.¹²

While this form of reimbursed medical tourism was not designed specifically to deal with waiting lists in Canadian provinces, it has been used for that purpose.¹³

10. Runnels & Packer, *ibid.*

11. *Ibid* at 138.

12. Runnels & Packer, *supra* note 8 at 139.

13. *Ibid* at 140.

These facts are relevant for my analysis, as I argue below that home countries have particularly strong moral obligations for government-prompted medical tourism. Especially where, as it appears, Canada does not merely passively support its citizens going abroad through reimbursing their care, but may also *cause* their need to go abroad in the first place based on funding decisions relating to health care availability domestically, its duties may be higher. These duties may entail sending Canadian patients only to foreign facilities that have taken steps to mitigate and/or ameliorate the negative impacts of medical tourism on health care for their domestic poor, paying subsidies to the local communities whose interests they may be stymieing.

II. Introduction

Medical tourism – the travel of patients who are residents of one country (the “home country”) to another country for medical treatment (the “destination country”) – represents a growing and important business. For example, by one estimate, in 2004, more than 150,000 foreigners sought medical treatment in India, a number that is projected to increase by fifteen percent annually for the next several years.¹⁴ Malaysia saw 130,000 foreign patients in the same year.¹⁵ In 2005, Bumrungrad International Hospital in Bangkok, Thailand, alone saw 400,000 foreign patients, 55,000 of whom were American (although these numbers are contested).¹⁶ By offering surgeries such as hip and heart valve replacements at savings of more than eighty percent from that which one would pay out-of-pocket in the United States, medical tourism has enabled underinsured and uninsured Americans to secure otherwise unaffordable health care.¹⁷ The title of a recent Senate hearing – “The

14. Glenn Cohen, “Protecting Patients with Passports: Medical Tourism and the Patient-Protective Argument” (2010) 95:5 Iowa L Rev 1467 at 1472 [Cohen, “Protecting Patients”].

15. *Ibid.*

16. *Ibid.*

17. See *e.g. ibid* at 1476-88, citing Arnold Milstein & Mark Smith, “Will the Surgical World Become Flat?” (2007) 26:1 Health Affairs 137 at 137, 139-40; US, *The Globalization of Health Care: Can Medical Tourism Reduce Health Care Costs?: Hearing Before the Special Committee on Aging*,

Globalization of Health Care: Can Medical Tourism Reduce Health Care Costs?” – captures the promise of medical tourism.¹⁸ US insurers and self-insured businesses have also made attempts to build medical tourism into health insurance plans offered in the United States, and states like West Virginia have considered incentivizing their public employees to use medical tourism.¹⁹ There have even been calls for Medicaid and Medicare to incentivize medical tourism for their covered populations.²⁰

Although hardly new, in recent years, the dramatic increase in the scope of the industry and the increasing involvement of US citizens as medical tourists to developing countries have made pressing a number of legal and ethical issues.²¹ While the growth of medical tourism has

109th Cong (Washington, DC: United States Government Printing Office, 2006) at 18 (Dr Arnold Milstein), online: US Government Information <<http://www.gpo.gov/fdsys/pkg/CHRG-109shrg30618/pdf/CHRG-109shrg30618.pdf>> [*The Globalization of Health Care*]; Devon M Herrick, “Medical Tourism: Global Competition in Health Care” (2007) NCPA Pol’y Rep 304 (November 2007) at 11 table 1, online: National Center for Policy Analysis <<http://www.ncpa.org/pdfs/st304.pdf>>, relying on data from Unmesh Kher, “Outsourcing Your Heart”, *Time* (21 May 2006) 44.

18. *The Globalization of Health Care*, *ibid* at 1.
19. See Cohen, “Protecting Patients”, *supra* note 14 at 1473, citing US, HB 4359, 77th Leg, 2d Spec Sess, W Va, 2006; Joe Cochrane, “Medical Meccas”, *Newsweek* (30 October 2006) 1; Mark Roth, “Surgery Abroad an Option for Those with Minimal Health Coverage”, *Post Gazette* (10 September 2006) online: Post Gazette <<http://www.post-gazette.com/life/travel/2006/09/10/Surgery-abroad-an-option-for-those-with-minimal-health-coverage/stories/200609100214>>.
20. See Cohen, “Protecting Patients”, *ibid* at 1473-74; Dean Baker & Hye Jin Rho, “Free Trade in Health Care: The Gains from Globalized Medicare and Medicaid” (2009) online: Center for Economic Policy and Research <<http://www.cepr.net/documents/publications/free-trade-hc-2009-09.pdf>>.
21. In some senses, medical tourism is a very old phenomenon. Ancient Greeks traveled to spas known as asklepiea in the Mediterranean for purification and spiritual healing, and for over two thousand years, foreign patients have traveled to the Aquae Sulis reservoir built by the Romans in what is now the British town of Bath. See Kerrie S Howze, “Note, Medical Tourism: Symptom or Cure?” (2007) 41:3 Ga L Rev 1013 at 1015-16; Anne Cearley & Penni Crabtree, “Alternative-Medicine Clinics in Baja Have History of Controversy”, *San Diego Union Tribune* (1 February 2006) A8. Moreover, in the United States, our most outstanding

represented a boon (although not an unqualified one)²² for US patients, what about the interests of those in the destination countries? From their perspective, medical tourism presents a host of cruel ironies. Vast medico-industrial complexes, replete with the newest expensive technologies to provide comparatively wealthy medical tourists hip replacements and facelifts, coexist with large swaths of the population dying from malaria, AIDS, and lack of basic sanitation and clean water. A recent New York Times article entitled “Royal Care for Some of India’s Patients, Neglect for Others,” for example, begins by describing the care given at Wockhardt Hospital in India to “Mr. Steeles, 60, a car dealer from Daphne, Ala., [who] had flown halfway around the world last month to save his heart [through a mitral valve repair] at a price he could pay.”²³ The article describes in great detail the dietician who selects Mr. Steeles’ meals, the dermatologist who comes as soon as he mentions an itch, and Mr. Steeles’ “Royal Suite” with “cable TV, a computer, [and] a mini-refrigerator, where an attendant that afternoon stashed some ice cream, for when he felt hungry later.”²⁴ This treatment contrasts with the care given to a group of “day laborers who laid bricks and mixed cement for Bangalore’s construction boom,” many of whom “fell ill after drinking illegally brewed whisky; 150 died that day.”²⁵ “Not for them [was] the care of India’s best private hospitals,” writes the article’s author; “[t]hey had been wheeled in by wives and brothers to the overstretched government-

facilities like the Mayo Clinic have long attracted medical tourists, and Middle Eastern patients, for example, have also sought care in other developed-world medical hubs, such as London.

22. As I have discussed elsewhere, medical tourism presents concerns regarding disparities in quality of care and medical malpractice recovery. See generally Cohen, “Protecting Patients”, *supra* note 14 (reviewing the risks of malpractice and care quality created by medical tourism and proposing regulations to protect patients). It is also uncertain whether the recently enacted health care reform, if fully implemented, will blunt some of the motivation to go abroad of US medical tourists currently paying out of pocket (since more will be insured), as well as whether it will result in more insurer-prompted medical tourism. See Howze, *ibid* at 1525-26, 1542-43.
23. Somini Sengupta, “Royal Care for Some of India’s Patients, Neglect for Others”, *New York Times* (1 June 2008) K3.
24. *Ibid.*
25. *Ibid.*

run Bowring Hospital, on the other side of town,” a hospital with “no intensive care unit, no ventilators, no dialysis machine,” where “[d]inner was a stack of white bread, on which a healthy cockroach crawled.”²⁶

These kinds of stark disparities have prompted intuitive discomfort and critiques in the academic and policy literatures. For example, David Benavides, a Senior Economic Affairs Officer working on trade for the United Nations, has noted that developed and developing countries’ attempts at exporting health services sometimes come “at the expense of the national health system, and the local population has suffered instead of benefiting from those exports.”²⁷ Rupa Chanda, an Indian professor of business, writes in the World Health Organization Bulletin that medical tourism threatens to “result in a dual market structure, by creating a higher-quality, expensive segment that caters to wealthy nationals and foreigners, and a much lower-quality, resource-constrained segment catering to the poor.”²⁸ While the “[a]vailability of services, including physicians and other trained personnel, as well as the availability of beds may rise in the higher-standard centres,” it may come “at the expense of the public sector, resulting in a crowding out of the local population.”²⁹ Similarly, Professor Leigh Turner suggests that “the greatest risk for inhabitants of destination countries is that increased volume

26. *Ibid.*

27. David Diaz Benavides, “Trade Policies and Export of Health Services: A Development Perspective” in Nick Drager & Cesar Vieira, eds, *Trade in Health Services: Global, Regional, and Country Perspectives* (Washington, DC: Pan American Health Organization Program on Public Policy and Health, 2002) 35 at 39, online: World Health Organization <<http://www.who.int/trade/resource/THS/en/>>.

28. Rupa Chanda, “Trade in Health Services” in Nick Drager & Cesar Vieira, eds, *Trade in Health Services: Global, Regional, and Country Perspectives* (Washington, DC: Pan American Health Organization Program on Public Policy and Health, 2002) 158 at 160, online: World Health Organization <<http://www.who.int/trade/resource/THS/en/>>.

29. *Ibid.*; see also Milica Z Bookman & Karla K Bookman, *Medical Tourism in Developing Countries* (New York: Palgrave MacMillan, 2007) (“[m]edical Tourism can thus create a dual market structure in which one segment is of higher quality and caters to the wealthy foreigners (and local high-income patients) while a lower quality segment caters to the poor ... [such that] health for the local population is crowded out as the best doctors, machines, beds, and hospitals are lured away from the local poor” at 176).

of international patients will have adverse effects upon local patients, health care facilities and economies.”³⁰ He explains that the kinds of investments destination-country governments must make to compete are in “specialized medical centres and advanced biotechnologies” unlikely to be accessed by “most citizens of a country [who] lack access to basic health care and social services.”³¹ Furthermore, higher wages for health care professionals resulting from medical tourism may crowd out access by the domestic poor.³² Thus, “[i]nstead of contributing to broad social and economic development, the provision of care to patients from other countries might exacerbate existing inequalities and further polarize the richest and poorest members” of the destination country.³³

The same point has also been made in several regional discussions: Janjaroen and Supakankunti argue that in Thailand, medical tourism threatens to both disrupt the ratio of health personnel to the domestic population and “create a two-tier system with the better quality services reserved for foreign clients with a higher ability to pay.”³⁴ Similarly, the Bookmans claim that in Cuba, “only one-fourth of the beds in CIREN (the International Center for Neurological Restoration in Havana) are filled by Cubans, and ... so-called dollar pharmacies provide a broader range of medicines to Westerners who pay in foreign currency.”³⁵ They describe a medical system so distorted by the effects of medical tourism as “medical apartheid, because it makes health care available to foreigners that is not available to locals.”³⁶ Numerous authors have made similar

30. Leigh Turner, “First World Health Care at Third World Prices’: Globalization, Bioethics and Medical Tourism” (2007) 2 *Biosocieties* 303 at 320.

31. *Ibid.*

32. *Ibid.*

33. *Ibid.* at 321.

34. Watatana S Janjaroen & Siripen Supakankunti, “International Trade in Health Services in the Millennium: The Case of Thailand” in Nick Drager & Cesar Vieira, eds, *Trade in Health Services: Global, Regional, and Country Perspectives* (Washington, DC: Pan American Health Organization Program on Public Policy and Health, 2002) 87 at 98, online: World Health Organization <<http://www.who.int/trade/resource/THS/en/>>.

35. Bookman & Bookman, *supra* note 29 at 177.

36. *Ibid.*

claims about medical tourism in India.³⁷ Similar concerns have even been raised as to medical tourism in developed countries. For example, an investigation by the Israeli newspaper Haaretz concluded, “medical tourists enjoy conditions Israelis can only dream of, including very short waiting times for procedures, the right to choose their own doctor and private rooms ... [a]nd these benefits may well be coming at the expense of Israeli patients’ care.” The investigation also suggested that allowing medical tourists to move to the front of the line on waiting lists for services meant that “waiting times for ordinary Israelis will inevitably lengthen – especially in the departments most frequented by medical tourists, which include the cancer, cardiac and in vitro fertilization units.”³⁸

Behind all of these claims – scholarly and popular – are some significant and interesting fundamental questions. How likely is medical tourism to produce negative consequences on health care access in Less Developed Countries?³⁹ If those effects occur, does the United States (or other Western countries or international bodies) have an obligation to discourage or regulate medical tourism to try to prevent such

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37. See *e.g.* Ami Sen Gupta, “Medical Tourism in India: Winners and Losers” (2008) 5:1 *Indian Journal of Medical Ethics* 4-5; Laura Hopkins et al, “Medical Tourism Today: What is the State of Existing Knowledge?” (2010) 31:2 *Journal of Public Health Policy* 185 at 194; Rory Johnston et al, “What is Known About the Effects of Medical Tourism in Destination and Departure Countries? A Scoping Review” (2010) 9:24 *International Journal for Equity in Health* 1.
38. Dan Even & Maya Zinshtein, “Haaretz Probe: Israel Gives Medical Tourists Perks Denied to Citizens”, *Haaretz* (18 November 2010) online: Haaretz.com <<http://www.haaretz.com/print-edition/news/haaretz-probe-israel-gives-medical-tourists-perks-denied-to-citizens-1.325275>>.
39. Of course, as a growing literature emphasizes, it is a mistake to fetishize health care in normative analysis instead of health, which may depend more on sanitation, housing, and social determinants than on medical services. See Norman Daniels, *Just Health* (New York: Cambridge University Press, 2008) at 79-102; Michael Marmot et al, “Contributions of Psychosocial Factors to Socioeconomic Differences in Health” (1998) 76:3 *Milbank Quarterly* 403 at 434. Although conscious of this issue, I will for the most part focus on health care access because this is the main margin in which medical tourism has been predicted to have negative effects, while acknowledging that it is the negative effects on health stemming from these diminutions in health care access that motivate the concern.

consequences? How might governments do so?

I examine those questions in this article, the first in-depth treatment focusing on the normative question of home countries' obligations.⁴⁰ In so doing, I draw on international development work on health systems and globalization, political philosophy work on international justice, and a more embryonic applied literature on the normative aspects of drug access and pricing in the developing world. While my focus is on medical tourism, this article also aims to further flesh out the intersection of health inequalities, trade, and Global Justice obligations.

I hope the analysis developed here will serve as a template for discussion of similar problems in the globalization of health care, including medical migration (that is, "brain drain"). Indeed, I see this work as a dialogue between the theory and its application. On the one hand, political theories on Global Justice can help us better understand our obligations regarding medical tourism. On the other hand, while our intuitions might suggest that some of these theories lead to predictable positions on medical tourism, their actual application to the case of medical tourism yields surprising results and unforeseen complexities, highlights areas in which the theories are underspecified, and suggests diverging paths for filling in *lacunae*. Thus, these theories of Global Justice cannot only teach us something about the concrete case of medical tourism, but medical tourism can also teach us something about these theories as applied to globalization.

More specifically, I begin in Part III by describing and distinguishing medical tourism by individuals purchasing care out-of-pocket from those whose use is prompted by insurers and governments. I then distinguish concerns about medical tourism's effect on health care access in the destination country – the focus of this article – from other concerns with

40. My focus in this article is on the obligations of home country governments and international bodies. Some of what I say may have implications for the obligations of two other groups: individual tourist patients and corporations involved in (or who incentive their covered populations to use) medical tourism, and I noted the instances where I see that relevance (*e.g.* in Nussbaum and Daniels' work). Translating ideas from political philosophy into the realms of moral philosophy or corporate social responsibility, however, is no easy task, and I make no pretension of fully doing so here.

medical tourism that I and others have discussed elsewhere. I unpack this concern as encompassing an empirical claim and a normative claim, which I examine in turn.

I begin with the empirical claim in Part IV, where I show that despite the expressions of concern of several prominent scholars and policymakers, there currently exists little empirical evidence that suggests medical tourism has adverse effects on health care access in destination countries. Nevertheless, both as a grounding for what follows and as an attempt to help formulate an empirical research project, I discuss six possible triggering conditions through which we would expect medical tourism to reduce access for the poor in destination countries.

In Part V, the heart of the paper, I turn to the normative claim and ask: assuming *arguendo* that medical tourism reduces health care access in destination countries for local populations (the empirical claim), under what conditions should such a reduction trigger obligations on the part of home countries and international bodies to regulate medical tourism or mitigate its negative effects? I demonstrate why arguments appealing to national self-interest in order to restrict medical tourism fail. I then examine three broad camps of Global Justice theory (Cosmopolitan, Statist, and Intermediate) and analyze whether they can be applied to medical tourism as grounds for these obligations.

Part VI examines how much of an overlapping consensus and divergence exists between the prescriptions of the theories in these rival camps, drawing some distinctions between kinds of medical tourism. I also discuss ways in which policymakers can use domestic and international law to translate ethical theory into reality.

A conclusion summarizes and charts some implications of my analysis for health care globalization more generally.

