

## **INTERNATIONAL HEALTH CARE CONVERGENCE: THE BENEFITS AND BURDENS OF MARKET-DRIVEN STANDARDIZATION**

NATHAN CORTEZ\*

### **INTRODUCTION**

Physicians educated in one country can practice in another because medical education and professional credentialing have become more standardized. Hospital chains can open branches in places as disparate as North America and Southeast Asia because more governments are opening their health sectors to foreign investment. The same pharmaceuticals and medical devices can be procured all over the world because groups like the International Conference on Harmonization and the Global Harmonization Task Force have helped harmonize regulatory requirements. And patients increasingly feel comfortable having invasive surgeries overseas because organizations like Joint Commission International and the International Organization for Standardization have proclaimed that certain hospitals meet internationally recognized standards.

How do we explain these recent international trends? What do we make of widespread physician emigration, or the growing phalanx of international hospital chains? Why have global sales of pharmaceuticals and medical devices grown by hundreds of billions of dollars in less than a decade? How do we explain the hundreds of thousands of patients that now seek medical treatments in foreign jurisdictions? And why is the health care industry increasingly outsourcing clinical trials, insurance claims processing, diagnostic test interpretations, and other tasks overseas?

In this article, I articulate a theory that helps explain the environment in which these trends have emerged. Although no single theory can fully account for these trends, I argue that they have all been enabled by growing “convergence” in the health care industry. Utilizing a new theory that I label “market-driven convergence,” I show that various methods, practices, and standards in the health care industry are converging—or becoming more alike across jurisdictions. For example, there are internationally recognized uses of many drugs and antibiotics. Hospital quality standards are spreading. The expectations for doing busi-

ness in health care are becoming more universal. And basic principles of scientific medicine are being taught. Modern medicine is converging.

In this article, I also demonstrate that convergence is being driven primarily by the private, rather than the public, sector. Private entities push for convergence because they benefit from it. Furthermore, the market provides incentives to eliminate inconsistencies.

Thus, this article attempts to establish a conceptual framework for understanding market-driven convergence, explains how it facilitates international trade in health care, and considers the implications—both good and bad.

Until now, health scholars have focused primarily on “policy convergence” in the public sphere. For over thirty years, scholars have asked whether policymakers emulate those in other jurisdictions, and whether health system reforms have followed the same general trends. For example, in 1994, the Organization for Economic Cooperation and Development (OECD) analyzed health system reforms in seventeen countries, finding that later reforms generally borrowed policies and innovations from earlier reforms.<sup>1</sup> Several other scholars have found evidence of public policy convergence in health care.

But what about the private health care sector? If public sector convergence warrants study, we should also investigate private sector convergence. In this article, I formulate a conceptual framework for thinking about private, market-driven convergence in health care. Given this framework, I consider the evidence for and against market-driven convergence before evaluating the benefits and burdens it presents. I conclude that although market-driven convergence generates many tangible benefits, it may do so at the expense of the already overburdened public health care systems in many countries.

I begin in Part I by discussing theories of public policy convergence in health care, the focus of most of the literature on convergence. In Part II, I utilize lessons from policy convergence to develop a conceptual framework for understanding market-driven convergence and dis-

---

\* Assistant Professor of Law, Southern Methodist University, Dedman School of Law. I thank Anthony Colangelo, Natalie Cortez, Jeffrey Kahn, Richard Saver, and Rose Cuisson Villazor for commenting on this Article. I also thank those who provided helpful comments at the Wisconsin Journal of International Law’s Dialogue on Cross-Border Health Care and the American Society of Law, Medicine, and Ethics’ panel session on Comparative and International Health Law. Finally, I thank Lincy George and Jamie Sorley for their research assistance. This research was supported by a generous grant from the Dedman School of Law.

<sup>1</sup> Organization for Economic Cooperation and Development, *The Reform of Health Care Systems: A Review of Seventeen OECD Countries*, HEALTH POL’Y STUD. NO. 5, 45 (1994).

cuss key differences between the theories. This section then evaluates several trends that illustrate market-driven convergence in action and concludes by addressing the arguments against convergence. In Part III, I explore the potential benefits and burdens of market-driven convergence. If methods, practices, and standards in the health care industry are converging internationally, what are the implications? First, I discuss the potential benefits of market-driven convergence, including increased efficiency in health care markets, gains from trade, higher quality goods and services, and enhanced patient choice and autonomy. However, I also weigh these potential benefits against the very real risks that market-driven convergence will undermine public health care. Market-driven convergence may not only exacerbate resource disparities in health care, but may also result in lower quality health care for low-income patients.

Throughout the article, I pursue two themes. First, I note, where applicable, how the United States has promoted market-driven convergence and explain the pitfalls of converging towards America's unique brand of health care. Second, I discuss how the potential benefits and burdens of market-driven convergence are particularly acute for developing countries, where the scramble for finite health care resources is even more desperate.

I conclude that although market-driven convergence presents several concrete benefits, these benefits may accrue disproportionately to the private sector at the expense of public programs. Therefore, I argue that policymakers should be wary of the risks of conforming to international, market-driven standards, particularly if it encourages their health care sectors to further privatize and commercialize.

Thus, this article establishes a conceptual framework for considering convergence in the private health care sector, using theories previously constructed for the public sector. Even though we have difficulty precisely delineating the public from the private in health care, some activities do tend to fall in either camp. I intend this article not only to help us understand the environment surrounding some significant international trends in health care, but also to evaluate the benefits and burdens of this environment.

## I. THEORIES OF PUBLIC POLICY CONVERGENCE

The idea that modern societies are becoming more similar, or “converging,” is an old one.<sup>2</sup> Observers have long noticed that policy-makers tend to emulate one another, borrowing particularly useful or clever innovations from their counterparts in other jurisdictions.<sup>3</sup> Modern travel and communications obviously accelerate this trend.<sup>4</sup>

Although convergence theories have gained popularity in recent years,<sup>5</sup> they have always been particularly appealing in health care.<sup>6</sup> Health is one of our most fundamental values—it transcends geographical, political, and cultural boundaries.<sup>7</sup> Most countries also struggle with the same challenges in health care: How do we provide quality care, to as many people as possible, for a reasonable price? Moreover, modern science and medicine have gradually influenced how most countries organize, manage, and provide health care.<sup>8</sup>

These commonalities invite theories of convergence. If policy-makers face similar challenges, why wouldn't they adopt somewhat simi-

<sup>2</sup> See generally David Mechanic, *The Comparative Study of Health Care Delivery Systems*, 1 ANN. REV. SOC. 43, 61 (1975) (discussing convergence of health care delivery systems in postindustrial societies); William Form, *Comparative Industrial Sociology and the Convergence Hypothesis*, 5 ANN. REV. SOC. 1, 5 (1979); CLARK KERR, *THE FUTURE OF INDUSTRIAL SOCIETIES: CONVERGENCE OR CONTINUING DIVERSITY?* 3 (Harvard Univ. Press 1983).

<sup>3</sup> Mark G. Field, *Comparative Health Systems and the Convergence Hypothesis: The Dialectics of Universalism and Particularism*, in HEALTH CARE SYSTEMS IN TRANSITION: AN INTERNATIONAL PERSPECTIVE 35, 37-38 (Francis D. Powell & Albert F Wessen eds., Sage Publications 1999); Colin J. Bennett, *What Is Policy Convergence and What Causes It*, 21 BRIT. J. POL. SCI. 215, 220-23 (1991).

<sup>4</sup> See Field, *supra* note 3, at 38; David Mechanic & David A. Rochefort, *Comparative Medical Systems*, 22 ANN. REV. SOC. 239, 239-40, 248 (1996).

<sup>5</sup> A brief search shows recent convergence scholarship in a wide variety of areas, including: constitutional law, Vicki C. Jackson, *Constitutional Comparisons: Convergence, Resistance, Engagement*, 119 HARV. L. REV. 109 (2005); corporate law, Chi-Wei Huang, *Worldwide Corporate Convergence within a Pluralistic Business Legal Order: Company Law and the Independent Director System in Contemporary China*, 31 HASTINGS INT'L & COMP. L. REV. 361 (2008) and Kenichi Osugi, *What is Converging? Rules on Hostile Takeovers in Japan and the Convergence Debate*, 9 ASIAN-PAC. L. & POL'Y J. 143 (2007); voting rights law, Christopher Manfredi & Mark Rush, *Electoral Jurisprudence in the Canadian and U.S. Supreme Courts: Evolution and Convergence*, 52 MCGILL L. J. 457 (2007); and labor law, *Bridging the Past and the Future: A Symposium on Comparative Labor Law, Part II: Convergence or Divergence?*, 28 COMP. LAB. L. & POL'Y J. 443-500 (2007).