III. Kinds of Medical Tourism, Kinds of Ethical Concerns

Medical tourism is one part of a larger move toward the globalization of health care, a globalization that encompasses, among other things, medical migration (the brain drain), medical outsourcing (such as teleradiology), research tourism (where US-based pharmaceutical companies perform

clinical trials abroad), and the parallel trade in approved pharmaceuticals (such as purchasing drugs from Canada). At a high level, medical tourism falls into three types, each of which raises ethical questions I have outlined elsewhere: (1) medical tourism for services that are illegal in both the patient's home and destination countries (such as organ purchase in the Philippines); (2) medical tourism for services that are illegal or unapproved in the patient's home country but legal in the destination country (such as fertility, euthanasia, experimental drug, and stem cell tourism); and (3) medical tourism for services legal in both the home and destination countries.⁴¹

In this article, I focus on the last category. I divide such medical tourism by patient population into three types, each relevant for the normative analysis that follows. The first is patients paying out-of-pocket. In the United States, this typically refers to uninsured or underinsured patients using medical tourism to achieve substantial cost savings for procedures like hip replacements.⁴² A second group consists of private-insurer-prompted medical tourism. In its weakest form, insurers simply cover the service abroad without any incentive, but in a more common form, Tourism-Incentivized plans offer individuals rebates, waived deductibles, or other payment incentives for receiving treatment abroad.⁴³ For example, a plan proposed by Hannaford Brothers Supermarkets in the northeastern United States gives employees incentives to seek treatment in Singapore at Joint Commission International (JCI)-accredited hospitals.⁴⁴ A final form is government-prompted medical tourism. For example, there have been recent proposals to give US Medicare and Medicaid patients incentives to use medical tourism (with estimates of USD \$18 billion in annual savings based on ten percent of the populace taking advantage of the incentives). Another version is already in place

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41. I Glenn Cohen, "Medical Tourism: The View from Ten Thousand Feet" (2010) Hastings Center Report 11 at 11-12 [Cohen, "Medical Tourism"].
 42. Cohen, "Protecting Patients", *supra* note 14 at 1479-81.
 43. *Ibid* at 1486-88, (discussing Tourism-Incentivized, Tourism-Mandatory, and Domestic-Extra possible configurations).
 44. *Ibid* at 1486, citing Bruce Einhorn, "Hannaford's Medical-Tourism Experiment", *Businessweek* (9 November 2008) online: Businessweek <<http://www.businessweek.com>>.

in the European Union, where member states face some obligations to reimburse their citizens for treatments received in other member states.⁴⁵

Medical tourism of any of these types raises a large number of ethical and legal concerns – concerns about protecting the tourist patient from poor quality of care; the *de facto* waiver of rights to medical malpractice compensation for any resulting medical error; the dynamic effects on health care provided at home (including the possibility of regulatory races to the bottom); and the structuring of fair health insurance plans.⁴⁶ In this article, I focus on a very different set of concerns: those pertaining to potential negative effects of medical tourism on health care access for the poor in the destination country.

IV. The Empirical Claim

While concerns about effects on health care access abroad are raised by academics and policymakers discussing medical tourism, they have thus far been under-theorized. These concerns are best thought of as consisting of an empirical claim – that medical tourism diminishes health care access in the destination country, usually with a focus on its effects on the poorest residents – and a normative one – that such diminished access creates obligations on the United States and other tourist patient home countries (or international bodies, or possibly corporations) to do something about medical tourism.⁴⁷

45. See *ibid* at 1488, citing *Watts v Bedford Primary Care Trust*, C-372/04 [2006] ECR I-04325; Nicolas P Terry, “Under-Regulated Health Care Phenomena in a Flat World: Medical Tourism and Outsourcing” (2007) 29:2 *W New Eng L Rev* 421 at 437. In 2011, the EU adopted a new directive on cross-border health care codifying some of this case law and altering and adding other elements. See *e.g.* Sophie Petjean, “Council Approves Compromise with Parliament”, *Europolitics* (10 February 2011) online: Europolitics <<http://europolitics.info/>>.

46. See generally Cohen, “Medical Tourism”, *supra* note 41 discussing these issues; Cohen, “Protecting Patients”, *supra* note 14 discussing similar issues; Nathan Cortez, “Recalibrating the Legal Risks of Cross-Border Health Care” (2010) 10:1 *Yale Journal of Health Policy, Law, and Ethics* 1.

47. This should be contrasted with a different claim that although medical tourism does not harm the interests of people in the destination country, in the sense that these individuals are just as or more well-off, all things

Although, as discussed, 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 access to health care for local 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

being considered, it could be designed in a way that could make them even better off or have fewer negative effects along with its positive ones. *C.f.* Seana Valentine Shiffrin, "Wrongful Life, Procreative Responsibility, and the Significance of Harm" (1999) 5:1 *Legal Theory* 117 (proposing a non-comparative model where "harm" and "benefit" are two separate things, and it is wrong to impose harm without consent in order to confer an even larger benefit).

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.⁴⁸ Thus, for example, Hopkins and her co-authors argue that this dynamic has taken place in Thailand, where “[a]lmost 6000 positions for medical practitioners in Thailand’s public system remained unfilled in 2005, as an increasing number of 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.”⁴⁹ 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.⁵⁰ 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

48. See Johnston et al, *supra* note 37 at 11.

49. Hopkins et al, *supra* note 37 at 194; see also Rupa Chinai & Rahul Goswami, “Medical Visas Mark Growth of Indian Medical Tourism” (2007) 85:3 Bulletin of the World Health Organization 164 (quoting Dr. Manuel Dayrit, Director, WHO’s Human Resources for Health Department, as saying, “[a]lthough there are no ready figures that can be cited from studies, initial observations suggest that medical tourism dampens external migration but worsens internal migration” at 165).

50. See Colleen M Flood, “Chaoulli’s Legacy for the Future of Canadian Health Care Policy” (2006) 44:2 Osgoode Hall LJ 273 (discussing evidence that “to the extent that prices are higher in the private sector and where specialists are free to do so, they will devote an increasing proportion of their time to private patients who are likely to have less acute or serious needs than those patients left behind in the public system” at 289); Colleen M Flood & Amanda Haugan, “Is Canada Odd? A Comparison of European and Canadian Approaches to Choice and Regulation of the Public/Private Divide in Health Care” (2005) 5:3 Health Economics, Policy and Law 319 at 320.

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 VI, 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.⁵¹

(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.⁵² 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

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51. See *e.g.* Gupta, *supra* note 37 (“[t]he government would have us believe that revenues earned by the industry will strengthen health care in the country. But we do not see any mechanism by which this can happen. On the contrary, corporate hospitals have repeatedly dishonoured the conditions for receiving government subsidies by refusing to treat poor patients free of cost – and they have got away without punishment. Moreover, reserving a few beds for the poor in elite institutions does not address the necessity to increase public investment in health to three to five times the present level” at 4-5); Johnston et al, *supra* note 37 at 5.
52. See Greg L Stoddart & Morris L Barer, “Will Increasing Medical School Enrollment Solve Canada’s Physician Supply Problems?” (1999) 161:8 *Canadian Medical Association Journal* 983; Abhaya Kamalakanthan & Sukhan Jackson, “The Supply of Doctors in Australia: Is There a Shortage?” University of Queensland, Discussion Paper No. 341 (2006) online: University of Queensland <http://espace.library.uq.edu.au/eserv.php?pid=UQ:8209&dsID=econ_dp_341_0506.pdf>.

to health care access abroad. For example, 61 percent of all graduates from the Ghana Medical School between 1986 and 1995 left Ghana for employment elsewhere (of those, 54.9 percent worked in the United Kingdom and 35.4 percent worked in the United States), and a 2005 study found that 25 percent of doctors in the United States are graduates of foreign medical schools.⁵³ A recent study of nurses in five countries found that 41 percent reported dissatisfaction with their jobs and one-third of those under age thirty planned on leaving to work elsewhere.⁵⁴ As Larry Gostin has put it, in the ordinary course of globalization, “[h]ealth care workers are ‘pushed’ from developing countries by the impoverished conditions: low remuneration, lack of equipment and drugs, and poor infrastructure and management,” and “[t]hey 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.”⁵⁵ 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.⁵⁶ Medical tourism may also enable the destination country to “recapture” some health care providers who left

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53. Fitzhugh Mullan, “The Metrics of The Physician Brain Drain” (2005) 353:17 *New Eng Journal of Medicine* 1810 at 1811; David Sanders et al, “Public Health in Africa” in Robert Beaglehole, ed, *Global Public Health: A New Era* (New York: Oxford University Press, 2003) 172. The cost to less developed countries and the benefit to the United States and other countries caused by the brain drain are staggering. A recent report suggested that it would have cost on average USD \$184,000 to treat each of the three million health care professionals who had migrated, such that richer nations saved \$552 billion, whereas poor nations lost \$500 million in training costs. Bookman & Bookman, *supra* note 29 at 106.
54. Linda H Aiken et al, “Nurses’ Reports on Hospital Care in Five Countries” (2001) 20:3 *Health Affairs* 43 at 45-46.
55. Lawrence O Gostin, “The International Migration and Recruitment of Nurses: Human Rights and Global Justice” (2008) 299:15 *Journal of the American Medical Association* 1827 at 1828.
56. See Matthias Helble, “The Movements of Patients Across Borders: Challenges and Opportunities for Public Health” (2011) 89:1 *Bulletin of the World Health Organization* 68 at 70 (discussing as-yet-unpublished data supporting this claim in Thailand).

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.⁵⁷ 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.⁵⁸ 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.⁵⁹ Unfortunately, such funding often comes from money devoted to other health programs, including basic health care and social services,⁶⁰ 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

57. For discussions of these possibilities in other contexts, see *e.g.* Ayelet Shachar, “The Race for Talent: Highly Skilled Migrants and Competitive Immigration Regimes” (2006) 81:1 NYUL Rev 148 at 168.

58. Bookman & Bookman, *supra* note 29 at 105-09.

59. *Ibid* at 65-82; Turner, *supra* note 30 at 314-15, 320.

60. See Benavides, *supra* note 27 at 55; Johnston et al, *supra* note 37 (“the hiring of physicians trained in public education systems by private medical tourism facilities is another example of a potentially inequitable use of public resources. Furthermore, physicians in [low and middle income countries] who might normally practice in resource-poor environments can instead treat high-paying international patients, thereby gaining access to advanced technologies and superior facilities while receiving a higher wage” at 5-6); Turner, *supra* note 30 at 320.

patient population.⁶¹ 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.⁶²

(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.⁶³ 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.⁶⁴ 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.

Notice, as it will become relevant in the normative analysis, that many of these triggering conditions are themselves in the control of the destination country government to some extent.

As I have said before, data on the effects of medical tourism on health care access in the destination country are scarce – in many cases, they rest on anecdote and speculation – and the analysis can only be done on a country-by-country basis, which is impossible, given the current paucity of data. In countries where the triggering conditions all obtain, one would expect medical tourism to cause some diminution in access to

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61. Nathan Cortez, “International Health Care Convergence: The Benefits and Burdens of Market-Driven Standardization” (2009) 26:3 *Wis Int’l LJ* 646.
 62. See *e.g.* Hopkins et al, *supra* note 37 (“[i]n India, medical professionals are trained in highly subsidized public facilities. The annual value of these public training subsidies to the private sector where many physicians eventually work is estimated at more than USD \$100 million, at least some of which accrues to the medical tourism industry. This diverts public funds that might otherwise have gone into improving public health care for the poor – to private care for more affluent individuals” at 194).
 63. Cortez, *supra* note 61 at 693-94, citing Alain Enthoven, “On the Ideal Market Structure for Third-Party Purchasing of Health Care” (1994) 39:10 *Social Science & Medicine* 1413 at 1420.
 64. Helble, *supra* note 56 at 70.

health care for the destination country's poorest due to medical tourism; as fewer factors obtain, this becomes less likely. This list of factors is certainly not exhaustive, and there may be additional factors in particular countries that push in the other direction. While I cannot prove that this result obtains in any country, and some readers will no doubt be skeptical, the claim seems at least plausible enough to merit a normative analysis.

In the following analysis, I will merely assume we have a home-destination country pairing where the empirical claim obtains. For purposes of illustration, I will use US medical tourists traveling to India as my example.⁶⁵ From this point on, my analysis thus adopts a sort of disciplinary division of labour: I leave to development economists attempts to corroborate and further specify these triggering conditions and to show where they are satisfied. I instead focus on the normative questions about the obligations that flow from potential diminutions, and the legal and institutional design questions about how to satisfy those obligations.

V. The Normative Question

Suppose that US medical tourism to India really does reduce health care access for India's poorest residents. Does the United States (or an international body) have an obligation to do something about it? For example, does it have an obligation to try to curb medical tourism use by US citizens? In this section, I try to determine how much of an overlapping consensus there is among several rival comprehensive moral theories.

In terms of priors, I think it useful to begin with some skepticism toward the claim that there is something morally wrong with medical tourism because of its negative effects on health care access by the destination country poor. After all, medical tourism appears to involve willing providers of services (destination country physicians and facilities)

65. While I focus on US medical tourists, much of what I say can be transposed to medical tourists from other countries; the exceptions relate to some elements of US health insurance and the regulatory tools available to deal with US insurer-prompted medical tourism.

and willing consumers (home country patients, insurers, governments) pursuing an ordinarily morally unproblematic activity (providing medical services). Moreover, unlike cases such as organ sale or clinical trials in sub-Saharan Africa of drugs that will not be readily available there when approved,⁶⁶ there is no plausible claim that the (in one sense) “voluntary” seller (or buyer) is being exploited. Instead, the harm occurs from the negative externalities of reduced access to care for third parties produced from these voluntarily nonexploitive transactions. I examine four types of theories that nonetheless purport to find fault with this arrangement.

A. Self-Interest

In making the case for curbing medical tourism to policymakers, it would be most desirable to appeal to national self-interest directly and claim that restrictions on medical tourism would serve the interests of US citizens (or the home country of other tourists, but from this point forward I will merely say “US” for simplicity). Such an argument would not require subscription to any theory of global justice, nor even a particularly strong commitment to distributive justice domestically. While many philosophers might chafe at the invocation of such an egoistic theory,⁶⁷ this argumentative strategy has been employed in parallel settings: to urge, among other things, action by developed countries to reduce medical migration from developing countries (especially “poaching” practices) and the loosening of intellectual property rights to vaccines in the developing world, in attempts to increase access to essential medicines at price points within the grasp of developing world populations.⁶⁸ Might

66. See *e.g.* Jennifer S Hawkins, “Research Ethics, Developing Countries, and Exploitation: A Primer” in Jennifer S Hawkins & Ezekiel J Emmanuel, eds, *Exploitation and Developing Countries: The Ethics of Clinical Research* (New Jersey: Princeton University Press, 2008) 21 at 21-55.

67. That this kind of argument may not appeal to most Global Justice theorists does not mean they should not consider it in attempting to persuade policy-makers. As I stress repeatedly in this article, to achieve that goal, it is desirable to achieve as much of an overlapping consensus as possible between rival views.

68. See William W Fisher & Talha Syed, “Global Justice in Health: Developing Drugs for the Developing World” (2007) 40:3 UC Davis L Rev 581 at 588-91; Lawrence O Gostin, “Meeting Basic Survival Needs

the same kinds of arguments have purchase in this context?

I can think of at least four types of arguments along these lines.

First, one might press patient-protective concerns or concerns about externalities borne by our domestic health care system when medical tourist patients experience poor care abroad and need additional health care here in the United States. For example, because the *Emergency Medical Treatment and Active Labor Act*⁶⁹ requires that US hospitals provide emergency services regardless of patients' insurance status or ability to pay, US hospitals will face the costs associated with meeting additional emergency health care needs due to medical tourism that harms US patients, and will pass these costs on to other paying patients.⁷⁰ Even assuming these are valid concerns regarding medical tourism (a matter itself subject to doubt),⁷¹ the larger problem is that the cases where this particular self-interest argument might push us to curb medical tourism will map on only by coincidence, if at all, to cases posing concerns about the destination country poor's health care access. That is, there can be cases where this particular self-interest concern would urge action but there are no health care access concerns, and cases where there are health care access concerns but this particular self-interest argument is not operative. The same response applies regarding concerns about the importation of diseases (especially antibiotic-resistant strains or "super-bugs") back to developed countries due to medical tourism, as has been

of the World's Least Healthy People: Toward a Framework Convention on Global Health" (2008) 96 Geo LJ 331 at 352-63.

69. 42 USC §§1395dd(a)-(d) (2010) [*EMTALA*].

70. *Ibid.* To put the point another way, some health care may be iatrogenic. That is, it may cause harm and thus present new health care needs that did not exist before the care was provided.