<sup>6</sup> Robert Blank & Viola Burau, *Setting Health Priorities Across Nations: More Convergence than Divergence?*, 27 J. PUB. HEALTH POL'Y 265, 267 (2006).

<sup>7</sup> Richard L. Guerrant & Bronwyn L. Blackwood, *Threats to Global Health and Survival: The Growing Crises of Tropical Infectious Diseases—Our “Unfinished Agenda,”* 28 CLINICAL INFECTIOUS DISEASES 966, 966 (1999).

<sup>8</sup> Mechanic, *supra* note 2, at 61-62.

lar solutions? If the tenets of modern medicine have truly spread, why wouldn't health care policies and practices become more alike?

In this section, I consider the theories of public policy convergence that have developed over the last thirty years. Examining these theories and how they have evolved help us to understand how convergence might occur in the private sector.

### A. THE BASIC THEORY OF CONVERGENCE

Over thirty years ago, in an article titled "The Comparative Study of Health Care Delivery Systems," David Mechanic argued that certain features of health care systems around the world were converging.<sup>9</sup> Building upon broader theories that modern societies were gradually converging, Mechanic argued that science, technology, and other broad sociological patterns were driving countries to adopt common solutions to common health care problems "despite strong ideological differences."<sup>10</sup> Since that time, other political scientists, sociologists, and health scholars have argued that health care systems are converging, pointing to various trends in health care policies, practices, organization, and/or management.

The basic theory of convergence is that health care systems are becoming more alike.<sup>11</sup> Scholars have focused the most attention on examining policy convergence—the hypothesis that formal policies, regulations, and the organization of health care systems are converging. Policy convergence theories argue, in general, that as countries develop and modernize, their health care systems and policies gradually converge.<sup>12</sup>

Many health policy analysts and economists have gathered evidence supporting the policy convergence hypothesis.<sup>13</sup> For example, Robert Blank found that basic policy priorities are converging internationally, although the specific content and preferred instruments of these policies still tend to diverge in practice.<sup>14</sup>

---

<sup>9</sup> *Id.*

<sup>10</sup> *Id.* at 61.

<sup>11</sup> Blank & Burau, *supra* note 6, at 266.

<sup>12</sup> *Id.*; Bennett, *supra* note 3, at 217.

<sup>13</sup> Richard B. Saltman, *Convergence Versus Social Embeddedness*, 7 EUROPEAN JOURNAL OF PUBLIC HEALTH 449, 449-450 (1997) (summarizing various studies); Mechanic & Rochefort, *supra* note 4, at 252-53 (describing different types of convergence).

<sup>14</sup> *See generally* Blank & Burau, *supra* note 6.

Nevertheless, given the breadth of the convergence hypothesis and the resulting diversity of claims, it is always important to ask: What exactly is converging?<sup>15</sup> Is it health care policies<sup>16</sup> or policy objectives?<sup>17</sup> Is it health care financing?<sup>18</sup> Health system organization?<sup>19</sup> Management?<sup>20</sup> Public versus private participation?<sup>21</sup> Health insurance?<sup>22</sup> Medical education?<sup>23</sup> Technology?<sup>24</sup> Products?<sup>25</sup> Practice standards?<sup>26</sup>

Although most scholars carefully limit their claims, “convergence” obviously connotes different things in different contexts. As one observer notes, convergence “is not a coherent theoretical position,” but “is a complicated package of different trends and processes reflecting a variety of theoretical and epistemological claims.”<sup>27</sup>

Among the different claims of convergence, health scholars have devoted by far the most attention to policy convergence. One theory is that science, technology, and capitalism are driving policy convergence, not just in the health care sector, but in industrial societies at large.<sup>28</sup> Another theory is that health policies have generally followed the development of modern medicine.<sup>29</sup> A common theme is that countries mimic

<sup>15</sup> See, e.g., *id.*

<sup>16</sup> See, e.g., Brian Abel-Smith, *Health Reform: Old Wine in New Bottles*, 1 LONDON SCHOOL OF ECONOMICS HEALTH 7-9 (1995); David Wilsford, *States Facing Interests: Struggles over Health Care Policy in Advanced Industrial Democracies*, 20 J. HEALTH POL. POL'Y & LAW 571, 578 (1995); See Mechanic & Rochefort, *supra* note 4.

<sup>17</sup> See, e.g., Jeremy W. Hurst, *Reforming Health Care in Seven European Nations*, HEALTH AFF., Fall 1991, at 7, 8-9 (1991); Mechanic & Rochefort, *supra* note 4.

<sup>18</sup> See, e.g., Dov Chernichovsky, *Health System Reforms in Industrialized Democracies: An Emerging Paradigm*, 73 THE MILBANK Q. 339, 340 (1995).

<sup>19</sup> See, e.g., *id.*; Diane Gibson & Robin Means, *Policy Convergence: Restructuring Long-Term Care in Australia and the UK*, 29 POL'Y & POL. 43 (2001) (discussing Australia and United Kingdom); Mechanic, *supra* note 2, at 61-62.

<sup>20</sup> See, e.g., Chernichovsky, *supra* note 18, at 340; Stephen Harrison, Michael Moran & Bruce Wood, *Policy Emergence and Policy Convergence: The Case of 'Scientific-Bureaucratic Medicine' in the United States and United Kingdom*, 4 BRIT. J. POL. & INT'L REL. 1 (2002).

<sup>21</sup> See, e.g., Hurst, *supra* note 17, at 19-20; JOSEPH WHITE, *COMPETING SOLUTIONS: AMERICAN HEALTH CARE PROPOSALS AND INTERNATIONAL EXPERIENCE* (1995) (comparing how the United States relies primarily on private financing while most of our peer countries, including Australia, Canada, France, Germany, Japan, and the United Kingdom rely on public financing).

<sup>22</sup> See generally Hurst, *supra* note 17; WHITE, *supra* note 21, at 5-6, 61-90 (describing the basic health insurance models established by Canada and Germany).

<sup>23</sup> See, e.g., Mechanic, *supra* note 2, at 46-47.

<sup>24</sup> See, e.g., Field, *supra* note 3, at 39, 40; Mechanic, *supra* note 2, at 46.

<sup>25</sup> See, e.g., Mechanic, *supra* note 2, at 46.

<sup>26</sup> See, e.g., Field, *supra* note 3, at 40-42.

<sup>27</sup> Bennett, *supra* note 3, at 230.

<sup>28</sup> Saltman, *supra* note 13, at 449; Field, *supra* note 3, at 35-37.

<sup>29</sup> See Mechanic, *supra* note 2, at 61-62.

each other because they face similar obstacles—how to afford health care, how to provide it to as many people as possible, and how to make sure that it meets certain quality standards.<sup>30</sup> Many countries also face aging populations, escalating health care costs, and rising patient expectations.<sup>31</sup>

Theories of policy convergence were reinvigorated in the late 1980s and early 1990s when several countries either proposed or implemented health system reforms. Scholars and policymakers began to compare these reform efforts, benchmarking other countries' experiences and drawing conclusions about health reform trends.<sup>32</sup> As noted above, the OECD identified broad policy convergence after analyzing health care reforms in seventeen countries:

The most remarkable feature of the health system reform among the seventeen countries is the degree of emerging convergence. Whether intentionally or not, the reforms follow in the general direction of those pioneered earlier in other countries.<sup>33</sup>

After this round of convergence scholarship focusing on health system reforms, scholars began to refine theories of convergence.<sup>34</sup> Colin Bennett (1991), Dov Chernichovsky (1995), David Mechanic and David Rochefort (1996), and Richard Saltman (1997) each improved previous convergence theories. More recently, scholars have more aggressively sought evidence of divergence (Blank, 2006), or criticized the theoretical foundations of convergence theories (Marmor, Freeman, and Okma, 2005).

The scholarship demonstrates not only that “convergence” can mean different things in different contexts, but that it is multivariate and often a matter of degree—the reality often lies somewhere between complete convergence on one end of the spectrum and complete divergence on the other. These refinements of convergence theories offer valuable lessons that I use to develop a framework for understanding market-driven convergence.

---

<sup>30</sup> Blank & Burau, *supra* note 6, at 265.

<sup>31</sup> *Id.*

<sup>32</sup> Saltman, *supra* note 13, at 449.

<sup>33</sup> Organization for Economic Cooperation and Development, *supra* note 1; *see generally* Mechanic, *supra* note 2, at 61.

<sup>34</sup> *See* Bennett, *supra* note 3 (1991), Chernichovsky, *supra* note 18 (1995), Mechanic & Rochefort, *supra* note 4 (1996), and Saltman, *supra* note 13 (1997).

## B. CONVERGENCE IS A PROCESS

In 1991, Colin Bennett refined how we think of convergence in several ways. First, he framed policy convergence as a process rather than as a static comparison between two or more countries.<sup>35</sup> He emphasized that convergence “should be seen as a process of ‘becoming’ rather than a condition of ‘being’ more alike.”<sup>36</sup> Bennett suggested that convergence represents a “movement over time toward some identified common point.”<sup>37</sup>

Second, Bennett identified five different types of policy convergence. Countries may adopt (1) similar policy goals, (2) similar policy content, (3) similar policy instruments, (4) similar policy outcomes, and/or (5) similar policy styles.<sup>38</sup> This helps us understand that convergence comes in different forms, which is important to note when discussing an industry as varied and as complex as health care.

Third, building on this framework, Bennett also identified four modes by which policies may converge (1) through emulation, (2) through networking by “elites” in discrete policy communities, (3) through international harmonization, and (4) through penetration by foreign actors and entities.<sup>39</sup> Each mode helps us understand how policies might converge and offers insights as to how private industry practices might converge.

Health policies converge under Bennett’s first mode via “emulation:” policymakers borrow ideas from their counterparts in other jurisdictions. But Bennett differentiated “emulation” from “diffusion.”<sup>40</sup> “Emulation” occurs when countries consciously copy or adapt practices from other jurisdictions.<sup>41</sup> “Diffusion” occurs when countries successively adopt similar policies or practices, with no evidence of conscious copying or adaptation.<sup>42</sup> In the private sector, “diffusion” might be more prevalent than “emulation” given the nature of market competition, al-

---

<sup>35</sup> Bennett, *supra* note 3, at 219.

<sup>36</sup> *Id.*

<sup>37</sup> *Id.* (quoting Alex Inkeles, *Convergence and Divergence in Industrial Societies*, in DIRECTIONS OF CHANGE: MODERNIZATION THEORY, RESEARCH AND REALITIES 13-14 (Mustafa O. Attir, Burkhard Holzner, & Zdenek Suda eds., Westview Press 1981) (internal quotations omitted)).

<sup>38</sup> *Id.* at 218.

<sup>39</sup> *Id.* at 220-229.

<sup>40</sup> *Id.* at 220-21.

<sup>41</sup> *Id.* at 220.

<sup>42</sup> *Id.* at 220-21.

though it might also be less important to differentiate the two for the purposes of understanding market-driven convergence.

Health policies converge under Bennett's second mode via "elite networking" or "policy communities:" experts with shared experiences formulate methods to deal with common problems.<sup>43</sup> In health care, this can occur through policy networks, scientific and/or medical networks, and other international networks that are concerned about the same issues. These networks exist in both the public and private spheres. For example, below, I discuss the International Conference on Harmonization (ICH), a partnership between public and private sector entities to harmonize various pharmaceutical regulatory standards.

Health policies converge under Bennett's third mode through international harmonization, which occurs when actors recognize their mutual interdependence.<sup>44</sup> As Bennett describes, harmonization springs from "a vague notion signifying a reliance on others for the performance of specific tasks to ensure complete and successful implementation or to avoid troubling inconsistencies."<sup>45</sup> Relying on theories of international relations and regimes, Bennett notes that harmonization requires local actors to sacrifice short-term independence for long-term commitments—as evidenced by organizations like the European Community (EC) and the OECD.<sup>46</sup> The ICH is a good example of market-driven convergence via international harmonization.

Finally, health policies may converge under Bennett's fourth mode when foreign actors and entities penetrate domestically.<sup>47</sup> This type of convergence may be the most forceful, but also the most chaotic.<sup>48</sup> Bennett found significant evidence of convergence when multinational businesses successfully lobbied for a common regulatory framework for their businesses and products.<sup>49</sup> Business interests may be well coordinated and well financed, and they can pressure governments to conform to prevailing international or regional standards.<sup>50</sup> Here, Bennett clearly contemplates foreign actors influencing domestic policy but

---

<sup>43</sup> *Id.* at 224-25.

<sup>44</sup> *Id.* at 225.

<sup>45</sup> *Id.*

<sup>46</sup> *Id.* at 226.

<sup>47</sup> *Id.* at 227.

<sup>48</sup> *Id.* at 227-28.

<sup>49</sup> *Id.* at 228.

<sup>50</sup> *Id.*

foreign businesses also undoubtedly affect domestic, private sector activities as well.

### C. REFINING THEORIES OF CONVERGENCE

During the mid-1990s, theories of policy convergence continued to evolve. In 1995, Dov Chernichovsky argued that many health care systems were converging towards a paradigm in which they financed health care publicly but incorporated market principles of competition and efficiency in providing health care goods and services.<sup>51</sup> This paradigm has been bolstered by the ongoing activities of multinational organizations like the OECD, the World Health Organization (WHO), the World Trade Organization (WTO), the World Bank, and regional trading blocs.<sup>52</sup> Chernichovsky revealed that even public health care systems have gradually looked for market mechanisms to control rising costs.

In 1996, David Mechanic and David Rochefort identified six major areas of health policy convergence, arguing that many countries have tried to (1) control costs and increase the efficiency and effectiveness of their health care systems, (2) promote health outside of their health care systems, (3) reduce inequalities within their systems, (4) improve primary care, (5) improve patient participation and choice, and (6) link health and social services.<sup>53</sup> Under the first category, many countries have implemented policies to promote competition and other market based principles in order to increase the efficiency and effectiveness of their health care systems.<sup>54</sup> Under the fifth category, the health care industries in many countries have been shaped by consumers' demand to choose among providers and treatment options.<sup>55</sup>

In 1997, Richard Saltman argued that studies of convergence often focus on related but distinct phenomena, identifying convergence within different parts of health care systems.<sup>56</sup> Saltman helps us recognize that health care—perhaps more than other industry—includes a

---

<sup>51</sup> Chernichovsky, *supra* note 18, at 347-48, 350 (noting that Australia, Italy, and Spain have adopted this approach, while the United Kingdom, the Netherlands, and Israel were in the process of doing so).

<sup>52</sup> Blank & Burau, *supra* note 6, at 266.

<sup>53</sup> Mechanic & Rochefort, *supra* note 4, at 253-61.

<sup>54</sup> *Id.* at 254.

<sup>55</sup> *Id.* at 259.

<sup>56</sup> Saltman, *supra* note 13, at 450.

staggering array of systems, actors, products, markets, and regulatory regimes.

To sort these distinct phenomena, and to categorize different types of health policy convergence, Saltman proposed a three-part framework. First, “social” convergence reflects the extent to which countries’ underlying cultures, values, norms, and priorities converge.<sup>57</sup> Second, “political” convergence reflects the extent to which countries’ health care systems, institutions, and policy priorities converge.<sup>58</sup> This includes the particular mix of public and private financing, varying regulatory priorities, and the balance countries have struck between equity and efficiency.<sup>59</sup> Finally, Saltman identified “technical” convergence between countries’ scientific and medical practices, institutional management, and payment systems.<sup>60</sup>

Saltman’s framework, thus, progresses from the highest level of abstraction to the finest level of detail. This framework is necessarily malleable. Furthermore, it marks the important distinction between “policies” and “practices.”<sup>61</sup> Saltman argues that at the most abstract level, there is “some small movement” towards “social” convergence, but countries’ distinct value systems remain stable—“Swedes still treasure security and equity, Germans emphasize order, while Americans prefer aggressive individualism.”<sup>62</sup>

#### D. CONVERGENCE OR DIVERGENCE?

More recently, scholars have increasingly sought evidence of continued policy divergence. For example, in 2006, Robert Blank analyzed whether nine developed, capitalist countries converged or diverged in rationing health care, given that demand for health care generally exceeds its supply.<sup>63</sup> Unsurprisingly, Blank found that along Saltman’s three-part framework, countries’ broad policy goals tended to converge in that countries rationed their scarce resources.<sup>64</sup> But Blank also found that the more detailed content and implementation of these policies di-

---

<sup>57</sup> *Id.*

<sup>58</sup> *Id.*

<sup>59</sup> *Id.*

<sup>60</sup> *Id.* at 450-52.