71. See Cohen, "Protecting Patients", *supra* note 14 at 1523-42 (discussing patient protection). To unpack this point, even if some medical tourism is iatrogenic, it seems possible (indeed, even plausible) that on net, medical tourism saves hospitals in terms of *EMTALA* costs; that is, the number of patients with new medical needs covered by *EMTALA* and caused by medical tourism may be dwarfed by the number of patients who now avoid the need for care covered by *EMTALA*, because they instead get care through medical tourism, preventing or forestalling the need for an emergency admission. This is, of course, an empirical question, and one that would be quite difficult to definitively answer, but it seems plausible to me that this is the case.

reported in a few case studies.⁷²

One might instead adapt to medical tourism other arguments made in the health care literature for the claim that the United States (or other countries) should care about the impact of US policies or US citizens' behavior on the health of those abroad. First, given the frequency of travel by Americans (and others who visit the United States) to India, medical tourism that results in decreased access to treatment for infectious diseases might increase the risk of transmission of those diseases to Americans.⁷³ Second, because Indians are valuable to the United States as producer-exporters of cheap goods and consumer-importers of our goods, improving Indian citizens' basic health care will improve that country's development and ensure more productive trading partners and affluent markets in which to sell US-made goods.⁷⁴ Finally, one might make the more attenuated argument that improving health care access abroad may reduce immigration pressures to the United States or increase national security by reducing global terrorism.⁷⁵

Unfortunately, these arguments are not very persuasive in this context. For the infection-transmission and consumer arguments, we should arguably be more concerned about the health of the higher-Socio-Economic-Status strata of Indian society, who are more likely to travel to our shores and be better able to buy our goods. While diminishing health care access to India's poorest, medical tourism services may actually improve the health care of the wealthier strata, at least those who are able to buy into these better facilities or take advantage of the diffusion of knowledge and technology. This is not to say there are no infection

72. See E Yoko Furuya et al, "Outbreak of *Mycobacterium Abscessus* Wound Infections Among 'Lipotourists' from the United States Who Underwent Abdominoplasty in the Dominican Republic" (2008) 46:8 *Clinical Infectious Diseases* 1181; Centre for Disease Control, "Brief Report: Nontuberculous Mycobacterial Infections After Cosmetic Surgery – Santo Domingo, Dominican Republic, 2003-2004" (2004) 53:23 *Morbidity and Mortality Weekly Report* 509.

73. *C.f.* Fisher & Syed, *supra* note 68 at 588; Gostin, *supra* note 68 at 353-55.

74. *Ibid.*

75. *C.f.* Fisher & Syed, *ibid* at 590; Gostin, *ibid* at 358-61. To be clear, Fisher, Syed, and Gostin are also not particularly impressed by these arguments, even in the health care globalization contexts about which they write.

concerns – Americans traveling to India for pleasure tourism may bring diseases back with them – but that they are less salient than in other contexts.

A more serious and general objection to deploying these self-interest arguments here is that even if it is in the American self-interest to help India's poor access health care for these reasons, it will frequently be even more in its self-interest to help its own poor citizens in this regard. As I have discussed here and elsewhere, and as the Senate recognized in its own hearing, medical tourism promises to improve the health care of poor Americans even while it (by hypothesis) reduces health care access to poor Indians, and the former effect might be thought to dominate in terms of US self-interest.⁷⁶ This objection is particularly salient for medical tourism by those paying out-of-pocket or for government-prompted medical tourism. It is less forceful an objection with respect to insurer-prompted medical tourism, because if medical tourism were restricted, many of the users would continue to have access to health care; they would just pay more for it. That said, at the margins, there may be populations whose access to health care will depend on the availability of lower-priced health insurance plans with some amount of medical tourism covered or incentivized, and particular services may be excluded from insurance coverage at a given price if medical tourism is curbed.⁷⁷ For similar reasons (discussed more fully below), this objection to the self-interest argument may be less forceful for certain sub-types of medical tourism, like cosmetic surgery. I return to these two distinctions (as to insurer-prompted medical tourism and certain sub-types of procedures) repeatedly in this paper.

In sum, for most types of medical tourism, we need to go beyond

76. Cohen, "Protecting Patients", *supra* note 14 at 1523-28; Cohen, "Medical Tourism", *supra* note 41 at 11-12.

77. Cohen, "Protecting Patients", *ibid* at 1546. That said, if these insured patients are paying more for their health insurance because medical tourism is excluded, their welfare will be negatively impacted (they are losing disposable income they could spend on other items) even if their access to health insurance and therefore health care is less likely to be negatively impacted. Whether that distinction matters may depend on whether one adopts the view that health has special moral importance (a separate spheres kind of view) or not. See Daniels, *supra* note 39 at 29-78.

pure national self-interest to mount a cogent defense for why one should be concerned about medical tourism's negative effects on health care access in the destination country.⁷⁸ I consider three families of political philosophy theories that seek to do that: Cosmopolitan, Statist, and Intermediate.

B. Cosmopolitan Theories

Cosmopolitan theories share a commitment to ignoring geographic boundaries in the application of moral theory. I consider what three cosmopolitan theory types – Utilitarian, Prioritarian, and the Nussbaum/Sen Functioning/Capabilities approach (which is in some senses Sufficientarian) – would say about medical tourism. This discussion should be understood as being at the level of ideal types, because there are many variants of these theories.

Utilitarians are committed to maximizing aggregated social welfare. Cosmopolitan Utilitarians take the Millian and Benthamite slogan “each to count for one, and none for more than one,”⁷⁹ and ignore national boundaries in determining who is the “each” to be counted.⁸⁰ Bracketing complicated questions about what it is that welfare consists of,⁸¹ there

78. John Stuart Mill, “Utilitarianism” (1863) reprinted in Alan Ryan, ed, *Utilitarianism And Other Essays* (New York: Penguin Books, 1987) 272 at 336.

79. This discussion has been premised on the current volume of medical tourism or a volume one might estimate as realistic in the next decade. If, for example, a third of the American populace started using medical tourism, that effect on lost revenue for the US domestic health care system and the dynamic effects on the US health care market would pose a quite separate set of self-interest concerns. I do not investigate those hypothetical concerns here, both because the volume of medical tourism needed to make them relevant seems extremely unrealistic and because, as with the *EMTALA* cost-related concerns discussed above, the concern is quite orthogonal to diminutions in health care access by the destination country poor.

80. See Peter Singer, “Famine, Affluence, and Morality” (1972) 1:1 *Philosophy & Public Affairs* 229 at 231; Peter Singer, “The Tanner Lectures on Human Values, A Response to Martha Nussbaum” (13 November 2002) *Utilitarianism*, online: *Utilitarian Philosophers* <<http://www.utilitarianism.net/singer/by/20021113.htm>>.

81. See generally LW Sumner, *Welfare, Happiness, and Ethics* (New York:

is a *prima facie* case that Cosmopolitan Utilitarians would find medical tourism normatively problematic. As William W Fisher and Talha Syed have suggested in the context of pharmaceutical R&D spending on diseases that predominantly affect the poorest countries, the fact of diminishing marginal utility from health care gives a good *prima facie* argument on Utilitarian grounds to favor interventions for the worst-off over the better-off, even if each group is a similarly sized population. Increasing health care access is more likely to raise the welfare of the poor than it is that of comparably richer individuals.⁸² This is true even if we grant the possibility that individual utility curves vary and we lack sufficient knowledge for interpersonal comparisons of utility; as long as one makes the minimal assumption that individual utility curves are distributed randomly, moving to a more equal distribution will maximize utility as a statistical matter because there is an equal chance that a person with a given curve will lose or gain the good from the equalizing transfer. In other words, “the harm of a loss (to a well-off person with that utility function) will be outweighed by the benefit (to a worse-off person with that curve).”⁸³ A similar case can be made for interventions to curb medical tourism – for example, to invoke one of the possible triggering conditions discussed above, if medical tourism causes fewer physicians to treat the poor and produces higher infant mortality.

This case is only a *prima facie* one, and more complicated than the R&D spending case for several reasons. First, many Cosmopolitan Utilitarians are concerned with welfare, not health *per se*, so increases in wealth (and thus welfare) to all the Indian populace from medical tourism, even if accompanied by decreases to the health of the poorest, have to be factored in, as do wealth increases to Americans based on savings from medical tourism, which might muddy the waters.⁸⁴ That said, if the wealth gains are also concentrated in the most well-off, the

Clarendon Press Oxford University Press, 1996) (exploring rival definitions).

82. Fisher & Syed, *supra* note 68 at 602-05.

83. *Ibid* at 605.

84. I say “many Cosmopolitan Utilitarians” because there could also be utilitarian views that attached a special importance to health, to which this particular objection might not apply.

same diminishing marginal utility principle will tend to reduce the value of these gains. Second, out-of-pocket or government-prompted medical tourism usually improves health care access for poor Americans⁸⁵ and for middle-class Indians who can use these facilities. Thus, in fact, the relevant trade-off is not rich American versus poor Indian, but poor American and middle-class Indian versus poor Indian. If the utility curves of the poor American and poor Indian are close enough in terms of diminishing marginal utility,⁸⁶ the addition of benefits to middle-class Indians may make up the weight. For reasons similar to those discussed above, this will be less of a problem with curbs on insurer-prompted medical tourism. Third, the discussion so far has assumed we are trading off one (stylized and hypothetical) increment of health care between the domestic citizen and the medical tourist, but there is no reason to think the world will actually be so neat. It could be true that in a world with medical tourism the Indian patient loses on net only one increment of

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85. As I have noted elsewhere, we lack specific demographic information on medical tourists, but the existing evidence suggests that in the US they are largely uninsured and underinsured patients who lack better options for getting necessary health care. Cohen, “Protecting Patients”, *supra* note 14 at 1480. In part because of the funding of and strict eligibility criteria for Medicaid in the United States, many of the uninsured who are not Medicaid recipients are themselves quite poor. A 2010 Kaiser Family Foundation Report estimated that 40 percent of uninsured individuals (*i.e.* not receiving either Medicaid or private insurance) fell below the US poverty level, which was USD \$22,050 for a family of four in 2010, and 90 percent of all uninsured in America were below 400 percent of the poverty level. Henry J Kaiser Family Foundation, “The Uninsured: A Primer - Key Facts About Americans Without Health Insurance” (Washington, DC: Kaiser Family Foundation, 2010) at 5.
86. That is, of course, a big “if.” To many, it may seem plausible that even a poor American who would make use of medical tourism is quite far away from the poor Indian in terms of diminishing marginal utility. That said, as I have discussed elsewhere in greater depth, see Cohen, “Protecting Patients”, *supra* note 14 at 1472-74, 1479-81, many of the current developed-world users of medical tourism are seeking heart bypass surgeries, heart valve replacement surgeries, spinal surgeries, and cancer treatments they cannot afford to have at home. These are serious – in many cases, life-or-death – surgeries, and the inability to access them will have very large utility consequences. Thus, we ought to be careful before too quickly dismissing this issue, even if one’s prior intuitions go the other way.

health care while the American tourist gains three – for example, medical tourism might have offsetting benefits in terms of improving medical technology and practice by Indian physicians who serve the domestic population. In such a world, while medical tourism makes Indians worse off, it does so less than it makes Americans better off. Of course, the opposite could be true, in which case the argument for banning medical tourism is stronger. None of this is to argue that the Cosmopolitan Utilitarian could not oppose medical tourism, but just that there are some indeterminacies here.

Many of those indeterminacies become less pressing under Cosmopolitan Prioritarianism. Unlike Utilitarians, Prioritarians do “not give equal weight to equal benefits, whoever receives them,” but instead give more weight to “[b]enefits to the worse off.”⁸⁷ Take, for example, John Rawls’s extremely Prioritarian Difference Principle: inequalities in “primary goods” (income, wealth, positions of authority or responsibility, the social bases of self-respect, and, after prompting from Norman Daniels, health) should be allowed to persist only if they work to the greatest benefit of the least-advantaged group.⁸⁸

While, as we will see shortly, Rawls cabined the principle’s application to within the nation-state, Charles Beitz, among others, has extended it to the international sphere. Beitz identifies two attractions in doing so: (1) the desire to avoid moral arbitrariness in the distribution of primary goods – that is, “we should not view national boundaries as having fundamental moral significance”⁸⁹ – and (2) that a limitation of Rawlsian redistribution to the domestic sphere is only justifiable on an account of nations as self-sufficient cooperative schemes, a position he views as untenable in today’s world of international interdependence, where those regulating trade (World Trade Organization) and capital (International Monetary Fund and World Bank) “[impose] burdens on poor and

87. Derek Parfit, “Equality or Priority?” (1997) 10:3 Ratio 202 at 213.

88. See John Rawls, *A Theory of Justice* (Cambridge, Mass: Harvard University Press, 1971) § 46 at 300-01, § 11 at 60-61 [Rawls, “Theory”]; John Rawls, *Justice as Fairness: A Restatement* (Cambridge, Mass: Harvard University Press, 2001) § 51.5 at 172; Daniels, *supra* note 39 at 44.

89. Charles R Beitz, *Political Theory and International Relations* (Princeton, NJ: Princeton University Press, 1979) at 151.

economically weak countries that they cannot practically avoid.”⁹⁰

Beitz offers a strong and weak version of his Cosmopolitan Prioritarian thesis. The strong version is that we should apply the Rawlsian redistributive principle internationally.⁹¹ This version clearly grounds a

90. Charles R Beitz, “Justice and International Relations” (1975) 4:4 *Philosophy & Public Affairs* 360 at 374.

91. Rawls is careful in *A Theory of Justice* to limit the ambit of his Difference Principle to the “basic structure” of society: “the way in which the major social institutions distribute the fundamental rights and duties and determine the division of advantages from social cooperation,” the sources of “deep inequalities.” Rawls, “*Theory*”, *supra* note 88, § 2 at 6-7, § 41 at 229. One pertinent question in constructing a Rawlsian-style Cosmopolitan Prioritarian perspective on medical tourism is whether the concept of “basic structure” is expansive enough to reach these kinds of meso- (if not micro-) level policy decisions. To crystallize the point, one might resist the application of a Rawlsian-style Cosmopolitan Prioritarianism to the medical tourism case not because one disagrees with it as the appropriate political theory to govern the international arena, but because one believes that in global context it should be limited to issues equivalent to those “basic structure” issues to which the Difference Principle applies in the domestic context, and that setting policy on medical tourism exceeds that “basic structure.” Beitz, the most notable advocate of expanding Rawls’ domestic Prioritarianism internationally, does not discuss the “basic structure” limitation in any depth in his book and takes as the possible target of a Global Difference Principle some quite specific policies. For example, he observes that “one might argue on the grounds of distributive justice for such policies as a generalized system of preferential tariffs for poor countries and the removal of nontariff barriers for trade, or for the use of Special Drawing Rights in the International Monetary Fund as a form of development assistance.” See Beitz, *supra* note 89 at 174. In the health setting, others have followed suit, treating an issue like the pricing of pharmaceuticals in the developing world as the possible target of a Rawlsian-style Cosmopolitan Prioritarian argument. See *e.g.* Fisher & Syed, *supra* note 68 at 652-59. I think it is an open question whether these policies are ones that are properly within the ambit of Rawls’ own conception of the “basic structure,” or whether these authors are instead embracing a Rawlsian-style Cosmopolitan Prioritarianism that relaxes the basic structure constraint or adopts an expansive version of that concept. In any event, in developing a Cosmopolitan Prioritarian approach to medical tourism, I will follow Beitz and others in allowing a version of the Difference Principle to apply to somewhat less grand policy decisions, such as whether to regulate medical tourism, while noting some doubts about whether this is fully consistent with Rawls’ own vision as to the ambit of the basic structure.

normative problem in medical tourism while avoiding a potential problem faced by the Utilitarian approach – the possibility of welfare gains to Americans or middle-class Indians counterbalancing welfare losses to poor Indians – because of the extreme priority given to the worst-off, who are likely to be India’s poor in this context.⁹² By contrast, the weaker version of Beitz’s approach instructs us to apply internationally whatever distributive justice policy one adopts domestically.⁹³ Its implication for medical tourism is less clear and depends on the degree of priority given to the worst off, although it would seem to more clearly promote interventions restricting medical tourism than the Utilitarian approach.

A third Cosmopolitan approach is Sufficientarianism, according to which justice is not concerned with improving the lot of the least well-off (Prioritarianism) or achieving equality *per se* (Egalitarianism), but instead with ensuring that individuals do not fall below a particular threshold of whatever is the “currency” of distribution.⁹⁴ Although emanating from a more Aristotelian starting point, we can understand Amartya Sen and Martha Nussbaum’s approach as roughly fitting this category. In a nutshell, their approach is to discern the “functionings” central to a flourishing human life, determine the “capabilities” needed to attain those functionings, and then identify and fix natural and social disparities to raise people to threshold in those capabilities.⁹⁵ In her latest work

92. I say “likely” because it would depend in part on how “worst-off” was defined; most welfarists would define it in terms of total welfare, but a welfarist focused on health in particular might press for a focus on “sickest” rather than total welfare. Either way, I think it plausible that the poor Indian would qualify.

93. Beitz, *supra* note 89 at 174.

94. See Roger Crisp, “Equality, Priority, and Compassion” (2003) 113:4 *Ethics* 745 at 756-63; Harry G Frankfurt, “Equality as a Moral Ideal” (1987) 98:1 *Ethics* 21 at 21-25; Alexander Rosenberg, “Equality, Sufficiency, and Opportunity in the Just Society” (1995) 12:2 *Social Philosophy & Policy* 54.