<sup>61</sup> *Id.*

<sup>62</sup> *Id.* at 450.

<sup>63</sup> Blank & Burau, *supra* note 6, at 269-72 (analyzing Australia, Germany, Japan, the Netherlands, New Zealand, Singapore, Sweden, the United Kingdom, and the United States).

<sup>64</sup> *Id.*

verged,<sup>65</sup> observing that “different health care systems focus widely disparate attention” on exactly how to ration health care—for example, whether to use supply or demand-side tools or price versus non-price rationing.<sup>66</sup>

However, even Blank acknowledges that no health care system is internally monolithic.<sup>67</sup> Each system uses a combination of different mechanisms to ration health care, including decisions by central agencies and ministries, decentralized regional entities, insurers, and down to individual hospitals or physicians.<sup>68</sup>

Finally, some scholars have criticized the theoretical foundations of policy convergence and the process of comparative health policy scholarship. For example, in 2005, Ted Marmor, Richard Freeman, and Kieke Okma argued that most health reform debates take place domestically, “largely free from the spread of foreign ideas.”<sup>69</sup> They argue that if countries consider similar policies, it is not because they consciously copy one another, but because they engage in “parallel thinking” to solve similar problems such as rising health care spending.<sup>70</sup> Under Bennett’s framework, this would qualify as “diffusion” rather than “emulation.”<sup>71</sup>

Marmor, Freeman, and Okma found “as much evidence of continued difference (or divergence) in national arrangements for the finance, delivery, and regulation of health care as there is of increasing similarity.”<sup>72</sup> They make the frequent criticism that convergence cannot be inevitable, or that the theory is “a kind of soft technological determinism.”<sup>73</sup> Finally, they dispute the conventional wisdom that international organizations like the European Union (EU), the WHO, the OECD, and the World Bank influence domestic health care policymaking.<sup>74</sup>

---

<sup>65</sup> *Id.*

<sup>66</sup> *Id.* at 270-71.

<sup>67</sup> *Id.* at 272.

<sup>68</sup> *Id.*

<sup>69</sup> Ted Marmor, Richard Freeman, & Kieke Okma, *Comparative Perspectives and Policy Learning in the World of Health Care*, 7 J. COMP. POL’Y ANALYSIS 331, 337 (2005) (internal quotations omitted).

<sup>70</sup> *Id.*

<sup>71</sup> Bennett, *supra* note 3, at 220-21.

<sup>72</sup> Marmor et al., *supra* note 69, at 338 (quoting a formal official from the OECD’s health policy unit as saying “[T]he delivery and finance of health care vary between nations more than any other public policy.”).

<sup>73</sup> *Id.* at 337.

<sup>74</sup> *Id.* at 337-38.

### E. LESSONS FOR MARKET-DRIVEN CONVERGENCE

From this varied body of scholarship we can derive several useful lessons.

First, as Bennett notes, convergence is a dynamic concept that is best understood as an ongoing process rather than a static snapshot of two or more countries.<sup>75</sup> Although convergence can mean different things in different contexts, it should always connote a process rather than a singular state of being. An organic, process oriented theory of convergence allows us to account for new factors that may affect the extent to which policies and practices converge or diverge over time.

Second, convergence is multivariate—it will almost always depend on multiple dependent and independent variables. If there is a trend toward convergence, we can almost always ascribe the trend to multiple causes. And convergence often manifests itself in many ways. Given the nature of health care, trends will generally have multiple causes and effects.

Third, scholars must carefully identify what is converging. Health care is a unique animal. It typically involves both the public and private sectors and a multiplicity of laws, regulations, industries, markets, and actors. Health systems and industries are not internally monolithic.

Finally, convergence theories are generally easier to defend at higher levels of abstraction, particularly when they allow for evidence of continued divergence. The more specific, rigid claims can easily be undermined by evidence of divergence or by the reality that causes and effects are not so easily identifiable. Even Marmor, Freeman, and Okma acknowledge that the debate between convergence and divergence “is one of degree rather than of kind.”<sup>76</sup> They recognize that “at the most general level,” similar countries will “develop *broadly* comparable arrangements for health care.”<sup>77</sup>

With these lessons in mind, I consider a new theory of market-driven convergence.

---

<sup>75</sup> Bennett, *supra* note 3, at 219.

<sup>76</sup> Marmor et al., *supra* note 69, at 338.

<sup>77</sup> *Id.* (emphasis in original).

## **II. A NEW FRAMEWORK: MARKET-DRIVEN CONVERGENCE**

### **A. THE THEORY OF MARKET-DRIVEN CONVERGENCE**

“Market-driven convergence” is the process by which the private sector encourages practices and standards in the health care industry to converge, or become more alike across jurisdictions. Private, profit seeking businesses in health care increasingly benefit from convergence. They operate more efficiently when international practices are standardized. And new business opportunities arise from harmonization.

For example, Western hospitals can meet surging demand for skilled medical professionals by importing them from developing countries where students are educated according to internationally recognized criteria. Medical students in developing countries become more marketable by receiving degrees that are recognized by hospitals and graduate medical education programs in Western countries. Hospitals market their international accreditations and certifications because it attracts customers. Pharmaceutical companies save a staggering amount of time and resources by conducting clinical trials that will satisfy multiple regulators around the world rather than conducting separate trials for each jurisdiction. In short, market forces are driving convergence. Private sector entities benefit from it. Supply and demand often necessitate it.

In this section, I propose a conceptual framework for market-driven convergence. I argue that the private health care sector is driving industry convergence internationally, and that this, in turn, might affect policies and other formal instruments in the long run. I attempt to explain the salient features of this theory and place it within the existing scholarship, examining how it both builds on, and departs from, the theories of public policy convergence that I discussed in Part I.

As a preliminary matter, any theory of convergence must account for both evidence of continuing divergence and the multivariate nature of convergence. For example, if actors in separate jurisdictions act similarly, we can virtually always differentiate their behavior in some respect or at least attribute the similarities to several complicated causes or coincidences. This caveat is particularly apt in health care, which is populated by a staggering assortment of actors, markets, and overlapping legal and regulatory regimes.

Nevertheless, recognizing that convergence will always be somewhat incomplete and multivariate should not paralyze us from discussing theories of convergence that specifically account for these complicating factors. In this article, I argue that private sector activities are causing industry practices and standards to converge. Obviously, one cannot point to a single cause or manifestation of this trend.

Saltman's organizational approach supports this reality, recognizing that health care convergence may be social, political, or technical.<sup>78</sup> Market-driven convergence is more technical than social or political because it encompasses converging medical practices, standards, and other industry activities.<sup>79</sup> For example, Saltman found "substantial convergence on many scientific medical matters," including the "appropriateness of using most pharmaceuticals."<sup>80</sup> Market-driven convergence may reflect (or even promote) a degree of "social" or "political" convergence under Saltman's framework,<sup>81</sup> but these connections are more attenuated, and I do not argue for them here.

Saltman also makes the important distinction between converging policies and converging practices.<sup>82</sup> Market-driven convergence tends to represent the latter. It is worth noting that public policy convergence is much more difficult to achieve than private sector convergence. Policy convergence takes longer to manifest itself. Cumbersome political processes may impede efforts by policymakers to conform to international standards. Or there might not be sufficient reason to follow international trends given the significant transaction costs associated with passing legislation or promulgating administrative rules. But these processes do not constrain private actors.

Policy convergence may also be inherently more difficult because it occurs within vastly different political systems and is more susceptible to shifting political consensuses. For example, in 1995, New Zealand followed the international trend and passed market based reforms in its health care system before subsequent ruling parties withdrew those reforms.<sup>83</sup> Private industry practices are not subject to the same political hurdles that might delay or even defeat efforts to converge.

---

<sup>78</sup> Saltman, *supra* note 13, at 450.

<sup>79</sup> *Id.* at 450-52.

<sup>80</sup> *Id.* at 451.

<sup>81</sup> *Id.* at 450-51.

<sup>82</sup> *Id.* at 451-52.

<sup>83</sup> Blank & Burau, *supra* note 6, at 279.

Importantly, my theory of market-driven convergence also acknowledges that the line between the “public” and “private” sectors is often blurred in health care. The public and private spheres overlap and dissipate in health care perhaps more than in any other industry. Few, if any, health care systems are internally monolithic. Every country has a mix of public and private participants.<sup>84</sup> Indeed, no purely “private” or purely “public” system has ever existed.<sup>85</sup> There are an infinite number of permutations for organizing, providing, financing, and regulating health care.<sup>86</sup> Thus, although it is still possible to differentiate “public” and “private” activities, these activities increasingly occur in both spheres. I simply note that private sector activities are gaining traction in even the most “public” systems.

My theory of market-driven convergence also fits within Colin Bennett’s framework, which explains that policies converge through (1) emulation, (2) networking, (3) harmonization, and (4) penetration from outside actors and entities.<sup>87</sup> Market-driven convergence may be perpetuated through each mode, but distinguishing the modes is perhaps less important in the private sector. For example, Bennett usefully distinguishes between “emulation” and “diffusion,” but it is less vital to make this distinction for market-driven convergence.<sup>88</sup> Private practices and standards may converge via both emulation and diffusion, and it matters not whether the convergence is intentional if encouraged by market incentives.

Networking and harmonization may also be very different in the private than in the public sector. For example, harmonization may be more haphazard and decentralized in the private sector, though no less impactful. Most companies must conform their practices to do business overseas. Bennett’s fourth mode of convergence—domestic penetration by foreign actors—might be the most powerful force in market-driven

---

<sup>84</sup> Albert F. Wessen, *The Comparative Study of Health Care Reform*, in HEALTH CARE SYSTEMS IN TRANSITION: AN INTERNATIONAL PERSPECTIVE, *supra* note 3, at 3, 12-13 (“[T]he systems of all nations have at least some market-oriented characteristics and are constrained to some degree by collective (governmental) action.”); Wendy Ranade, *Introduction*, in MARKETS AND HEALTH CARE: A COMPARATIVE ANALYSIS 1, 2 (Wendy Ranade ed., Addison Wesley Longman Ltd. 1998) (“All health systems are a mixture of public and private elements . . .”).

<sup>85</sup> Chernichovsky, *supra* note 18, at 340.

<sup>86</sup> See John Appleby, *Economic Perspectives on Markets and Health Care*, in MARKETS AND HEALTH CARE: A COMPARATIVE ANALYSIS, *supra* note 84, at 34, 41.

<sup>87</sup> See generally Bennett, *supra* note 3.

<sup>88</sup> Bennett, *supra* note 3, at 220-21.

convergence, as companies take advantage of new opportunities in foreign health care markets.

It is worth noting that two trends are driving these opportunities. First, many governments, particularly among developing countries, are privatizing parts of their health care sectors and are opening their systems to foreign investment and other forms of foreign participation.<sup>89</sup> Most health care systems have incorporated at least some market based tools to increase competition and efficiency, which tends to invite more private sector participation.<sup>90</sup> It is no coincidence that the United States' health care system relies most heavily on these market principles among developed countries and also invites the most private sector participation.

Second, health care "consumerism" seems to be spreading,<sup>91</sup> based in part on privatization, and based in part on the rising demand among patients to choose their providers and treatments.<sup>92</sup> As a result, many health care systems have tried to give patients greater freedom of choice.<sup>93</sup> These efforts also generally invite more private sector participation in health care. From a theoretical perspective, this development is particularly interesting because once patients enjoy more choice and autonomy it may be difficult for policymakers to rein in these privileges for the sake of rationing or managing resources.

These trends have been accounted for in some convergence theories. Robert Blank recognizes that health care systems of all stripes are increasingly adopting market mechanisms to ration health care resources.<sup>94</sup> Yet, despite widespread adoption of market or quasi market mechanisms, Blank thinks that "[i]t would be a mistake to interpret these diverse changes as policy convergence."<sup>95</sup> In a similar vein, although Blank recognizes that countries have converged in placing a high priority on containing costs; their specific strategies to contain costs continue to vary.<sup>96</sup> Overall, Blank concludes that even though countries must deal with similar problems, they continue to adopt different strategies to deal with these problems.<sup>97</sup> In short, Blank acknowledges that public policies

---

<sup>89</sup> See *infra* Part II.B.4.

<sup>90</sup> Chernichovsky, *supra* note 18, at 347-48, 350; Mechanic & Rochefort, *supra* note 4, at 254.

<sup>91</sup> See generally Mark A. Hall & Carl E. Schneider, *Patients as Consumers: Courts, Contracts, and the New Medical Marketplace*, 106 MICH. L. REV. 643 (2008).

<sup>92</sup> Mechanic & Rochefort, *supra* note 4, at 259.

<sup>93</sup> *Id.*

<sup>94</sup> Blank & Burau, *supra* note 6, at 272-273 (citing Ranade, *supra* note 84).

<sup>95</sup> *Id.* at 274.

<sup>96</sup> *Id.* at 275.

<sup>97</sup> *Id.* at 277.

may converge at the broadest, “ideational” level, but holds that specific policy instruments used to achieve these policy goals or ideas continue to differ.<sup>98</sup>

Saltman also limits his claims of policy convergence: “Depending on the issue involved, one can find examples of convergence, of formal convergence but practical divergence and of consistent divergence.”<sup>99</sup> There will always be a mix of convergence and divergence. Even within the United States, health care policies and practices can differ from state to state or even city to city. Nevertheless, in Saltman’s three-part framework, he found substantial convergence at the third level, reflecting convergence among technical and scientific practices.<sup>100</sup> He points to the growing standardization of medical procedures, the use of pharmaceuticals, and the use of certain payment tools such as capitated payments.<sup>101</sup>

My focus on health industry practices aligns with Saltman’s findings that although countries continue to employ different health care policies, the practices and standards within the industry are converging considerably.<sup>102</sup> Thus, perhaps it is not surprising that the more flexible aspects of health care more easily succumb to international market pressures to converge, while the less flexible aspects—such as formal laws and regulations—tend to remain embedded.

Thus, recognizing that convergence theories can be too deterministic,<sup>103</sup> I refrain from arguing that health care systems or practices will cease to be distinctive.<sup>104</sup> Instead, I argue that—although proponents of convergence and divergence are both correct<sup>105</sup>—there are several trends that strongly suggest that standards and practices within the health care industry are converging as a result of private sector activities. Indeed, Mark Field has argued that health systems are converging because there are now “universal means of medical production,” deriving from research, science, and technology.<sup>106</sup> For example, the standard use of antibiotics or insulin is not constrained by geographical or national bounda-

---

<sup>98</sup> *Id.* at 274.

<sup>99</sup> Saltman, *supra* note 13, at 451.

<sup>100</sup> *Id.*

<sup>101</sup> *Id.*

<sup>102</sup> *Id.* at 452.

<sup>103</sup> Field, *supra* note 3, at 42.

<sup>104</sup> Olaug S. Lian, *Convergence or Divergence? Reforming Primary Care in Norway and Britain*, 81 *THE MILBANK Q.* 305, 307 (2003).

<sup>105</sup> Saltman, *supra* note 13, at 452.

<sup>106</sup> Field, *supra* note 3, at 39.

ries.<sup>107</sup> I extend this trend into a full-fledged theory of market-driven convergence, by which the argument is made that the private sector is driving convergence within the health care industry.

## B. TRENDS SUPPORTING THE THEORY

The theory of market-driven convergence may appeal to us intuitively, but what evidence is there that the health care industry's standards and practices are converging? And how is convergence being driven by the private rather than the public sector? In this section, I discuss several international trends that support the theory of market-driven convergence, including trends among health care professionals, medical educators, hospitals, insurers, and medical products manufacturers.<sup>108</sup>

In discussing these trends, I pursue two related themes. First, I discuss how American medicine has influenced many of these phenomena, for both better and worse. Second, I describe how convergence has influenced the health care industries in developing countries. Historically, developing countries have struggled to modernize their health care sectors due to recessions, diseases, wars, and other large scale impediments.<sup>109</sup> However, the following trends demonstrate that many developing countries have begun to cultivate and modernize their health care sectors, albeit with some troubling distributional consequences.

### 1. CONVERGENCE AMONG MEDICAL PROFESSIONALS, EDUCATION, AND SCIENCE

The most significant evidence of market-driven convergence can be found in international trends surrounding the practice of medicine. Methods, standards, and practices have gradually converged due to the mobility of medical professionals, harmonization of medical education, and the diffusion of modern scientific medicine.