95. See generally Martha Nussbaum, *Frontiers of Justice* (Cambridge, Mass: Harvard University Press, 2006) at 155-216, 273-315 [Nussbaum, “*Frontiers*”] (setting out the Capabilities approach); Martha Nussbaum, *Women and Human Development: The Capabilities Approach* (Cambridge: Cambridge University Press, 2002) at 4-14 (describing the Capabilities approach similarly); Amartya Sen, *Inequality Reexamined* (New York: Harvard University Press, 1992) at 39-53 (describing the Capabilities

on the subject, *Frontiers of Justice*, which speaks directly to the issue of international justice, Nussbaum delineates ten capabilities, two of which are central for our purposes: “Life [– b]eing able to live to the end of the human life of normal length; not dying prematurely, or before one’s life is so reduced as to be not worth living” and “Bodily Health [– b]eing able to have good health, including reproductive health.”⁹⁶ Nussbaum indicates that the responsibility to achieve the threshold on these capabilities falls at all levels: on national governments, on international bodies, and even on corporations, and the failure of one institution to meet its obligations does not reduce the obligation of the others.⁹⁷ She also makes clear that the thresholds are non-relativistic. For example, the threshold for adequate “life” or “bodily health” is the same if the citizen is American or Indian.⁹⁸

This approach offers powerful reasons why the effects of medical tourism on health care access in destination countries ought to be a matter of substantial concern. While she does not attempt to operationalise where the health or life capability threshold should be set, Nussbaum’s description of these thresholds plausibly suggests that the Indian poor fall below the thresholds due to poor health care access (among other reasons, such as lack of adequate sanitation). On her theory, it would then be the responsibility of the United States, India, international bodies, and even the hospitals, insurers, and intermediaries involved in medical tourism to try to rectify that result.

That said, in applying the Sufficientarian approach to medical tourism, some problems latent in the theory become manifest. For out-of-pocket or government-prompted medical tourism, many American users are poor and may themselves be below the threshold on life and bodily health. Consider, for example, a 1990 study suggesting that an African-American man living in Harlem was less likely to live until age sixty-five than a Bangladeshi man, and tracing this in part to lack of

approach similarly).

96. Nussbaum, “*Frontiers*”, *ibid* at 76-78.

97. *Ibid* at 171, 313-19.

98. *Ibid* at 78-81. For an application of Nussbaum’s approach to global health specifically, see Gostin, *supra* note 68 at 343-47.

health care access.⁹⁹ We may thus face a situation where we cannot raise everyone to the capability threshold, that is, a case of below-threshold tradeoffs. A number of authors have criticized Nussbaum for failing to provide guidance in such cases.¹⁰⁰ Again, this is less of a problem for insurer-prompted medical tourism, whose users will usually lie above the threshold. It may also not be a problem for restricting medical tourism for certain subcategories of treatments by Western patients that are not “health” related – cosmetic surgery and fertility tourism, for example (although whether the latter counts as “health” is a contested question),¹⁰¹ because these treatments are less important for promoting the capabilities. This is an important divergence from the Utilitarian approach, which treats all inputs into welfare equally, whether classified as health or not.

A second problem with this theory has to do with Nussbaum’s refusal to allow tradeoffs between capabilities. We may face conflicts between raising individuals to threshold on the Life/Health capabilities and raising

99. Colin McCord & Harold P Freeman, “Excess Mortality in Harlem” (1990) 322:3 *New England Journal of Medicine* 173.

100. See *e.g.* Anita Silvers & Michael Ashley Stein, “Disability and the Social Contract” (2007) 74:4 *U Chicago L Rev* 1615 at 1638; Singer, *supra* note 80; Mark Stein, “Nussbaum: A Utilitarian Critique” (2009) 50:2 *BCL Rev* 489 at 504-14. This may mean that a modified version of the Capabilities approach that breaks from Nussbaum in this regard will do better as a Cosmopolitan theory that can ground duties relating to medical tourism.

101. See *e.g.* I Glenn Cohen & Daniel Chen, “Trading-Off Reproductive Technology and Adoption: Does Subsidizing IVF Decrease Adoption Rates and Should It Matter?” (2010) 95:1 *Minn L Rev* 485 at 500-05; Daniels, *supra* note 39 (offering a theory of health tied to whether a deficit causes a “departure from normal functioning that reduces an individual’s fair share of the normal opportunity range and gives rise to claims for assistance” and finding infertility to count because it interferes with “basic functions of free and equal citizens, such as reproducing themselves biologically, an aspect of plans of life that reasonable people commonly pursue” at 59); Nussbaum, “*Frontiers*”, *supra* note 95 at 76 (including reproductive health within the “bodily health” capability). Fleshing out what is and is not penumbral to “health” and on what theory is not my focus in this article. I will, however, note that even discussing categories like “cosmetic surgery” may be too crude in the final analysis; to the extent the category encompasses both sex change operations and breast augmentation, each may call for a quite different analysis.

them to threshold on one or more of the eight other coequal capabilities we have thus far not discussed – for example “Play [– b]eing able to laugh, to play, to enjoy recreational activities” and “Senses, Imagination, and Thought, [– b]eing able to use the senses to imagine, think, and reason – and to do these things in a ‘truly human’ way, a way informed and cultivated by an adequate education.”¹⁰² If medical tourism improves recreational or educational opportunities (by increasing Indian GDP), it is unclear whether these increases to threshold in other capabilities could outweigh medical tourism’s negative effects on the “Bodily Health” and “Life Capabilities.”¹⁰³ These questions somewhat mirror those discussed as to the Cosmopolitan Utilitarian approach. One could try to alter the theory to adopt one of a series of methods of dealing with below-threshold cases: help the person who will make the biggest capability gain, help the person lowest down on the capabilities level, or maximize the number of people who are above threshold,¹⁰⁴ each of which would somewhat strengthen the case against medical tourism. Such alterations would still, however, leave open the problem of across-capability tradeoffs.

While clearly aware of these problems, Nussbaum appears resistant to altering her theory much in this regard. She makes clear that “all ten of these plural and diverse ends are minimum requirements of justice, at least up to the threshold level,”¹⁰⁵ that “the capabilities are radically

102. Nussbaum, “*Frontiers*”, *supra* note 95 at 76-77.

103. There is a separate set of issues relating to thresholds and timeframes. For example, medical tourism may in the short-term make it harder to achieve the threshold for currently existing Indian populations on these capabilities, but the development of India’s health sector and trickle-down may in the long-term raise more Indians (including not-yet-existing ones) to threshold. In part because of their complexity, see generally Louis Kaplow, “Discounting Dollars, Discounting Lives: Intergenerational Distributive Justice and Efficiency” (2007) 74:1 U Chicago L Rev 79 (discussing complications involved with intergenerational discounting); John Broome, “Should We Value Population?” (2005) 13:4 Journal of Political Philosophy 399 (discussing complications in reasoning about the interests of future generations, and in part because these are domain-general questions that almost all theories face in almost all contexts rather than specific problems for the Capabilities approach as to medical tourism, I note but largely bracket these issues here).

104. Stein, *supra* note 100 at 509-20.

105. Nussbaum, “*Frontiers*”, *supra* note 95 at 175.

non-fungible: deficiencies in one area cannot be made up simply by giving people a larger amount of another capability.”¹⁰⁶ Her “theory does not countenance intuitionistic balancing or tradeoffs among them,” but instead “demands that they all be secured to each and every citizen, up to some appropriate threshold level.”¹⁰⁷ She recognizes that “[i]n desperate circumstances, it may not be possible for a nation to secure them all up to the threshold level, but then it becomes a purely practical question what to do next, not a question of justice,” because “[t]he question of justice is already answered: justice has not been fully done here.”¹⁰⁸ That posture, however, makes her theory less useful as a tool for normative analysis of medical tourism.

With the possible exception of Beitz’s strong Cosmopolitan Prioritarian thesis, perhaps surprisingly, the other Cosmopolitan theories also face some indeterminacies and problems when faced with the case study of medical tourism. That said, I think it is fair to say that they offer a strong *prima facie* case (if not a completely certain one) for condemning some forms of it.

There are, however, two more pressing and related problems with relying too heavily on the Cosmopolitan theories to urge restrictions on medical tourism – one theoretical and one pragmatic.

The theoretical problem is that what these theories offer us is not a theory of when we are responsible for harms stemming from medical tourism, but when we ought to improve the lives of the badly-off simpliciter. In one sense, causation matters: only if restricting medical tourism causes an improvement in welfare for the worst off, the raising of health capabilities, etc., are we required to take the action. In another sense, however, causation in the historical and responsibility senses is irrelevant because it is the mere fact of the destination country’s citizens’ needs that imposes upon us the obligation to help them in whatever way we can, and not anything about medical tourism specifically. Thus, in one direction, the duties may persist even when medical tourism is eliminated or its harms are remedied in that the source of the obligation

106. *Ibid* at 166-67.

107. *Ibid* at 175.

108. *Ibid*.

is not anything we have done, but instead the destitute state of those abroad. In the other direction, once the theories' goals are met (for example, they reach the sufficient level on the capabilities, to use one variant), we do not bear an obligation (at least under distributive justice principles) to prevent medical tourism or remedy its ill-effects, even if medical tourism continues to produce significant health care deficits for the destination country poor that would not occur if it were curbed. Moreover, it is possible that other forms of aid or assistance might "cancel out" whatever negative effects medical tourism has in terms of the global cosmopolitan calculus.

To put the point another way, the problem is that the Cosmopolitan theory tells us to help those in the destination country who are badly-off by curbing medical tourism, whether or not medical tourism caused them to be badly-off; this is to be contrasted with a different kind of theory (more corrective justice in spirit) that would urge us to curb medical tourism because it causes people in the destination country to be worse off.

Further, these approaches also face what I will call a "self-inflicted wounds problem," a problem that I will return to several times in this article. These theories imply (subject to a qualification) that it is not relevant to the scope of the home country's obligation that some of the factors (discussed above) that cause medical tourism to negatively impact health care access in the destination country are within the destination country's government's control, *i.e.* that the destination country is partially responsible. The qualification is that, to the extent that we could induce the destination country to alter these facts about its self-governance, such influence would be one tool to meet our obligations under these theories. But to the extent we are unable to prompt these alterations, under the Cosmopolitan approach, our responsibility to improve the welfare and capabilities of the poor in the destination country attaches even for the elements for which their own sovereign is actually responsible.¹⁰⁹

109. Nussbaum is the most explicit of the theorists in suggesting that the responsibility to achieve the threshold on these capabilities falls at all levels – on national governments, on international bodies, even on corporations – and that the failure of one institution to meet its obligations does not reduce the obligation of the others. See Nussbaum, "*Frontiers*", *supra*

To some, these implications may seem problematic; from others, the reply will be, “It is just not that kind of theory.” More troubling, though, may be a pragmatic corollary: if we need to rely on these theories to convince public policymakers to take action on medical tourism, they threaten to prove too much. To borrow a phrase that Charles Fried has used in discussing Utilitarianism generally, all of these approaches threaten to become “oppressive in the totality of the claim they make on the moral agent”;¹¹⁰ addressing the harms caused by medical tourism is a small drop in the bucket in terms of what these theories would call upon us to do to right the balance between developed and developing countries. For starters, they would further demand that we radically increase taxes for all strata in our nation to fund large-scale water purification, housing, and other interventions in Less Developed Countries (LDCs). As Thomas Pogge has stressed, unless a theory of Global Justice is politically feasible, it is “destined to remain a philosopher’s pipe dream.”¹¹¹ It seems hard to believe that a principle as broad and demanding as the one espoused by Cosmopolitans of this sort would be compelling to US policymakers.

Again, some philosophers might chafe at this approach and say that if the Cosmopolitan approach is “right,” it matters not a lick that US political elites would never accept it. Even if we think that within the ambit of philosophy that response is correct,¹¹² Pogge is also surely

note 95 at 313-19. There are some complicated dynamic elements I gloss over here. For example, if it turned out that, because of moral hazard issues, a theory of moral obligation that did hold the destination country responsible for its own role in these health care access deficits in the long run actually improved the welfare/capabilities of the population more than one that did not – because the destination country sovereign would then have a greater incentive to clean its own house – then we might in fact adopt a system that apportioned responsibility even on these theories; however, that apportioning of responsibility would be pragmatic and instrumental, not because these theories suggests that the responsibility of the destination country diminishes that of the patients’ home country.

110. Charles Fried, *Right and Wrong* (Cambridge, Mass: Harvard University Press, 1978) at 13.
111. Thomas W Pogge, “Human Rights and Global Health: A Research Program” (2005) 36:1-2 *Metaphilosophy* 182 at 185.
112. *C.f.* David Estlund, “Human Nature and the Limits (if Any) of Political Philosophy” (2011) 39:3 *Philosophy & Public Affairs* 207 (discussing whether the fact that human nature is such that we will never do

correct that, when it comes to trying to shift public policy, these kinds of considerations are king. In any event, to find common ground with both those who would reject Cosmopolitanism as a philosophical matter and those who would reject it as a pragmatic matter, it would be desirable to show a normative obligation to correct health care access diminution from medical tourism on less demanding theories as well. I consider two sets of such theories next, Statist and Intermediate.¹¹³

C. Statist Theories

Unlike Cosmopolitans, Statists reach the conclusion that the obligations of distributive justice apply only within the nation-state and not to citizens of other nations. I discuss the arguments of two of the best-known expositors of this view, John Rawls and Thomas Nagel, before applying those arguments to medical tourism. As one might expect, justifying duties to curb medical tourism is difficult for Statist approaches. However, what one might not expect, and as I show, is that even these approaches might mandate some limited regulatory interventions grounded in the Rawlsian duty to aid burdened states and the Nagelian duty of humanitarian aid. That said, I also express some misgivings about these ways out of the problem.

Statists limit justice-based duties of redistribution to the nation-state because “[w]hat lets citizens make redistributive claims on each other is not so much the fact that they share a *cooperative* structure,” but that societal rules establishing a sovereign state’s basic structure are “coercively imposed.”¹¹⁴ Nagel clarifies that this is because for Rawls (and *contra* the

that which is called for by a political philosophy should matter for its evaluation).

113. A different response is that we need not be so philosophically pure: we can endorse Cosmopolitanism in this limited domain while rejecting it elsewhere. That is, of course, an option, but then one bears the burden of justifying why, if one accepts the principle, one should adopt it here but not elsewhere. It is not clear to me that those espousing Cosmopolitanism only for medical tourism have a good answer to this question.
114. Mathias Risse, “What We Owe to the Global Poor” (2005) 9:1-2 *Journal of Ethics* 81 at 99-100 [emphasis in original]; see also John Rawls, *The Law of Peoples* (Cambridge, Mass: Harvard University Press, 1999) at 16 [Rawls, “*Peoples*”] (making a similar argument for the Statist approach);

Cosmopolitans), the “moral presumption against arbitrary inequalities is not a principle of universal application”; rather “[w]hat is objectionable is that we should be fellow participants in *a collective enterprise of coercively imposed legal and political* institutions that generates such arbitrary inequalities.”¹¹⁵ It is the “complex fact” that in societal rules establishing a sovereign state’s basic structure “we are both putative joint authors of the coercively imposed system, and subject to its norms, i.e., expected to accept their authority even when the collective decision diverges from our personal preferences – that creates the special presumption against arbitrary inequalities in our treatment by the system.”¹¹⁶

Increasing globalization does not change the picture, say Nagel and Rawls, because “it is not enough that a number of individuals or groups be engaged in collective activity that serves their mutual advantage”; that is, “mere economic interaction does not trigger the heightened standards of socioeconomic justice.”¹¹⁷ Nor does the existence of international institutions such as the United Nations or World Trade Organization (WTO) trigger those obligations, according to Nagel, because their edicts “are not collectively enacted or coercively imposed in the name of all the individuals whose lives they affect.”¹¹⁸ That is, “[n]o matter how substantive the links of trade, diplomacy, or international agreement, the institutions present at the international level do not engage in the same kinds of coercive practices against individual agents”; it is “[c]oercion, not cooperation, [that] is the *sine qua non* of distributive justice.”¹¹⁹

Michael Blake, “Distributive Justice, State Coercion, and Autonomy” (2001) 30:3 *Philosophy & Public Affairs* 257 at 285-89 (making a similar argument for the Statist approach).

115. Thomas Nagel, “The Problem of Global Justice” (2005) 33:2 *Philosophy & Public Affairs* 113 at 127-28 [emphasis added].
116. *Ibid* at 128-29; see Blake, *supra* note 114 at 265, 289.
117. Nagel, *supra* note 115 at 138; see also Rawls, “Peoples”, *supra* note 114 at 115-19 (making a similar point).
118. Nagel, *ibid*.
119. Blake, *supra* note 114 at 265, 289. Blake goes on to qualify this somewhat by indicating that this is “not to say that coercion does not exist in forms other than state coercion. Indeed, international practices can indeed be coercive – we might understand certain sorts of exploitative trade relationships under this heading, and so a theory concerned with autonomy must condemn such relationships or seek to justify them ...