---

<sup>107</sup> *Id.*

<sup>108</sup> This is not to say that convergence is inevitable, or that each trend supporting it is equally robust. Some trends are quite embryonic, and some may be fleeting. Nor is this a definitive empirical study of each trend, as such an undertaking would require a much narrower analysis of each separate trend, focusing on a more well-defined group of countries. Rather, I provide a macro-analysis of the various trends that, together, demonstrate how the private health care sector is driving convergence.

<sup>109</sup> Mechanic & Rochefort, *supra* note 4, at 244 (citing R. DESJARLAIS, L. EISENBERG, B. GOOD, & A. KLEINMAN, *WORLD MENTAL HEALTH: PROBLEMS AND PRIORITIES IN LOW-INCOME COUNTRIES* (1995)).

First, standards and practices are converging because medical professionals increasingly emigrate. Although it is difficult to characterize this trend as purely a private sector phenomenon—given that medical professionals are frequently educated and/or employed by the public sector—their mobility is driven by market demand for their services. The worldwide demand for physicians, nurses, and other skilled health care professionals clearly exceeds the supply, which creates incentives for trade. In turn, widespread professional emigration has generally helped standardize medical practices across jurisdictions.

The medical professions have become incredibly mobile. To date, most of the global trade in health services has been the movement of medical professionals, including physicians, nurses, researchers, paramedics, midwives, technicians, consultants, management personnel, and other skilled professionals.<sup>110</sup> One powerful example is the prevalence of international medical graduates in the United States. Of all physicians practicing in the United States, approximately one quarter were educated overseas.<sup>111</sup> And the eight largest suppliers of physicians are developing countries, including (in order of contribution): India, the Philippines, Cuba, Pakistan, Iran, Korea, Egypt, and China.<sup>112</sup> Moreover, nearly one-fifth of the faculty at American medical schools was educated overseas.<sup>113</sup> Foreign educated nurses also comprise roughly 14 percent of nurses practicing in the United States, again, many of whom relocate from developing countries.<sup>114</sup>

Other countries' medical professions are similarly diverse.<sup>115</sup> For example, in 2006, the WHO estimated that 34 percent of physicians practicing in New Zealand were trained abroad, 33 percent in the United

---

<sup>110</sup> Rupa Chanda, *Trade in Health Services*, reprinted in *TRADE IN HEALTH SERVICES: GLOBAL REGIONAL, & COUNTRY PERSPECTIVES* 35, 37 (2002).

<sup>111</sup> THOMAS PASKO & DEREK R. SMART, *PHYSICIAN CHARACTERISTICS AND DISTRIBUTION IN THE US: 2004-2005* (AMA Press 2004); James A. Hallock, Stephen S. Seeling, & John J. Norcini, *Perspective: The International Medical Graduate Pipeline: Whether to Depend on IMGs to Remedy the U.S. Physician Shortfall Involves Global Ethical Considerations*, *HEALTH AFF.*, July-Aug. 2003, at 94, 94.

<sup>112</sup> Graham T. McMahon, *Coming to America—International Medical Graduates in the U.S.*, 350 *New Eng. J. Med.* 2435, 2437 (2004); see also Aaditya Mattoo & Randeep Rathindran, *Does Health Insurance Impede Trade in Health Care Services?* 14 (World Bank, Policy Research Working Papers, Working Paper No. 3667, 2005), available at [http://papers.ssrn.com/sol3/papers.cfm?abstract\\_id=770970](http://papers.ssrn.com/sol3/papers.cfm?abstract_id=770970).

<sup>113</sup> Mattoo & Rathindran, *supra* note 112, at 14 (citing data from M. Liu and H. Yamagata, *Trends Among Foreign Graduate Faculty at U.S. Medical Schools*, 3 *AM. ASS'N OF MED. C. ANALYSIS IN BRIEF* 1 (2003), available at [http://www.aamc.org/data/aib/aibissues/aibvol3\\_no1.pdf](http://www.aamc.org/data/aib/aibissues/aibvol3_no1.pdf).)

<sup>114</sup> *Id.* at 15.

<sup>115</sup> *Id.*

Kingdom, 27 percent in the United States, 23 percent in Canada, 21 percent in Australia, and 6 percent in France and Germany.<sup>116</sup> The number of foreign trained nurses was also significant: 21 percent in New Zealand, 14 percent in Ireland, 10 percent in the United Kingdom, and 5 percent in the United States.<sup>117</sup> And there are significant exporters as well; Indian physicians are the best example, with large numbers of Indian medical graduates practicing in Australia, Canada, the United Kingdom, and United States.<sup>118</sup>

Recent data also confirms that medical professionals tend to migrate from less developed to more developed countries.<sup>119</sup> For example, physicians from Sub-Saharan Africa migrate to South Africa; they also migrate from South Africa to Canada; from India to the United States, the United Kingdom, and Canada; and from Pakistan to the United Kingdom and the United States.<sup>120</sup> Developing countries have always been concerned about the “brain drain,” but these concerns are growing with physician shortages in many areas.<sup>121</sup>

How does this evidence support market-driven convergence? One obvious reason for the “brain drain” is that medical professionals in developing countries increasingly meet Western standards, making them ripe for export. For example, many developing countries are changing their medical curricula to conform to North American or Western European standards, with some offering classes in English.<sup>122</sup> Unsurprisingly, North American and Western European countries increasingly accept foreign graduates into graduate medical education programs. Over a quarter of all interns, residents, and fellows in the United States graduated from foreign medical schools.<sup>123</sup> Some graduates return home and

---

<sup>116</sup> World Health Organization, *Working Together for Health: The World Health Report 2006*, at 98 (2006), available at <http://www.who.int/whr/2006/en/>.

<sup>117</sup> *Id.* Note that Mattoo and Rathindran estimate a significantly higher proportion of foreign-educated nurses in the United States than the WHO study.

<sup>118</sup> Fitzhugh Mullan, *Doctors for the World: Indian Physician Emigration*, 25 HEALTH AFFAIRS 380, 381 (2006) (stating that over 59,000 Indian medical graduates, or 10% of all registered Indian physicians, practiced in these four countries).

<sup>119</sup> Hallock, Seeling, & Norcini, *supra* note 111, at 95.

<sup>120</sup> *Id.*

<sup>121</sup> *Id.* at 95-96.

<sup>122</sup> Christophe Segouin, *Globalization in Health Care: Is International Standardization of Quality a Step toward Outsourcing?*, 17 INT'L J. FOR QUALITY IN HEALTH CARE 277, 277 (2005).

<sup>123</sup> Physicians who did not attend a medical school in the United States or Canada are known as international medical graduates (IMGs). To enter a GME program in the United States that is accredited by the Accreditation Council for Graduate Medical Education (ACGME), IMGs must be certified by the Educational Commission for Foreign Medical Graduates (ECFMG). John R. Boulet et al., *The International Medical Graduate Pipeline: Recent Trends in Certification and*

some become board certified and practice in the United States before returning.<sup>124</sup> For example, a large cohort of Indian physicians has recently repatriated, and many Indians now believe that it is passé to claim that India is suffering from a straightforward brain drain.<sup>125</sup> Pakistan also reports that some physicians are returning.<sup>126</sup> Every time a health care professional changes venues, he or she contributes to the converging practice of medicine.

The demand for Western trained professionals also contributes to the converging practice of medicine, particularly in developing countries. Hospitals around the world increasingly utilize large numbers of foreign physicians. One striking example is Bumrungrad Hospital in Bangkok, Thailand, a private hospital claiming over 200 physicians that were board certified in the United States.<sup>127</sup> Several other hospitals in developing countries promote the presence of physicians who were board certified and practiced in the United States or other Western countries.<sup>128</sup> So eager to put themselves on par with Western hospitals, more hospitals in developing countries are hiring personnel that meet internationally accepted standards.

The second reason for market-driven convergence in the medical profession is the growing harmonization of medical education. Albert Wessen notes that “the content of medical curriculum differs only slightly from country to country.”<sup>129</sup> In 1999, the World Federation for Medical Education published international standards for medical curricula, with blessings from the WHO and the World Medical Association.<sup>130</sup>

---

*Residency Training*, 25 HEALTH AFF. 469, 469 (2006); Graham T. McMahon, *Coming to America – International Medical Graduates in the United States*, 350 NEW ENG. J. MED. 2435, 2435 (2004).

<sup>124</sup> Mattoo & Rathindran, *supra* note 112, at 13.