All of this seems to construct a dead end for Statist support for distributive justice-based duties in the medical tourism sector, as can be gleaned by comparing the medical tourism case to Nagel's similar analysis of immigration. Nagel argues that, while "[t]he immigration policies of one country may impose large effects on the lives of those living in other countries," this is not sufficient to "imply that such policies should be determined in a way that gives the interests and opportunities of those others equal consideration."¹²⁰ This is because "immigration policies are simply enforced against the nationals of other states; the laws are not imposed in their name, nor are they asked to accept and uphold those laws" and it is a "sufficient justification" of these policies that they "do not violate [the immigrants'] prepolitical human rights."¹²¹ In a similar vein, the medical tourism policies of home countries – whether merely permitting their citizens to purchase medical tourism out-of-pocket, permitting insurer-prompted medical tourism, or, in the extreme case of government-prompted medical tourism, creating state incentives to use medical tourism – are not being imposed in the name of destination country citizens, nor are those citizens or their governments being forced to open themselves up to medical tourism.¹²²

Nevertheless, I believe there exist in Statist theories at least two open avenues for grounding some limited obligations of home countries and international bodies to regulate medical tourism or mitigate its negative effects on health care access in destination countries.

The first avenue stems from Rawls' recognition of a duty (separate from those relating to distributive justice) to assist "burdened societies" – those whose "historical, social, and economic circumstances make their achieving a well-ordered regime, whether liberal or decent, difficult if not impossible" – to "manage their own affairs reasonably and rationally"

[But] ... only the relationship of common citizenship is a relationship potentially justifiable through a concern for equality in distributive shares." *Ibid* at 265.

120. Nagel, *supra* note 115 at 129.

121. *Ibid* at 129-30.

122. See below notes 132-48 and accompanying text for a discussion of one complication related to the General Agreement on Trade in Services.

in order to become “well-ordered societies.”¹²³ These societies “lack the political and cultural traditions, the human capital and know-how, and, often, the material and technological resources needed to be well-ordered” but, with assistance, can over time come to “manage their own affairs reasonably and rationally and eventually to become members of the Society of well-ordered Peoples.”¹²⁴ Being a well-ordered society requires having a “decent system of social cooperation,” meaning that the state secures “a special class of urgent [human] rights, such as freedom from slavery and serfdom, liberty (but not equal liberty) of conscience, ... security of ethnic groups from mass murder and genocide” and formal equality, that citizens view their law as imposing duties and obligations “fitting with their common good idea of justice” and not “as mere commands imposed by force,” and that officials believe that “the law is indeed guided by a common good idea of justice,” not “supported merely by force.”¹²⁵

Can regulation of medical tourism by patients’ home countries or international bodies be justified on this rationale? Grounding medical tourism-related obligations in this kind of duty presents four challenges.

First, there is a question of coverage. Many of the destination countries in question may not be burdened societies; India, Mexico, Thailand and Singapore, for example, may have poor populations facing deficits in health care access, but they seem to meet Rawls’ more minimal criteria for being well-ordered. Thus, these obligations will apply, at most, only to medical tourism to a subset of destination countries. That itself is not fatal – the United States (or perhaps an international body) could theoretically prevent, tax, or allow incentives for medical tourism only to some destination countries in a manner akin to the “channeling” regimes I have elsewhere discussed¹²⁶ and return to in Part VI below – but it does complicate the picture, and it may be that the same factors that make these states burdened may make them unlikely to develop robust medical tourism industries.

123. Rawls, “Peoples”, *supra* note 114 at 90, 111.

124. *Ibid* at 106, 111.

125. *Ibid* at 66-68, 79.

126. Cohen, “Protecting Patients”, *supra* note 14 at 1515-23, 1559-61.

Second, there is a problem as to the kind of aid envisioned by this duty. Rawls seems focused on institution building, and Mathias Risse suggests the duty's targets as building things like "stable property rights, rule of law, bureaucratic capacity, appropriate regulatory structures to curtail at least the worst forms of fraud, anti-competitive behavior, and graft, quality and independence of courts, but also cohesiveness of society, existence of trust and social cooperation, and thus overall quality of civil society."¹²⁷ Foreign aid by home countries to help the destination countries improve their ability to produce more medical providers, or policy aid in designing health care system regulations designed to control how much time doctors spend in the public or private system – both factors likely to contribute to diminutions in access, as discussed above – seem to fit nicely into this category and are well-supported by this approach. It is less clear that the same is true of regulation aimed at trying to prevent or make it more expensive for home country patients to travel to the destination country for medical tourism.

Third and relatedly, Rawls cautions that "well-ordered societies giving assistance must not act paternalistically, but in measured ways that do not conflict with the final aim of assistance: freedom and equality for the formerly burdened societies."¹²⁸ Again, economic aid for those abroad does not seem unduly paternalistic (unless perhaps conditioned on certain ways of spending or meeting certain conditions), but attempts by home countries or international bodies to limit the use of medical tourism by their populations (out-of-pocket, insurer-prompted, or government-prompted) when the destination country is ready to take all-comers may run afoul of this limitation. Thus, this approach may limit the type of intervention a home state government can enact regarding medical tourism.

Fourth, it is also at least possible that the Rawlsian duty to aid burdened states might actually support leaving medical tourism unregulated (or even encouraging it). Because the duty does not aim to address diminutions in health care access caused by medical tourism (nor health needs at all *per se*), but instead fostering institution building, it is

127. Risse, *supra* note 114 at 85.

128. Rawls, "Peoples", *supra* note 114 at 111.

possible that medical tourism may actually help build institutions in the destination country aiding the burdened state while diminishing health care access for the destination country poor. For example, the rise in GDP and the need for corporate accountability to support a medical tourism industry attractive to Westerners might carry with it benefits to the destination country in terms of establishing the rule of law or property rights. If so, medical tourism might itself represent aid to burdened states even while it diminishes health care access to the destination country's poor.

Thus, the Rawlsian duty to aid burdened states seems to support only duties to help build up the health care capacity of the destination country and foreign aid more generally, and then only for the sub-set of states that qualify as burdened states. Further, those duties attach only so long as the burdened state has not transitioned to a well-ordered society; once it has made that transition, these duties are satisfied even if medical tourism continues to significantly diminish health care access in the destination countries. Finally, the duty to aid burdened states is also not a perfect fit for the argument because it is at least possible for medical tourism that diminishes health care access to the poor to itself serve in building institutions and aiding burdened states, in which case it ought to be encouraged or left alone rather than prohibited. Thus, the approach justifies only a much smaller sub-set of possible interventions regarding medical tourism, but does not rule out a duty of home state action entirely.

The other avenue is Nagel's separate conception of humanitarian duties of aid. Nagel suggests that "there is some minimal concern we owe to fellow human beings threatened with starvation or severe malnutrition and early death from easily preventable diseases, as all these people in dire poverty are," such that "some form of humane assistance from the well-off to those in extremis is clearly called for quite apart from any demand of justice, if we are not simply ethical egoists."¹²⁹ Although he is self-admittedly vague, he thinks "the normative force of the most basic human rights against violence, enslavement, and coercion, and of the most basic humanitarian duties of rescue from immediate danger,

129. Nagel, *supra* note 115 at 118.

depends only on our capacity to put ourselves in other people's shoes," and speaks of obligations to relieve others, whatever their nation, "from extreme threats and obstacles to [the freedom to pursue their own ends] if we can do so without serious sacrifice of our own ends."¹³⁰ In a similar vein, Michael Blake suggests a duty to provide "access to goods and circumstances" enabling people "to live as rationally autonomous agents, capable of selecting and pursuing plans of life in accordance with individual conceptions of the good" and singles out "famine, extreme poverty, [and] crippling social norms such as caste hierarchies," as the kinds of things against which we have obligations to intervene notwithstanding the citizenship of the victim.¹³¹

Can this approach ground duties relating to medical tourism? Fisher and Syed suggest that a duty of Western countries to expand access to drugs in LDCs can be grounded in these humanitarian duties because there "is little question that millions of people are suffering and dying from contagious diseases in developing countries and that the residents of developed countries could alleviate that suffering with relative ease."¹³²

A parallel argument, however, seems somewhat harder to make in the context of medical tourism interventions. For one thing, while we lack good empirical data on the ill effects of medical tourism on health care access abroad, it is unlikely at present that it is causing "millions of people" to die in destination countries – its effects are more marginal. Of course, the millions of deaths in the drug development case are not the *sine qua non* for humanitarian duties; there may be "early death from easily preventable diseases" that curbing medical tourism might prevent. Lack of access to care is as sure a killer as is famine or lack of needed pharmaceuticals, and, over a longer time horizon, its effects may be more significant. Still, we should be cautious when specifying the level of deprivation needed to trigger these humanitarian duties since the resulting duties are not medical-tourism-specific; that is, if we decide a particular kind of deprivation is enough to trigger our duty to intervene here, we will bear a comparable duty to all citizens of that

130. *Ibid* at 131.

131. Blake, *supra* note 114 at 271.

132. Fisher & Syed, *supra* note 68 at 649.

foreign country in comparable conditions. Too expansive a conception of the humanitarian duty will result in few meaningful differences between obligations of humanitarian and distributive justice and may have significant implications for issues like our general immigration policy that Nagel (and other Statists) have rejected.¹³³ That is, if the health care deficits experienced due to medical tourism are enough to ground humanitarian duties regarding medical tourism, should we not also open our immigration doors to those suffering comparable deficits in their home countries?¹³⁴ Too expansive a conception would raise the very pragmatic and political concerns about the scope of the demands placed upon us that we aimed to avoid by seeking a non-Cosmopolitan approach.

Second, the question of whether we “could alleviate that suffering with relative ease” or “without serious sacrifice of our own ends” (to use Nagel’s terms) is more difficult in this context in ways that mirror our discussion of Cosmopolitan theories. At least for medical tourism by those paying out-of-pocket and, to a lesser extent, for some forms of government-prompted medical tourism, trying to satisfy humanitarian duties to the global poor by curbing medical tourism is more likely to come at the expense of our own poor than in the pharmaceutical case. Thus, in the exceptional case, we may face tradeoffs not only between satisfying our humanitarian duties to our own poor versus those to the poor abroad, but also between our distributive justice duties to our poor and our humanitarian duties to the destination country poor. Neglecting our duties to our own poor patients would seem to count as “serious sacrifice of our own ends,” suggesting the obligations may more clearly attach to some forms of medical tourism, including insurer-prompted medical tourism, where paying more for health insurance is less clearly a “serious sacrifice of our own ends.” Similarly, the humanitarian duty

133. Nagel, *supra* note 115 at 129-30.

134. The “without serious sacrifice of our own ends” constraint discussed in the next section might be thought to distinguish the immigration case, although Nagel at least wants to dispose of the immigration case on the threshold question of whether humanitarian duties attach (*ibid*). In any event, as I discuss in the next paragraph, there are problems with that constraint as to medical tourism as well.

approach might more easily justify curbing medical tourism for services like cosmetic surgeries that are more penumbral to health. This restriction may also limit us to interventions that do not restrict access to health care via medical tourism for our citizens but instead aid the destination country in building capacity; even that is tricky, though, for dollars spent on foreign aid could always be reallocated to improving Medicaid coverage for America's poor, to give but one example.¹³⁵

Finally, notice that, like the Cosmopolitan theories, the duty towards humanitarian aid is actually somewhat divorced from medical tourism – if we have satisfied the duty of humanitarian aid, then even if medical tourism continues to have harmful effects on the destination country we have no obligation to restrict it; if foreign citizens still remain below the

135. A different way forward, at least in the US case, would be to get at the presumptive “root” of the problem prompting much of the medical tourism trade: that too many Americans are uninsured or underinsured or lack affordable care options, and turn to medical tourism as a solution. See Cohen, “Protecting Patients”, *supra* note 14 at 1479-81. In principle, that would be a very desirable solution, but the Obama Health Care Reform, the most ambitious move in this direction in the last fifty years, has been estimated by the most recent Congressional Budget Office (CBO) scoring to leave twenty-three million nonelderly residents uninsured if and when it is fully implemented in 2019, and countless more underinsured; Letter from Douglas W Elmendorf, Dir, Cong Budget Office, to Nancy Pelosi, Speaker, US House of Representatives (18 March 2010) table 2, online: Congressional Budget Office <<http://www.cbo.gov/publication/21327>>. That reform is now under significant attack in the courts, the Congress, and in US public opinion, but even if it withstands the barrage, the bill as passed would still leave many US users of out-of-pocket medical tourism, and it is hard to conceive that there will be political will to make the necessary investments to further reduce the number of un- and underinsured in the foreseeable future. Here again is a place where it seems plausible to me that the philosophical and policy discourse split – it may be that the United States ought to deal with medical tourism by cleaning its own house first, but if we concede (as I think we should) that this is not within the political feasibility set, then we are back in a philosophically second-best world where we must ask what steps the United States should take regarding medical tourism directly. Another way of putting this point is that in a world of ideal justice, there would be no uninsured medical tourists, and these comments should be understood as speaking to the non-ideal world. *C.f.* Rawls, “*Theory*”, *supra* note 88 § 39 at 244-46.

humanitarian level after medical tourism is eliminated or its harms are remedied, we still must aid more. To the extent that one was convinced that this aspect of Cosmopolitan theories was undesirable as a ground for duties as to medical tourism, one should also be wary of the Statist humanitarian duties approach.

While, as expected, the Statist theories reject grounding duties as to medical tourism in the distributive justice obligations to those abroad, there may be some room for obligations grounded in duties to aid burdened states or provide humanitarian aid. While the former may create obligations to help build institutional capacity to deliver health care abroad or foreign aid, it will not be appropriate for many destination countries. The latter may be more promising, but if the threshold for humanitarian need is kept relatively high, as I believe it should be, home countries will owe humanitarian duties relating to medical tourism only when acting will prevent grave humanitarian disasters and when the burden on home country citizens will not be serious. As I have argued, such duties will most likely affect only cases of insurer-prompted medical tourism and medical tourism for less-essential service and may be limited to providing aid rather than curbing the home countries' citizens' medical tourism use. Further, as with the Cosmopolitan theories, I have expressed concern that these approaches generate theories about satisfying health needs, rather than about obligations stemming from medical tourism.

D. Intermediate Theories

A final set of theories seeks to position itself between the Statist and Cosmopolitan camps. I consider two such intermediate theories and their application to medical tourism: the first is put forth by Joshua Cohen and Charles Sabel, and applied to health care by Norman Daniels, and the second is put forth by Thomas Pogge. I think these are the most fertile grounds for a Global Justice-based theory of obligations to regulate medical tourism because they generate a kind of theory more appropriate for the task: one that focuses on the harms and institutions stemming from particular existing practices rather than one that focuses on the relative holdings of particular individuals at the current moment and counsels a more general reallocation of primary goods. That said, as

applied to this specific problem, the theories run into some problems.

1. Cohen, Sabel & Daniels

The Cohen, Sabel, and Daniels approach suggests the Statists are too demanding in requiring coercion as the touchstone of distributive justice principles and also too “all-or-nothing” in the deployment of those principles. Instead, these authors propose lesser duties of “inclusion” internationally, which fall short of full-blown distributive justice but are greater than the minimal humanitarian duties endorsed by Statists: the state should treat those outside of the coercive structure of the nation-state as individuals whose good “counts for something” (not nothing) even if it falls short of the full consideration a state would give its own citizens.¹³⁶

Cohen and Sabel suggest these duties of inclusion may be triggered *inter alia* by the “coercion-lite” (my term) actions of international bodies such as the WTO; that is, “[e]ven when rule-making and applying bodies lack their own independent power to impose sanctions through coercion,” they still shape conduct “by providing incentives and permitting the imposition of sanctions” and “withdrawing from them may be costly to members (if only because of the sometimes considerable loss of benefits),” such that “[i]n an attenuated but significant way, our wills – the wills of all subject to the rule making-authority – have been implicated, sufficiently such that rules of this type can only be imposed with a special justification.”¹³⁷

They offer the example of the WTO, suggesting that “[o]pting out is not a real option” because no country in the developed or developing world could really survive without participation in the WTO, and once one is in for a penny, one is in for a pound; a member country cannot pick and choose which parts of the WTO’s demands to comply with, such that “there is a direct rule-making relationship between the global

136. See Joshua Cohen & Charles Sabel, “Extra Rempublicam Nulla Justitia?” (2006) 34:2 *Philosophy & Public Affairs* 147 at 154-55; Daniels, *supra* note 39 at 351.