<sup>125</sup> Stephen Bach, *International Migration of Health Workers: Labour and Social Issues* 13, (Int'l Labour Office, Geneva, Working Paper No. 209, 2003), <http://www.equinet africa.org/bibl/docs/BACHres300108.pdf>.

<sup>126</sup> Saad Shafqat & Anita K.M. Zaidi, *Pakistani Physicians and the Repatriation Equation*, 356 NEW ENG. J. MED. 442, 442 (2007).

<sup>127</sup> *News Hour with Jim Lehrer*, statement of Bumrungrad Hospital spokesman (PBS television broadcast Feb. 21, 2005) (transcript available at [http://www.pbs.org/newshour/bb/health/jan-june05/thailand\\_2-21.html](http://www.pbs.org/newshour/bb/health/jan-june05/thailand_2-21.html)).

<sup>128</sup> Healthbase, Hospitals, <https://www.healthbase.com/hb/pages/hospitals.jsp> (last visited Oct. 25, 2008). For example, the Raffles Hospital (Singapore), Piyavate Hospital (Thailand), the Wockhardt Hospitals chain, the Anadolu Medica Center (Turkey), and Hospital Punta Pacifica (Panama) promote the presence of physicians that were board certified in the United States.

<sup>129</sup> Wessen, *supra* note 84, at 5.

<sup>130</sup> J.J.P. van Niekerk et al., *WFME Global Standards in Medical Education: Status and Perspectives following the 2003 WFME World Conference*, 37 MED. EDUC. 1050, 1050 (2003); see also World Federation for Medical Education, <http://www.wfme.org/> (last visited Oct. 27, 2008).

Medical education is also being standardized by the Institute for International Medical Education, which published Global Minimum Essential Requirements to identify specific educational objectives for medical graduates.<sup>131</sup> What is interesting is not that these organizations have published international standards, but that these standards “are already influencing national and regional systems of recognition and accreditation of medical schools.”<sup>132</sup>

Moreover, the Global Alliance for Medical Education has begun to discuss harmonizing continuing medical education (CME).<sup>133</sup> The UK-Nordic Medical Educational Trust has developed a transnational CME program involving the American Medical Association, the Alliance for CME, the European Academy of Medical Training, the Norwegian Medical Association, the Royal College of Physicians, and the World Federation for Medical Education.<sup>134</sup> It is notable that these efforts are being promoted primarily by professional organizations.<sup>135</sup>

The third reason why standards and practices in the medical profession are converging is the persistent spread of scientific medicine. The biosciences have led a revolution that is influencing nearly all aspects of health care, including the procedures, practices, technologies, education, ideologies, and professional and organizational methods we use.<sup>136</sup> Modern information, communications, and imaging technologies are creating “a collective global health care knowledge base.”<sup>137</sup> Odin Anderson’s study of six industrialized countries concluded that “[t]he most astonishing observation may be that, regardless of country, scientif-

---

<sup>131</sup> Hans Karle, *Global Standards in Medical Education – An Instrument in Quality Improvement*, 36 MED. EDUC. 604, 604 (2002); see also, Institute for International Medical Education, <http://www.iime.org/iime.htm> (last visited Oct. 27, 2008).

<sup>132</sup> Van Niekerk et al., *supra* note 130, at 1050.

<sup>133</sup> For example, Global Alliance for Medical Education (GAME) has held several conferences to harmonize CME standards throughout the world. See GAME, 12th Annual Meeting of the Global Alliance for Medical Education, “Harmonizing CME Systems Around the World”; and GAME, 13th Annual Meeting of the Global Alliance for Medical Education, “Global CME Harmonization 2.0: Strategy for the Future”, <http://www.game-cme.org/meetings/index.html> (last visited Oct. 26, 2008).

<sup>134</sup> Jane Sarasohn-Kahn, *Information and Communication Technology*, in GLOBAL HEALTH CARE MARKETS: A COMPREHENSIVE GUIDE TO REGIONS, TRENDS, AND OPPORTUNITIES SHAPING THE INTERNATIONAL HEALTH ARENA 94, 99-100 (Walter W. Wieners ed., Jossey-Bass Inc. 2001) [hereinafter GLOBAL HEALTH CARE MARKETS].

<sup>135</sup> Dave Davis, *Continuing Medical Education: Global Health, Global Learning*, 316 BRIT. MED. J. 385, 388 (1998), available at <http://bmj.bmjournals.com/cgi/content/full/316/7128/385>.

<sup>136</sup> Wessen, *supra* note 84, at 4.

<sup>137</sup> Sarasohn-Kahn, *supra* note 134, at 94.

ic medicine seems to have created similar types of health services, facilities, and personnel.”<sup>138</sup>

Thus, standards and practices within the medical profession are converging due to mobile medical professionals, harmonized educational standards, and the spread of modern scientific medicine. Of course, the private sector is not solely responsible for these trends, but international market forces undoubtedly have been key contributors.

## 2. CONVERGENCE AMONG HOSPITALS AND INSURERS

Recent international trends among hospitals and health insurers also support the theory of market-driven convergence. The hospital and health insurance industries are becoming increasingly international, which should gradually spread the basic standards and practices they employ. For example, Albert Wessen notes that “hospitals and clinics throughout the world have similar goals and attempt to practice similar methods of diagnosis and care.”<sup>139</sup> Many hospitals and insurers have begun competing in foreign markets, which also drives convergence.

The best example of market-driven convergence is the increased harmonization of hospital standards. Several groups have tried to create international standards for health care quality.<sup>140</sup> For instance, in the public realm, the EU evaluates the health care quality monitoring systems across EU Member States.<sup>141</sup> In the private realm, the International Society for Quality in Health Care (ISQua) created an International Accreditation Program to harmonize international health care standards and accreditation processes.<sup>142</sup> ISQua also runs a federation of accreditors called the Agenda for Leadership in Programs for Healthcare Accreditation (ALPHA).<sup>143</sup> A group of countries led by New Zealand even established a program for evaluating the accreditors themselves.<sup>144</sup>

---

<sup>138</sup> ODIN W. ANDERSON, *THE HEALTH SERVICES CONTINUUM IN DEMOCRATIC STATES* 6 (1989).

<sup>139</sup> Wessen, *supra* note 84, at 5.

<sup>140</sup> *Id.*; Elma G. Heidemann, *Moving to Global Standards for Accreditation Processes: The ExPeRT Project in a Larger Context*, 12 INT’L J. FOR QUALITY IN HEALTH CARE 227, 227 (2000).

<sup>141</sup> Heidemann, *supra* note 140, at 227. The EU created the ExPeRT Project (External Peer Review Techniques) in 1996 for this purpose.

<sup>142</sup> *Id.* at 228-229.

<sup>143</sup> K. Tina Donahue, *Accreditation and Globalization*, in *GLOBAL HEALTH CARE MARKETS* 81, 85 (Walter W. Wieners, ed., 2001).

<sup>144</sup> Heidemann, *supra* note 140, at 227-228. This group is called “The Wellington Group” because it was led by the New Zealand Council on Healthcare Standards, now the Health Accreditation Program of New Zealand, in Wellington, New Zealand.

More tangibly, hospitals and medical facilities around the world increasingly demand some form of international, mutually recognizable hospital accreditation. The demand has been met initially by Joint Commission International (JCI), which has accredited approximately 140 hospitals and medical facilities worldwide.<sup>145</sup> The breadth of accreditation is impressive. JCI has accredited facilities in thirty-three different countries, including Brazil (15 facilities), China (5), India (11), Ireland (11), Jordan (4), Mexico (3), Saudi Arabia (20), Singapore (13), Spain (17), Thailand (22), Turkey (17), and one each in Egypt, Ethiopia, Indonesia, Korea, and Pakistan.<sup>146</sup> Furthermore, as I have casually observed, the demand for JCI accreditation has spiked the past few years.

JCI essentially is an American entity, operated by the same private organization that accredits hospitals in the United States—the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).<sup>147</sup> Although neither JCI nor JCAHO regulate the quality or safety of medical care per se, accreditation generally signals that the hospital or facility itself meets certain minimum standards.<sup>148</sup>

The JCAHO and JCI stamp of approval carries significant weight internationally. First, JCAHO and JCI are governed by the major U.S. trade associations, including the American Medical Association, the American Hospital Association, the American College of Surgeons, and the American College of Physicians.<sup>149</sup> Second, hospitals around the world covet JCI accreditation because it may help them apply for coverage from insurers in the United States and in other lucrative markets.<sup>150</sup> Finally, JCI's allure stems in part from the Joint Commission's quasi-governmental status in the United States. Over forty years ago, Congress granted JCAHO statutory authority to both establish and monitor com-

---

<sup>145</sup> Joint Commission International (JCI) Accredited Organizations, <http://www.jointcommissioninternational.org/23218/fortiz/> (last visited Oct. 26, 2008).