137. Cohen & Sabel, *ibid* at 165.

bodies and the citizens of different states.”¹³⁸ They argue that for the WTO, duties of inclusion would mean that the rulemakers are “obligated to give some weight to the reasonable concern of the rule takers (who are themselves assumed to have responsibility to show concern for the interests of their own citizens).”¹³⁹

The authors also suggest consequential rulemaking by international bodies “with distinct responsibilities,” such as the International Labor Organization (ILO), might require those bodies to adopt duties of inclusion.¹⁴⁰ More specifically, they claim that this obligation follows from three facets of the ILO: that the ILO has taken on the responsibility for formulating labour standards (geared towards eliminating child and forced labour, ending employment discrimination, promoting collective bargaining, etc.); that the ILO claims that its rulemakings have significant consequences; and that the ILO believes that, if it were to disappear, no comparable entity would emerge.¹⁴¹

Daniels adds that certain kinds of international independencies may also give rise to duties of inclusion, giving the example of medical migration (brain drain). He argues that the International Monetary Fund (IMF)’s historical requirement that countries like Cameroon make severe cutbacks in their publicly-funded health care systems in order to reduce deficits that result in poorer working conditions for medical personnel (a “push” factor), combined with the attempt by the United Kingdom and other OECD countries to recruit medical personnel from developing countries (a “pull” factor), gives rise to a duty on the part of Western countries and the IMF to address the ill effects of this migration.¹⁴² Among the methods to satisfy that obligation, he urges altering “the terms of employment in receiving countries of health workers from vulnerable countries,” compensating for “the lost training costs of these workers,” “prohibit[ing] recruitment from vulnerable countries,” and “giv[ing] aid to contributing countries in order to reduce the push factor.”¹⁴³

138. *Ibid* at 168.

139. *Ibid* at 172.

140. *Ibid* at 170-71.

141. See *ibid*.

142. See Daniels, *supra* note 39 at 337-39.

143. *Ibid*.

Can this approach be readily applied to medical tourism? One might be tempted to draw three analogies, but each of them faces problems that make the medical tourism case harder than the ones these authors have taken on.

First, one might suggest that intermediaries, and particularly medical tourism accreditors like the Joint Commission International (JCI), bear some duties to build consideration of the effects of medical tourism to a particular facility on health care access for destination country poor into their accreditation processes, in analogy to the ILO example. One might argue that the JCI is like the ILO in that it has taken on responsibility for formulating standards, it claims its rules have significant consequences (determining who gets accredited, causing facilities to alter their procedures), and perhaps if it disappeared no other institution would take its place.¹⁴⁴

On reflection, though, the analogy is problematic. The JCI's role is to accredit foreign hospitals, specifically to examine their procedures and determine whether those procedures meet relevant standards of practice.¹⁴⁵ While this might be loosely thought of as a kind of "rulemaking," the JCI does not purport to regulate the medical tourism market, let alone to weigh the advantages or disadvantages of a particular country or particular hospital opening itself up to medical tourism. The same points apply even more strongly to intermediaries who are largely for-profit entities.

Second, we might analogize to the medical migration example and say that, for patients paying out-of-pocket, the lack of affordable health

144. This last point of comparison seems dubious. Even with the JCI in place, it faces competition in accreditation, including from the International Organization for Standardization (ISO). The ISO has a less popular certification program that has been used to certify some hospitals in Mexico, India, Thailand, Lebanon, and Pakistan. See Arnold Milstein & Mark Smith, "America's New Refugees – Seeking Affordable Surgery Offshore" (2006) 355:16 *New England Journal of Medicine* 1637 at 1639. Thus, if the JCI were to disappear, there is every reason to believe others would take its place. That said, while Daniels describes the ILO as having these three characteristics, it may be that meeting the first two is sufficient to ground the duties he has in mind.

145. See Cohen, "Protecting Patients", *supra* note 14 at 1485; Cortez, *supra* note 46 at 83-84.

insurance in the US system, and its failure to prevent insurer-prompted medical tourism, drives medical tourism, much like the United Kingdom's recruitment of foreign nurses drives migration. Accepting that analogy, however, would cause the intermediate theory to lose much of its appeal. In medical tourism by patients paying out-of-pocket, we do not have the US government or international bodies directly creating push and pull factors. True, the US government has not taken steps to prevent travel to India for medical procedures – for example, by criminalizing consumption in the way it does child sex tourism abroad under the *PROTECT Act* of 2003¹⁴⁶ – but if merely not acting and following a background norm of permitting travel to consume goods and services abroad is sufficient under Daniels' intermediate theory, the theory loses much of its attraction as a middle ground between the Cosmopolitan and Statist poles because so much of the day-to-day workings of international trade will trigger obligations under the theory.

That said, it seems to me that government-sponsored medical tourism initiatives such as that considered by West Virginia and that proposed for Medicare and Medicaid would fit the medical migration analogy quite well and might create US obligations to destination countries, at least insofar as tourism is incentivized and not merely covered in a way that is cost-neutral from the point of view of the patient. Medical tourism in universal health care countries prompted by long wait times might also better fit the analogy – the failure to produce sufficient medical practitioners in the patient's home country might prompt attempts either to recruit foreign providers (brain drain) or to incentivize medical tourism. However, the propriety of that last potential analogy seems to be a closer question, and it is unclear where the stopping point is from that analogy to the (problematic) conclusion that the fundamental organization of one's domestic health care system might trigger duties of inclusion internationally based on home country patients' reactions to it.¹⁴⁷

146. 18 USC § 2423(c), (f) (2006); see also Cohen, "Protecting Patients", *supra* note 14 at 1511-16 (discussing this as a possible intervention for regulating medical tourism).

147. To put the point in an exaggerated way: suppose that the underlying principle advocated by these authors was "for any domestic policy choice

Third, one might focus on the obligations some destination countries have undertaken to open up their health care sectors to medical tourism under the *General Agreement on Trade in Services* (GATS)¹⁴⁸ and argue that it plays a “coercion-lite” role analogous to the obligations of WTO membership discussed by these authors.¹⁴⁹ While GATS imposes general obligations that apply to all WTO members, it imposes obligations relating to “market access”¹⁵⁰ and “national treatment”¹⁵¹ on countries that have explicitly elected to be bound by them. These obligations – called “specific commitments” – are made as to particular service sectors and particular modes of service (consumption abroad, cross-border supply, etc.).¹⁵² Violations of these obligations are subject to trade sanctions. Medical tourism might be implicated by a country’s specific commitment to open up its “Hospital Services” sector, which includes *inter alia* surgical, medical, ob-gyn, nursing, laboratory, radiological, anesthesiological, and rehabilitation services.¹⁵³

our country makes, be it health, education, transportation, etc., we are responsible for remediating any effects that follow, whether the conduit is changes in trade, consumption, or travel by our populace.” That would make it mysterious why they paid such careful attention to particular institutional relations, such as the ILO, TRIPS, or poaching of doctors. On this principle that analysis was superfluous, the answer was much, much simpler. I thus have serious doubts that this is what these authors had in mind. Of course, that is a matter of interpretation. Perhaps more pointedly, if this is the principle that underlies the intermediate approach, it ceases to be a distinctive middle ground between the Cosmopolitan and Statist theories that can focus on particular institutional arrangements, coercion, and interdependency. Further, such a broad principle reintroduces the pragmatic policy-oriented worry I discussed above that the intermediate approach advantageously seemed poised to avoid.

148. 15 April 1994, 33 ILM 1167 (entered into force 1 January 1995) [GATS].

149. See Patricia J Arnold & Terrie C Reeves, “International Trade and Health Policy: Implications of the GATS for US Healthcare Reform” (2006) 63:4 *Journal of Business Ethics Reform* 313 at 315; Cohen, “Protecting Patients”, *supra* note 14 at 1521, n 213.

150. GATS, *supra* note 148 at art XVI.

151. *Ibid*, art XVII.

152. *Ibid*.

153. *Ibid*, art III; see also Arnold & Reeves, *supra* note 149 at 316-18 (discussing the relationship between GATS and trade in health services); Cohen, “Protecting Patients”, *supra* note 14 at 1521, n 213 (discussing

To be sure, the analogy (and thus, duties of inclusion) will only apply to countries that have undertaken obligations under GATS to open up their health care systems. Even as to these countries, though, the theory faces the self-inflicted wounds problem. The decision to become a signatory of GATS and open up one's medical system to medical tourism is itself within the control of the destination country, so how could it give rise to duties of inclusion on the part of the other signatories? In responding to a similar objection to their WTO example, Cohen and Sable suggest the point "seems almost facetious" because "[o]pting out is not a real option (the WTO is a 'take it or leave it' arrangement, without even the formal option of picking and choosing the parts to comply with), and given that it is not, and that everyone knows it is not, there is a direct rule-making relationship between the global bodies and the citizens of different states."¹⁵⁴ This same response, however, is much less persuasive in the GATS/medical tourism context because unlike the all-or-nothing WTO agreements, the GATS specific commitment obligations are incredibly versatile, with individual states making individual commitments as to individual modes for individual sectors.¹⁵⁵ The proof is to some extent in the pudding: as WTO officials Rudolf Adlung and Antonia Carzaniga recently observed, across the board there is a "generally shallow level of [GATS-specific] commitments on health services" with "no service sector[s] other than that of education [having] drawn fewer bindings among WTO Members than the health sector."¹⁵⁶ Indeed, in 2001 across all GATS modes only forty-four members made commitments as to hospital services and only twenty-nine to services provided by nurses, midwives, etc.; and, while there are generally more commitments in LDCs, the pattern is far from uniform.¹⁵⁷ Thus, the take-it-or-leave-it, offer-you-can't-refuse type of argument relied on by Cohen, Sable, and Daniels in their discussion seems to have less traction

the relationship between GATS and medical tourism).

154. Cohen & Sabel, *supra* note 136 at 168.

155. *Ibid.*

156. Rudolf Adlung & Antonia Carzaniga, "Health Services Under the General Agreement on Trade in Services" (2001) 79:4 Bulletin of the World Health Organization 352 at 356-58.

157. *Ibid.*

here.

This difficulty may not be fatal, and one way out might be to borrow two ideas from the philosophical work done by Gopal Sreenivasan on the effect of GATS rules on national choices and how those rules restrict efforts to expand public health care. In responding to a similar self-inflicted wounds problem, Sreenivasan first suggests (though he does not fully embrace the idea) that while “[v]olunteering for treaty obligations is an exercise of sovereign authority ... sovereignty and democratic legitimacy are not the same thing,” and the issue of democratic legitimacy turns on the “kind of popular mandate [that] existed for various decisions taken in relation to the GATS.”¹⁵⁸

This would obviously rule out the validity of GATS restrictions for dictator states, but also, he suggests, call into question the validity of other less-than-democratic forms of mandate: he contrasts the way GATS was subject to the possibility of a popular referendum in Switzerland before approval with the way the US Congress ratified the agreement not as a treaty, but as ordinary legislation, and did so via approval of the Uruguay Round, in which all the terms of the agreement had to be accepted or rejected at once.¹⁵⁹ By analogy, one could argue that because some of the destination countries also ratified GATS in these less-than-democratic ways, the fact that they chose to enter GATS should not stand in the way of establishing obligations to these countries on Daniels’ intermediate theory (*i.e.* compliance with GATS should not be considered a “self-inflicted wound”). Sreenivasan himself seems understandably ambivalent about how far to take this response, and wonders whether we should instead presume a popular mandate as to ordinary legislation.¹⁶⁰

Second, and I think more confidently, Sreenivasan argues that because GATS imposes obligations in an intergenerational sense and the penalties for exiting GATS are so large, GATS should be thought of as more akin to constitutional obligations, like a Bill of Rights, than ordinary legislation. Sreenivasan’s conclusion is not that “nothing can

158. Gopal Sreenivasan, “Does the GATS Undermine Democratic Control Over Health?” (2005) 9:1-2 *Journal of Ethics* 269 at 274-75.

159. *Ibid* at 275.

160. *Ibid* at 275-76.

confer democratic legitimacy on effectively compulsory obligations that span generations,” which “would certainly be going too far”; instead, his claim is that these kinds of obligations “require special measures of democratic scrutiny in order to gain legitimacy,” such as the supermajority and dedicated referendums that are commonly required for constitutional amendments.¹⁶¹

I do not attempt to fully assess the merits of Sreenivasan’s argument here. Instead, my more limited goal is to show that, although Sreenivasan’s work is on democratic legitimacy and not international justice obligations, it is possible that Cohen, Sable, and Daniels might graft his approach (or a variant of it) onto their own theory to offer a different kind of response to the self-inflicted wounds problem in the medical tourism context; indeed, this solution, suggested by the application to this case, may be a more generalized direction in which their theory might be extended. Doing so might mean that duties of inclusion arise as to medical tourism, but only as to the subset of destination countries who have made GATS commitments impinging on their ability to resist medical tourism, that (1) are dictatorships (or perhaps without a popular mandate) or (2) have ratified GATS in ways that do not meet specified requirements for democratic legitimacy of “effectively compulsory obligations that span generations.”¹⁶²

While this may adequately deal with the “self-inflicted” wounds problem relating to GATS, several of the triggering conditions for medical tourism’s negative effects on health care access in the destination country – the supply of health care professionals, whether the system is regulated in such a way that requires professionals to spend time in both the public and private systems – are, as I stressed above, also at

161. *Ibid* at 277-79.

162. I say “might” because one might counter that the self-inflicted wounds problem is “turtles, turtles all the way down.” If these features of the destination country’s political system led to deficits in ratifying GATS, one might counter that those features are themselves “self-inflicted wounds,” within the control of the destination country. On such an argument, it would not only be the GATS-ratifying decision itself, but also the constitutional or other political structure that sets up this mechanism for ratifying treaties that would itself have to have contain the features Sreenivasan suggests are necessary for democratic legitimacy.

least partially within the control of the destination country governments. These decisions represent ordinary legislation, not the extraordinary kind relating to GATS and, in most cases, will enjoy a popular mandate of some sort.¹⁶³

Do these kinds of self-inflicted wounds not blunt the claim that home country governments or international bodies bear responsibility for deficits associated with medical tourism? Yes and no. As Daniels has persuasively argued, even countries with similar domestic policies experience significant differences in population health, such that “[e]ven if primary responsibility for population health rests with each state, this does not mean that the state has [the] sole responsibility.”¹⁶⁴ In order to clarify home countries’ obligations, we ought to try to factor out the elements of destination countries’ population health deficits caused by medical tourism that are a result of the domestic policy decisions¹⁶⁵ and then apply the Cohen, Sable, and Daniels duties of inclusion only to the remaining deficits that meet the theories’ requirements.

This ability to apportion responsibility between the destination and home countries seems like a major theoretical advantage of this approach as against the prior ones discussed. Of course, while conceptually simple to state, actually doing such apportioning would be extremely difficult in practice, and the absolute best we can practicably hope for is a rough approximation. Thus, only in instances of medical tourism where a plausible case of “coercion-lite” or other pressure can be said to give rise to a duty of inclusion will such duties attach, and only then as to the proportion of the deficits caused by medical tourism to health care access by the destination country poor that is outside the control of the destination country.

163. Again, it remains open to press the stronger version of the argument about which Sreenivasan is ambivalent – that even ordinary legislation requires a form of direct democratic or supermajoritarian check to “count” as the will of the people for international justice purposes and create a self-inflicted wound. I feel ambivalent enough about this claim (as I think Sreenivasan does) that I would not want to press this as a way of avoiding the self-inflicted wounds problem, but others may find it a more appealing approach to the issue.

164. Daniels, *supra* note 39 at 345.

165. See *ibid* at 341-45.

Even if one of these routes validly triggers a duty of inclusion on some home countries or international bodies for some sets of medical tourism, there is the further question of what that duty entails. The authors are self-admittedly somewhat vague about the contours of these kinds of duties, telling us that it is not a duty of “equal concern” or redistributive justice on the one hand, but that it requires more than mere humanitarian duties on the other, and that it requires treating individuals abroad as individuals whose good “counts for something” (not nothing) while making decisions that will impact their life.¹⁶⁶

That leaves a fair amount of room to maneuver. One could imagine the duties mandating something like “notice and comment rulemaking” in administrative law – which would merely require acknowledging that these interests were considered, but found to be outweighed¹⁶⁷ – to something approaching a weighting formula in which the welfare of those abroad is counted as .8 while those in the nation state are counted as 1 (to use purely fictional discounting factors).

In discussing the brain drain example, Daniels seems to suggest duties of inclusion should have significant bite, arguing that they might prohibit recruitment from vulnerable countries, force recruiting countries to restrict the terms they offer foreign health workers, compensate for losses suffered when health care workers are lost, or give aid to help reduce push factors.¹⁶⁸ By analogy, in the context of medical tourism, such duties could perhaps require the United States to prevent its citizens from traveling abroad, channel its patients to medical tourism facilities or countries with programs to ameliorate health care deficits that result, tax medical tourists, intermediaries, or insurers, and use that revenue as aid aimed at amelioration, or provide more general aid to build institutional health care capacity in the destination country or, more appropriately, regulate its health care sector. I return to regulatory design options in greater depth in the next Part.

166. Cohen & Sabel, *supra* note 136 at 154-55; see also Daniels, *supra* note 39 at 351 (making a similar point in the health context).

167. See *Administrative Procedure Act*, 5 USC § 553 (2000); John F Manning & Matthew C Stephenson, *Legislation and Regulation* (New York: Foundation Press, 2010) at 604-40.

168. Daniels, *supra* note 39 at 353-54.

2. Pogge

A quite different intermediate theory, to which it will be difficult to give justice in this short space, is suggested by Thomas Pogge. Pogge begins with the idea that all people have rights to a “minimally worthwhile life” and therefore require a share of minimum levels of basic goods, including health care, that are essential to a decent life – he terms such goods “human rights.”¹⁶⁹ According to Pogge’s theory, citizens of one state have an obligation to avoid “harming” citizens of another state by imposing “deficits” on their access to these human rights; that is, he argues that “[w]e are harming the global poor if and insofar as we collaborate in imposing” a “global institutional order ... [that] foreseeably perpetuates large-scale human rights deficits that would be reasonably avoided through foreseeable institutional modifications.”¹⁷⁰

Pogge applies his approach to many examples, but the closest to ours is his claim that wealthy countries have an obligation to loosen their enforcement of the intellectual property rights of pharmaceutical companies to drugs that LDCs desperately need. In this application of his approach, Pogge suggests that “[m]illions would be saved from disease and death if generic producers could freely manufacture and market life-saving drugs” in those countries.¹⁷¹ Part of his ire is focused on the Trade-Related Aspects of Intellectual Property Rights (TRIPS) Agreement, membership in which was made a condition of joining the WTO and requires members to grant twenty-year product patents on new medicines. Pogge suggests that the TRIPS Agreement, which he claims was disastrous for LDCs, “foreseeably excludes the global poor from access to vital medicines for the sake of enhancing the incentives to develop new medicines for the sake of the affluent,” and asks, “[h]ow can the imposition of such a regime be justified to the global poor?”¹⁷²

169. Thomas Pogge, *World Poverty and Human Rights* (Cambridge, Mass: Polity, 2002) at 48-49; see also Fisher & Syed, *supra* note 68 at 644-45 (discussing Pogge’s account).

170. Thomas Pogge, “World Poverty and Human Rights” (2005) 19:1 *Ethics & International Affairs* 1 at 5; see also Daniels, *supra* note 39 at 337-39 (discussing Pogge’s account).

171. Pogge, *ibid* at 6; Pogge, *supra* note 169 at 74.

172. Thomas Pogge, “Access to Medicines” (2008) 1:2 *Public Health Ethics* 73

Pogge instead proposes a tax-based fund that operates as a prize system rewarding drug companies for their products' contribution to reductions in the global burden of disease.¹⁷³

In a second example paralleling one used by Cohen, Sable, and Daniels, he claims that many WTO policies cause human rights deficits because they permit the affluent countries' "continued and asymmetrical protections of their markets through tariffs, quotas, anti-dumping duties, export credits and huge subsidies to domestic producers," and thereby "greatly [impair] export opportunities for the very poorest."¹⁷⁴ In response, Pogge suggests that the rich countries have an obligation to "[scrap] their protectionist barriers against imports from poor countries," which he claims would lower unemployment and increase wage levels in those countries.¹⁷⁵

Might the same claims hold as to medical tourism? One might say it also "foreseeably excludes the global poor from access to" health care "for the sake of enhancing" the health care access and cost savings in the West. Further, like Pogge's own examples, one could say that medical tourism is supported by the existing institutional order insofar as that order facilitates things like international travel; standard settings; the accreditation of foreign hospitals; the training and credentialing of foreign doctors in the United States and other developed countries; etc.¹⁷⁶

However, there are a few problems (or at least open questions) that become manifest through this application to medical tourism. First, what is the content of a human right to health? Or, to put it otherwise, how

at 75.

173. *Ibid* at 76-78.

174. Pogge, *supra* note 170 at 6.

175. *Ibid.* As a descriptive matter, Pogge's account of the negative effects of TRIPS is not without dissenting view. See *e.g.* Rachel Brewster, "The Surprising Benefits to Developing Countries of Linking International Trade and Intellectual Property" (2011) 12 *Chicago J Int'l L* 1.

176. See generally Cortez, *supra* note 46 (discussing the way these things facilitate medical tourism); Aaditya Mattoo & Randeep Rathindran, "How Health Insurance Inhibits Trade in Health Care" (2006) 25:2 *Health Affairs* 358 (presenting a similar discussion); Graham T McMahon, "Coming to America – International Medical Graduates in the United States" (2014) 350:24 *New England Journal of Medicine* 2435 (discussing the reliance on foreign doctors in the US health care system).

much health care must one have before one's human rights are being violated?¹⁷⁷ In answering this question, the theory faces a problem that parallels one we discussed for Nussbaum and Sen – if the threshold is set too low, the negative effects of medical tourism may not cause a “deficit” to the human right; if the threshold is set too high, then it will cause a deficit, but so will not allowing that tourism to go forward (given the needs of the American patients using medical tourism). Pogge has offered a response to a somewhat similar criticism by suggesting the *proviso* to his theory that “these human rights deficits must be reasonably avoidable in the sense that a feasible alternative design of the relevant institutional order would not produce comparable human rights deficits or other ills of comparable magnitude.”¹⁷⁸ But, as in our discussion of a somewhat similar *proviso* by Nagel, one might wonder what “reasonably avoidable” really means and how much of the institutional order we should feel free to redesign in a given moment. Once again, this problem seems least acute for insurer-prompted medical tourism and medical tourism for services like cosmetic surgery.

Second, Pogge has tried to avoid some of the pragmatic and political feasibility problems of the Cosmopolitan theories by trying to use a kind of act-omission distinction, with the ideas of “harm” and “imposing ... deficits.” But, as Daniels has remarked, “[i]nternational harming is complex in several ways. The harms are often not deliberate; sometimes benefits were arguably intended.” Daniels has also argued that “harms are often mixed with benefits” such that “great care must be taken to describe the baseline in measuring harm,” and the “complex story about motivations, intentions, and effects might seem to weaken the straightforward appeal of” Pogge's theory.¹⁷⁹ To illustrate: as in Pogge's examples (by hypothesis), the existence of the phenomenon of medical tourism leads to a “deficit” in one human right – health care – and one might say that medical tourism is supported by the existing

177. *C.f.* Daniels, *supra* note 39 (asking whether Pogge's human right to health is frustrated “[w]henver a country fails to meet the levels of health provided, say, by Japan, which has the highest life expectancy” at 337).

178. Thomas Pogge, *World Poverty and Human Rights: Cosmopolitan Responsibilities and Reforms* (Cambridge, Mass: Polity, 2008) at 26.

179. Daniels, *supra* note 39 at 340.

institutional order insofar as that order facilitates things like international travel, standard setting, and accreditation of foreign hospitals. But do these institutional elements “harm” the human right to health care of destination country citizens in our case?¹⁸⁰

In Pogge’s examples, we have identifiable state and international actors, chief culprits if you will, at whom he can point the finger as actors who caused the deficit in question: the WTO, the TRIPS Agreement, and those who support them.¹⁸¹ For medical tourism, by contrast, we

180. In discussing Pogge’s proposal to create a prize system to spur innovation in drugs targeting the global burden of disease, Daniels critiques whether what is going on is really “harming” versus “not optimally helping?” Daniels, *supra* note 39 at 337. A similar worry seems less apposite as to medical tourism where it is the actions of home country citizens that are setting back the interests of those abroad, assuming *arguendo* that medical tourism makes the Indian poor worse off than they would otherwise be.

181. Others writing in much the same vein as Pogge on access to essential pharmaceuticals in LDCs have emphasized similar facts about this context that strain the analogy to medical tourism and suggest the case for Global Justice obligations may be much stronger in the pharmaceutical context. For example, Outterson and Light, working on an analogy to duties to engage in easy rescue when there are special relationships, suggest several specific reasons why that analogy is applicable in the drug context: the fact that “the patent-based drug companies created the global intellectual property system and are actively preventing rescue by others” with the explicit goal of prohibiting “free trade of low-priced generics from the emerging pharmaceutical industries in developing countries” thereby having created the danger, the fact that the drug companies receive public monies and are able to block development through the patent system, and (according to these authors) the fact that that innovation rewards could be set up in such a way to make this a case of “easy rescue” wherein pharmaceutical companies would not lose much if anything from their bottom line. Kevin Outterson & David W Light, “Global Pharmaceutical Markets” in Helga Kuhse & Peter Singer, eds, *A Companion To Bioethics*, 2d ed (Malden, Mass: Wiley-Blackwell, 2009) 417 at 417-29. None of these points seems true as to the United States’ or other home countries’ involvement in medical tourism by those individuals paying out of pocket. That said, some elements (such as the use of public funds) are more analogous to government-prompted medical tourism, and some of these points (pursuit of profit-maximizing strategies that may run counter to destination-country health care access) may in appropriate cases provide reasons for subjecting medical tourism intermediaries to the same approbation these authors foist on drug companies. This latter point on corporate social responsibility raises questions beyond the scope

have a much more complex web of acts and omissions that together form the system. We have the private decisions of individual citizens in the home country to satisfy health care needs in a foreign country, which seems like causing harm, but that need may be itself caused by a state-level failure to secure universal health care, or even more indirectly by the failure to adopt more redistributive taxation approaches. What about the role played by US health insurance companies in pricing their plans that in part determines how many Americans are uninsured (which, in turn, is partially a function of the wage demands of health care workers)? We also have the background international law and trade principles allowing for free travel by citizens to foreign states and the consumption of goods and services abroad, but are those causes of deficits?¹⁸² To put the point another way, the baseline against which Pogge's concept of harm is drawn is extremely slippery as to medical tourism – a problem that legal realism has emphasized in legal discourse.¹⁸³

of this article, which is focused on governmental and intergovernmental obligations.

182. Larry Gostin has made a similar point as to these kinds of theories more generally: "National policies and globalization have benefited the rich and contributed to global health disparities, but so have many other factors. Blame for harms in the Third World, however, is hard to assess. States usually do not intend to cause harm to poor countries, and political leaders may believe they are doing good. International policies, moreover, often have mixed benefits and harms that defy any simple assignment of blame. Finally, countries themselves may have contributed to the harms due to inadequate attention to population health, excessive militarization, or simple incompetence or corruption. At bottom, reasonable people disagree as to who bears the responsibility for health inequalities and who owes a duty to right the perceived wrongs." Gostin, *supra* note 68 at 345-46.
183. It is also worth emphasizing that not every "harm" in the sense that Pogge uses the term may morally obligate us to compensate the victim. If I open up a flower shop next door to yours, and my shop siphons off your best florists by offering higher wages that causes a diminution in your business, we do not ordinarily think that I have wrongfully harmed you or that I owe you recompense for the setback to your interest. This is true even if I open my shop with the intention of driving you out of business. If this is the mechanism by which medical tourism reduces access to health care for the destination country poor (one of several of the possible mechanisms I sketched above) – that doctors who served the destination country poor instead move over to the medical tourism facility to treat their patients

All that said, I do not want to overstate the point. The subset of government-sponsored medical tourism seems to nicely parallel Pogge's own examples: this form of medical tourism has both a clear causal pathway of "harm" and easy-to-specify institutional rearrangements, such that under Pogge's view, it should give rise to obligations on home countries. How well the theory extends into medical tourism by patients purchasing out-of-pocket (or even insurer-prompted medical tourism), however, is less clear.

VI. Convergence, Divergence & Policy Prescriptions

In this article, I have tried to tackle head-on the pressing question of medical tourism and access to health care abroad. While I hope to have made some progress, part of the point has been to show how complex the issue is and how, on the philosophical side, it identifies *lacunae* and poses hard questions for many major theories.

I began by identifying the biggest unknown in the question – what effect medical tourism is actually having on health care access in the destination country – and have sought to assist the empirical project of answering that question by specifying several plausible triggering conditions through which we would expect medical tourism to reduce access to medical services for the poor in the destination country.

Assuming *arguendo* that the empirical claim that medical tourism impairs health care access by the destination country poor in some cases is satisfied, I then examined the normative question: under what conditions would a diminution in health care access by the destination country poor due to medical tourism trigger obligations on the part of home countries and international bodies? I rejected the simplest argument appealing to national self-interest in restricting medical tourism because it is implausible. I then examined three broad camps of Global Justice theory (Cosmopolitan, Statist, and Intermediate) as grounds for obligations, but

– it seems that the facility should similarly not owe recompense or remediation; if the medical tourism facility does not owe the destination country poor for this action, why should the home country whose causal role in the harm is still more attenuated? I am indebted to Nir Eyal for this suggestion.

that examination has not pointed in one clear direction. I have expressed a preference for the approach of the Intermediate theories because they try to offer us a theory of obligations stemming from medical tourism, rather than a more general theory of what we owe to those abroad quite divorced from medical tourism. In particular, the institutional-focused approach of Cohen, Sable, and Daniels seems to me an extremely fertile way forward in this area, though I have suggested reasons why its actual application to this case study might suggest a more restricted set of obligations than that championed by many of the commentators (academic and popular) discussed in the introduction.

Taking a step back, what can we say about the larger landscape of Global Justice theories, access to health care, and medical tourism? While I think a true overlapping consensus or incompletely theorized agreement between these different theories eludes us in this area, I do think it is fair to say we can identify two “central tendencies” among the group of theories: insurer-prompted medical tourism and government-prompted medical tourism are the areas where the argument that states and international bodies have a moral obligation to intervene is the strongest, for two different (but on some theories also overlapping) reasons. The case for curbing insurer-prompted medical tourism is stronger because preventing these services is less likely to expose the state’s own citizens to deficits in health care access,¹⁸⁴ which would be in tension with the same concerns regarding those abroad. Similar reasoning suggests that there is a greater obligation to restrict medical tourism for inessential services or services that are more penumbral to the concept of health (such as cosmetic surgery and, on some accounts, fertility tourism). The case for intervening in government-prompted medical tourism is stronger because there is a fairly direct causal tie between the state’s action and the deficits caused by medical tourism (which matter on the intermediate theories). Claims of an obligation on the part of the home country government or international bodies to do something about medical tourism by those

184. To be sure, as I cautioned above, even restricting insurer-prompted medical tourism poses some risk of diminution in access domestically; it is just that it appears to pose less of that risk such that the case for intervention is concomitantly stronger.

purchasing essential services out-of-pocket seem concomitantly weaker.

Beyond these central tendencies, however, there is a fair amount of divergence among the theories in picking out which circumstances give rise to obligations (*e.g.*, only medical tourism to “burdened states”? Only medical tourism to states whose method of ratifying GATS seems suspect?) and whether there are limits on the means by which those obligations can be met (only foreign aid, targeted or otherwise, or more paternalistic attempts to control the flow of home countries’ patients as well?). The Nagelian conception of humanitarian aid might be thought of as a floor on which these other theories can add, but, as I have shown above, its demands are somewhat independent of medical tourism and instead stem from the existence of desperate need, regardless of its causal relation to medical tourism.

In any event, my ambition here has been to lay out the terrain of Global Justice theories, their application to medical tourism, and the problems that arise from that application.¹⁸⁵ Going further and deciding the exact content of those obligations requires choosing between these rival theories and filling many of the *lacunae* I have identified in their application. Although I have made some tentative suggestions here and there, I have not attempted that task in this paper. Instead, my goal has been to open a dialogue between moral and political theorists and those making on-the-ground policy prescriptions relating to medical tourism’s negative effects on the health of the poor in the destination country.

My own tentative conclusion is that there is a more persuasive case for restricting insurer-and government-prompted medical tourism, and medical tourism for services that are inessential or more in the penumbra of “health.” By contrast, due to concerns about health care access in the home country, I find less convincing the case for restricting medical tourism for those purchasing essential health services out-of-pocket, especially when this represents these individuals’ best way of getting these services.¹⁸⁶

185. While my own theoretical preferences lean towards the Cohen, Sable, and Daniels approach as the most useful approach in this area, I have tried to maintain a relatively Catholic attitude towards the different contenders so as to pave the way for those more drawn to one of the rival accounts.

186. One lingering concern with that conclusion is that it seems to “reward”

Interestingly, that ordering mirrors my conclusions on the policy side as to the ease by which home states can implement policies to curb medical tourism of different varieties, as I have suggested in other work on medical tourism.¹⁸⁷

For government-prompted medical tourism, the United States could, by regulation or legislation, restrict facilities or countries to which it sends patients to those with health care access guarantees or amelioration plans. It could also leave the market unregulated but dedicate foreign aid to destination countries based on the volume of medical tourism to particular regions. Of course, in so doing, it would have to rely on foreign sovereigns to spend aid appropriately or devise a system whereby nongovernmental organizations (NGOs) are given the aid or monitor its spending. As long as such policies did not result in significantly longer waiting times or fewer procedures covered, the effect on health care access for the US poor would be small.

For insurer-prompted medical tourism, the United States could by state or federal insurance regulation prevent sending patients to facilities or countries without health access amelioration plans.¹⁸⁸ The United

the “bad” countries that have not secured universal health care in their home state, and thus have given more of their domestic poor the incentive to go abroad. Of course, it is beyond cavil that countries like the United States that have failed to secure truly universal health care have not failed to do so in order to be able to send their poor abroad for medical tourism without acting unjustly, but that does not seem an adequate response. Here are two that may be more (if not entirely) satisfying. First of all, to repeat something I said earlier, *supra* note 135, in a world of ideal justice, the United States would have achieved universal health care, but we are faced with a very different world and are asking what obligations we can realistically impose upon it under the circumstances. Second, while we may be “rewarding” the “bad” states, we also want to avoid “punishing” their poor citizens who lack better options than medical tourism.

187. See Cohen, “Protecting Patients”, *supra* note 14 at 1506-17, 1544-46. For a more in-depth discussion of the tools and drawbacks for regulating medical tourism, including extensive discussion of home country, destination country, and multilateral possibilities for regulations, see I Glenn Cohen, “How To Regulate Medical Tourism” [unpublished, archived at Virginia Journal of International Law Association] [Cohen, “How to Regulate”].
188. *C.f. ibid* at 1544-46. But see *supra* note 51 and sources cited therein for skepticism as to how well such regulation is actually enforced in a

States could also (in addition or separately) tax insurers by their volume of medical tourism and redistribute those sums towards health care access amelioration in the destination country. This would mirror to some extent the UNITAID scheme; UNITAID is an NGO aimed at scaling up access to treatment for HIV/AIDS, malaria, and tuberculosis, primarily for people in low-income countries. A large share of its funding (72 percent) stems from twenty-nine supporting countries (including France and Chile) that have voluntarily chosen to impose on airlines departing from their countries a tax on departing passenger tickets collected by the airlines set by the country – for example, France imposes a €1 and €10 tax on domestic economy, and a €4 and €40 tax on departing international flights, respectively.¹⁸⁹ One might also think about this in analogy to the use of taxes on tobacco products to offset some of the costs those products impose on the health care system.

It is much harder to regulate the behavior of US medical tourists paying out-of-pocket. Even here, though, we do have some options. The United States could hypothetically render illegal some forms of medical tourism (compare the *PROTECT Act*, making it a crime to engage in child sex while abroad), or render less attractive some forms of medical tourism (for example, by exempting them from the tax deduction available for qualifying medical expenses), but as I have said before, I worry that these regulatory interventions are either too draconian or not terribly effective.¹⁹⁰ The United States could also tax intermediaries and use the revenue to support health care access in LDCs (in a way similar to that discussed above) or try to force JCI to build health care access into accreditation standards. Less paternalistically, the United States or international bodies could create a separate third-party labeling or accreditation standard that audits facilities and informs tourists of how attentive a facility is to health care access concerns regarding the local population, as Nir Eyal has proposed under the moniker “Global Health Impact Labels” in analogy to Fairtrade Coffee.¹⁹¹ I have some

destination country such as India.

189. About UNITAID online: UNITAID <<http://www.unitaid.eu>>.

190. Cohen, “Protecting Patients”, *supra* note 14 at 1511-15.

191. Nir Eyal, “Global Health Impact Labels” in Ezekiel Emanuel & Joseph Millum, eds, *Global Justice in Bioethics* (Oxford: Oxford University Press,

doubts about how effective these labels are likely to be, since medical tourism patients are likely to choose facilities based on quite different and much more important priorities (for example, location of service, quality of doctor, and price) than coffee drinkers, though to be fair, this is an empirical question. Finally, foreign aid is always a possibility.

These are, for the most part, unilateral strategies focused on what steps medical tourist patients' home states could take. Destination country and multilateral strategies are also possible, but for reasons I have discussed in greater depth elsewhere, these seem less feasible.¹⁹²

Destination country governments can tax medical tourism providers and redistribute the proceeds to pay for health care access for the poor, regulate the behavior of their physicians and impose requirements that they spend certain amounts of their time serving domestic rather than foreign patients, require a uniform reimbursement rate or limit the disparities, etc. In destination countries where certificates or other licensure is required in order to build a new hospital or expand an existing one, the government can limit the number of entrants into the medical tourism market that exist or extract commitments (such as those pertaining to providing care for indigents) from the facilities. There are many other possible interventions, and the exact details will vary country by country, depending on their existing domestic health care regulation.

However, to the extent medical tourism offers an influx of foreign capital to the destination country and its costs occur mostly to the destination country poor (many of whom may be somewhat disenfranchised in the political system), there is a clear conflict of interests between those who regulate and those who are burdened by medical tourism. Even when these regulations are formally put in place, there is no guarantee destination country governments will enforce them or that the regulations will be much more than a paper tiger, as several commentators have suggested regarding medical tourism in India.¹⁹³

2012) 241.

192. Cohen, "How to Regulate", *supra* note 187.

193. See *e.g.* Johnston et al, *supra* note 37 at 1; Gupta, *supra* note 37; see also Chinai & Goswami, *supra* note 49 (discussing the Confederation of Indian Industry certification system for medical tourist facilities that requires hospitals "to limit the charges to foreigners as part of a dual

Turning to the multilateral approach, we have thus far not seen multilateral trade agreements pertaining to trade in health services, even in the places where such agreements would seem most natural. While the United States has pushed for more harmonization of the health care systems covered by the North American Free Trade Act (NAFTA), those calls have thus far been resisted by Canada and Mexico.¹⁹⁴ While the European Union has the most comprehensive regulatory regime for trading health services in the world – requiring *inter alia* national health insurance systems in member states to cover treatments in other member states, and mutual recognition of the credentials of doctors, nurses, and pharmacists – the World Health Organization (WHO) has concluded that “there has been little progress in developing a common regulatory framework for health services or in establishing common standards of training and practice,” and stated that “[r]egulation of professional practice in health care remains very different across the member countries.”¹⁹⁵

Although it is in theory possible for the WHO to make rules governing medical tourism through the powers granted to it by the International Health Regulations, I share with others skepticism that this is a likely way forward – importantly, it would mean straying a fair amount from the International Health Regulations’ origins and its purpose, the prevention of disease migration.¹⁹⁶ Similarly, the multiple references to a human right to health in the UN Charter, International Covenant on Economic, Social, and Cultural Rights, WHO constitution, and elsewhere have thus far resulted in remarkably little international health care regulation,¹⁹⁷ and given the various powerful pro-medical tourism

pricing system that offers domestic patients lower prices,” but noting that “even these lower prices are too high for the vast majority of India’s 1.1 billion population” at 164-65).

194. Nathan Cortez, “Patients Without Borders: The Emerging Global Market for Patients and the Evolution of Modern Health Care” (2008) 83:1 Ind LJ 71 at 128.
195. *Ibid*, quoting Rupa Chanda, “Trade in Health Services”, WHO Communication on Macroeconomics and Health, (2001) Working Paper Series, 1, 73, Paper No WG 4:5.
196. See Gostin, *supra* note 68 at 375-81.
197. See *Universal Declaration of Human Rights*, GA Res 217A(III), UNGAOR, 3rd Sess, Supp No 13, UN Doc A/810, (1948) 71; *International Covenant on Economic, Social, & Cultural Rights*, 16

constituencies, regulation restraining the medical tourism industry seems unlikely as a starting place for such an approach. Gostin has proposed a Framework Convention on Global Health, of which medical tourism could certainly play a part, but as he recognizes, there are formidable obstacles to achieving this goal, such that middle-or short-term action of this sort seems unlikely.¹⁹⁸

VII. Conclusion: From Medical Tourism to Health Care Globalization

A number of authors in both the popular and academic literature have expressed concern about the effects of medical tourism on access to health care for the poor of the destination country and have claimed that this is a normative problem calling for regulatory intervention. In this article, I have broken down this claim into its empirical and normative components and put pressure on both. On the empirical side, I have noted the current absence of evidence for diminutions in health care access by the destination country poor due to medical tourism, and tried to specify triggering conditions that could be further studied by developmental economists under which this diminution would be most likely. Assuming *arguendo* that such negative effects occur, I then examined the normative question of destination country governments and international bodies' obligations as to medical tourism having such effect. I canvassed Cosmopolitan, Statist, and Intermediate theories, and suggested ways in which application of these theories to medical tourism highlights gaps and indeterminacies, as well as reasons why some of these theories may not be good fits for this kind of applied ethics inquiry, and built on existing discussions of pharmaceutical pricing and medical migration. I have tried to map divergences and convergences between these theories, and tentatively conclude that the claim for Global Justice obligations stemming from medical tourism is strongest (but not without problems) for insurer-and government-prompted medical tourism and

December 1966, 999 UNTS 302, S Exec Doc D 95-2 1978; *Constitution of the World Health Organization preamble*, 22 July 1946, 14 UNTS 185, art 1, 62 Stat 2679; Gostin, *supra* note 68 at 381.

198. Gostin, *supra* note 68 at 383-91.

for tourism for inessential services, such as cosmetic surgeries, while it is quite weak for medical tourism by those paying out-of-pocket for essential services. Finally, I have outlined the types of regulatory policy levers available to developed countries and international bodies to seek to remedy deficits in destination country health care access due to medical tourism.

While my focus has been on medical tourism, as I suggested above, I think the discussion here has some important implications for analysis of other manifestations of the globalization of health care, and indeed, perhaps, for globalization more generally. Here are six tentative lessons I think the work I have done in this article might teach us in shaping future analyses.

First, at the highest level, while it is somewhat philosophically “impure,” I think the method of analysis provided here is useful, especially for work aimed at policymakers. The empirical and normative approaches are jointly necessary in establishing the need for action. More subtly, within the normative sphere, it is useful to consider both more and less demanding theories of Global Justice and to map their convergences and divergences; even if one thinks some of these theories are “too stingy” or “get it wrong,” they are useful for persuading policymakers and other audiences that one need not be a full-blown Cosmopolitan (with all the implications that would mean) in order to justify some actions. Thus, in medical migration (the medical brain drain), it is helpful to show, for example, that even on the narrower Statist approaches, the duty to aid burdened states may establish obligations to engage in institution-building so as to educate providers and increase capacities; on the Cohen, Sabel, and Daniels Intermediate approach, the existence of rulemaking bodies with some claim of dominion over the field (the ILO, according to Daniels) and the international interdependence fostered by push and pull factors may ground the need for action; and on the Poggean approach, the more that migration is thought of as the unjust “taking” of doctors, the more easily obligations to avoid or mitigate that activity can be understood as flowing from an obligation to avoid “harming” a “human right” to health.

Second, I think that the national self-interest arguments for

Western governments intervening in medical tourism are also weak in other instances of health care globalization. For example, I think such arguments suffer similar deficits as to medical migration. To adapt those arguments: even assuming *dubitante* that patients in the country where migrating doctors go (the “receiving country”) suffer indirectly because these new physicians provide lower quality care – or there is an increase in disease transmission to the receiving countries because of the depletion of providers in the sending country (the country from which the doctors migrate), or the sending country’s citizens are less able to purchase our goods due to their poorer health caused by migration, or migration increases immigration pressure from sending countries or national security threats to receiving countries – these negative effects are likely outweighed by the self-interested benefits of migration for the receiving country. Thus, just as with medical tourism, it seems as though we will need some form of Global Justice theory to ground obligations to intervene.

Third, the cleavage I have introduced between types of Global Justice theories has broader application to other instances of health care globalization and globalization more generally. The Cosmopolitan theories and the duty of humanitarian aid under Statist theories do not offer us a theory of when we are responsible for harms stemming from medical tourism, medical migration, or other forms of globalization, but instead a theory of when we ought to improve the lives of the badly-off simpliciter. Let me illustrate with medical migration. Again, in one sense, causation matters: only if restricting migration causes an improvement in the well-being of those in the sending country (up to a capability threshold, up to the threshold of humanitarian needs, or in the interest of increasing welfare, depending on the theory) are we required to take the action. In another sense, however, causation in the historical and responsibility senses is irrelevant because it is the mere fact of the other country’s citizens’ needs that imposes upon us the obligation to help them in whatever way we can, and not anything about migration and its effects specifically. Thus, in one direction, the duties may persist even when migration is halted or its harms are remedied in that the source of the obligation is not anything we have done, but instead the destitute state of

those abroad. In the other direction, once the theories' goals are met, we do not bear an obligation (at least under distributive justice principles) to prevent migration or remedy its ill effects, even if migration continues to produce significant health care deficits for the destination country poor that would not occur if it were curbed. Moreover, it is possible that other forms of aid or assistance might "cancel out" whatever negative effects migration has in terms of the global Cosmopolitan calculus.

In effect, these theories tell us to help those in the sending country who are badly-off by curbing or mitigating the effects of medical migration, regardless of whether that migration caused them to be badly off; this is to be contrasted with a different group of theories (such as several variants of the Intermediate approach) that would urge us to curb medical migration because it causes people in the sending country to become worse off. This distinction does not make the latter group of theories "better" than the former, but it does suggest they may be better suited at answering questions about the Global Justice implications of a particular manifestation of globalization (such as medical tourism or migration) as opposed to questions of redistribution between nations at the highest level of generality.

Fourth, my analysis here draws attention to the "self-inflicted wounds" problem that is endemic in attempts to address Global Justice concerns regarding negative impacts of globalization as well as ways to deal very directly with this concern. Again, to use medical migration as an example, there are ways in which some sending countries might increase the supply of health care providers to mitigate migration's negative effects but do not do so because of the lobbying efforts of members of the profession seeking to protect their wages by reducing supply. Moreover, there are ways in which some of these sending countries might implement programs that help them retain more providers in the face of the pull of recruiting countries, not only by improving employment conditions (easy to recommend, hard to implement), but through mechanisms like conditional scholarships that require a number of years of in-country service as a condition for forgiving student loans for medical school.¹⁹⁹

199. See *e.g.* Delanyo Dovlo & Frank Nyongator, "Migration by Graduates of the University of Ghana Medical School: A Preliminary Rapid Appraisal"

Especially on the Intermediate theories of Global Justice, the fact that a sending country in principle has these interventions available but in practice does not use them ought not to completely immunize receiving countries from Global Justice obligations, but it should also not be completely ignored in the calculus. Rather, we ought to try to factor out the elements of the sending country's population health deficits caused by medical migration that are a result of the domestic policy decisions and then apply the obligations of Global Justice to only the remainder of deficits.

As to one more specific variant of the "self-inflicted wounds" problem relating to obligations to open up one's service sector to medical tourism undertaken as a GATS signatory, I have offered an analysis that could equally be employed as to other kinds of treaty obligations relating to trade – a recurring problem as to Global Justice analysis of globalization. To the extent the obligations under these treaties span generations and are effectively compulsory due to their penalties for defection or exit, I have suggested that they might count as self-inflicted wounds reducing other countries' Global Justice obligations only insofar as these treaties meet heightened requirements for democratic legitimacy such as referenda rather than the standards of ordinary legislation.

Fifth, the analysis here has emphasized that medical tourism is a heterogeneous practice and that its different constituent forms (government-prompted, insurer-prompted, out-of-pocket, etc.) may lead to different Global Justice analyses. I have also suggested we need to pay careful attention to who benefits in the home country from medical tourism, and their counterfactual care and welfare if the practice is stymied. The same seems true as to other manifestations of health care globalization. Again, let me use medical migration to illustrate. Just as I have suggested that there is a greater obligation to restrict medical tourism for inessential services or services that are more penumbral to the concept of health (such as cosmetic surgery), it seems to me that medical

(1999) 3:1 Human Resources For Health Development Journal 40; Nir Eyal & Till Bärnighausen, "Conditioning Medical Scholarships on Long Future Service: A Defense" [unpublished, archived at Virginia Journal of International Law Association].

migration is most problematic when it would recruit sending country physicians to provide services that are inessential or penumbral to health in the receiving country. This might, for example, serve as a basis for limiting the recruiting of less developed sending country physicians for US (or Canadian or other) cosmetic surgery (or other) medical residency programs, but not residencies in other specialties. It might also lead us to allow recruiting of foreign physicians only for underserved areas in the receiving country and not more generally.

I have also argued that the case for intervening in government-prompted medical tourism is stronger because there is a fairly direct causal tie between the state's action and the deficits caused by medical tourism (which matter on the Intermediate theories). Similarly, there may be a stronger argument for intervention in medical migration in cases where a receiving country's governmental health care system – such as the National Health Service (NHS) in Britain, or the individual provinces in Canada – are the ones directly recruiting physicians from places like Ghana, as opposed to cases involving recruitment by individual private hospitals.²⁰⁰ To be sure, there are many ways in which this analogy is inexact. Unlike individual patients traveling abroad for health care, with hospitals recruiting foreign physicians, we are still dealing with institutions, and thus the Intermediate theories are better-poised to impose duties upon them. Moreover, since governmental health care systems tend to achieve better domestic distributive justice by ensuring universal coverage, there may be something worrying about penalizing them in terms of Global Justice in the analysis as compared to more privatized systems, although perhaps not if that universal coverage is attained through improper

200. The Canadian provinces are single-payers, but the doctors are individual contractors, not employees of the provinces, and hospitals may be publicly or privately owned. In the British National Health Service, by contrast, physicians in general practice are capitated employees, while specialty physicians are salaried employees of the National Health Service (NHS), and hospitals are primarily publicly owned. See *e.g.* Deborah J Chollett, "Health Financing in Selected Industrialized Nations: Comparative Analysis and Comment" excerpted in Mark A Hall et al, *Health Care Law and Ethics*, 7th ed (New York: Aspen Publishers, 2007). I leave it to other work to consider whether these differences between the two systems may be relevant in the analysis.

physician recruitment from less developed countries.

Again, I do not aim for what I have said here to provide a final analysis of Global Justice issues in medical migration, let alone other forms of health care globalization or globalization more generally. Instead, I have aimed to show how my analysis of these issues in regards to medical tourism helps us identify the right questions to ask as to the larger field of health care globalization, and perhaps globalization generally.