<sup>146</sup> *Id.*

<sup>147</sup> JCI was formed in 1994 by JCAHO and the non-profit arm of JCAHO, Quality Healthcare Resources, Inc. In 1998, JCAHO formed a subsidiary, Joint Commission Resources, Inc. (JCR). JCI is now a division of JCR. See The Joint Commission, A Journey Through the History of the Joint Commission, [http://www.jointcommission.org/AboutUs/joint\\_commission\\_history.htm](http://www.jointcommission.org/AboutUs/joint_commission_history.htm) (last visited Oct. 26, 2008). JCI launched its international accreditation program in 1999 in response to growing interest in worldwide accreditation and quality improvement.

<sup>148</sup> John C. Goodman & Gerald L. Musgrove, *Patient Power: Solving America's Health Care Crisis*, in HEALTH CARE LAW AND ETHICS 1071, 1074 (Mark A. Hall et al eds., 2003).

<sup>149</sup> *Id.* at 1073-1074.

<sup>150</sup> G.V.R.K. Acharyulu & B. Krishna Reddy, Hospital Logistics Strategy for Medical Tourism 6, 15 (Jun. 10, 2004) (unpublished manuscript on file with author).

pliance with hospital standards.<sup>151</sup> Medicare, Medicaid, and countless other third-party payors require hospitals to be accredited by JCAHO in order to qualify for reimbursement.<sup>152</sup> JCI accreditation is separate from JCAHO's, but it seems to carry the worldwide imprimatur that an accredited facility meets U.S. government standards.

Apart from its accreditation function, JCI is beginning to play a more active role in promulgating international hospital standards. In 2008, it plans to host a "Practicum on Quality Improvement and Accreditation" for facilities throughout the Asia-Pacific region.<sup>153</sup> The stated purpose of the practicum is to discuss "the best practices, standards, and processes needed to deliver the gold-standard of care."<sup>154</sup> JCI will also hold practica in Europe, Latin America, and the Middle East.<sup>155</sup> These sessions would represent "elite networking" under Bennett's framework.<sup>156</sup>

Aside from quasi-governmental organizations like JCI, several private hospitals are responsible for globalizing the hospital industry. In Singapore, the Parkway Group and the Raffles Medical Group operate properties in Malaysia, India, Sri Lanka, and the United Kingdom.<sup>157</sup> In fact, Gleneagles International, the international chain of the Parkway Group, is now one of the largest private health care organizations in Asia.<sup>158</sup> In India, the Apollo Group is both establishing and acquiring facilities in Malaysia, Nepal, and Sri Lanka.<sup>159</sup>

U.S. based hospital chains have also expanded internationally. Adventist Health International operates more than 500 Christian non-

---

<sup>151</sup> Social Security Amendments of 1965, Pub. L. No. 89-97, 79 Stat. 286, 326-27 (codified as amended at 42 U.S.C. § 1395bb (2000)). Hospitals accredited by JCAHO are "deemed" to be in compliance with the conditions for participating in Medicare.

<sup>152</sup> HHS regulations require hospitals and other facilities participating in Medicaid to satisfy "Medicare Conditions of Participation," which include JCAHO accreditation. *See, e.g.*, 42 C.F.R. § 482.1 (2007); DEP'T. OF HEALTH AND HUMAN SERV., OFFICE OF INSPECTOR GEN., THE EXTERNAL REVIEW OF HOSPITAL QUALITY: THE ROLE OF ACCREDITATION, 30 (1999), available at <http://www.oig.hhs.gov/oei/reports/oei-01-97-00051.pdf>.

<sup>153</sup> Joint Commission International, Dubai Practicum 2008, <http://www.jointcommissioninternational.org/32245> (last visited Oct. 26, 2008).

<sup>154</sup> *Id.*

<sup>155</sup> Joint Commission International, Education, <http://www.jointcommissioninternational.org/24165/> (last visited Oct. 26, 2008).

<sup>156</sup> *See generally* Bennett, *supra* note 3.

<sup>157</sup> Chanda, *supra* note 110, at 37.

<sup>158</sup> David Díaz Benavides, *Trade Policies and Export of Health Services: A Development Perspective*, in *TRADE IN HEALTH SERVICES: GLOBAL, REGIONAL, AND COUNTRY PERSPECTIVES* 53, 67 (Nick Drager & Cesar Vieira eds., 2002).

<sup>159</sup> Chanda, *supra* note 110, at 37.

profit hospitals, including a flagship hospital in Malaysia.<sup>160</sup> CHRISTUS Health, based in Texas, now operates seven health care facilities in Mexico.<sup>161</sup> Many of these hospitals were specifically designed with international standards in mind to cater to an increasingly international clientele.

Perhaps the best example of a hospital centered on international standards is the Bumrungrad International Hospital in Bangkok, Thailand. Bumrungrad is a private hospital that caters to foreign patients. It is managed by hospital administrators from the United States, Australia, Singapore, Thailand, and the United Kingdom.<sup>162</sup> It was the first hospital in Asia to be accredited by Joint Commission International.<sup>163</sup> And it is a publicly traded company whose major investors are the large private companies and a wealthy Thai family.<sup>164</sup> Market incentives have led Bumrungrad and other hospitals to adopt international standards and pursue international accreditation.

Health insurers and managed care organizations are also doing more cross border business, which may begin to harmonize traditionally localized insurance practices. For example, some insurers in California now cover treatments in Mexico under recent state legislation allowing these arrangements.<sup>165</sup> Health Net, SIMNSA, and Blue Shield offer plans with lower premiums and deductibles to patients living in the United States who are willing to seek care by Mexican providers.<sup>166</sup> These plans

---

<sup>160</sup> See Adventist Health International, <http://www.adventisthealthinternational.org> (last visited Oct. 27, 2008); Penang Adventist Hospital, About Us, [http://www.pah.com.my/about\\_us/index.asp](http://www.pah.com.my/about_us/index.asp) (last visited Oct. 27, 2008).

<sup>161</sup> CHRISTUS Health | Facility Search, <http://www.christushealth.org/FacilitySearchMain.aspx> (last visited Oct. 27, 2008).

<sup>162</sup> Bumrungrad International Hospital, Management, <http://www.bumrungrad.com/overseas-medical-care/About-Us/management.aspx> (last visited Oct. 27, 2008).

<sup>163</sup> First Asian Hospital to Get International Accreditation – Bumrungrad Hospital Thailand, <http://www.bumrungrad.com/overseas-medical-care/About-Us/hospital-accreditation.aspx> (last visited Oct. 27, 2008).

<sup>164</sup> Bumrungrad International Hospital, Factsheet, <http://www.bumrungrad.com/overseas-medical-care/about-us/factsheet.aspx> (last visited Feb. 11, 2009).

<sup>165</sup> Arturo Vargas Bustamante, Gilbert Ojeda & Xochitl Castañeda, *Willingness to Pay for Cross-Border Health Insurance Between the United States and Mexico*, 27 (1) HEALTH AFFAIRS 169, 170 (2008) (describing California's Knox-Keene Act of 1998); Richard Marosi, *Healthcare is Migrating South of the Border*, L.A. TIMES, Aug. 21, 2005, at A1; Sarah Skidmore, *Cross-Border Health Insurance is a Hit with Employers and Workers*, SAN DIEGO UNION-TRIB., Oct. 16, 2005, at H1.

<sup>166</sup> Deborah Crowe, Andy Fixmer & Anne Riley-Katz, *Health Net Expands Latino Outreach*, L.A. BUS. J., June 12, 2006, at 13; Sistemas Medicos Nacionales, S.A. de C.V. (SIMNSA), Our Company, <http://www.simnsa.com/about.html> (last visited Oct. 27, 2008); Marosi, *supra* note 165, at A1; Skidmore, *supra* note 165, at H1; Access Baja Health Products for Small Groups – Blue Shield of California, <http://www.blueshieldca.com/producer/smallgroups/products/health/baja/> (last visited Oct. 27, 2008).

should encourage standards in the insurance and provider industries in California and Mexico to begin to converge.

Some health insurers cover foreign hospitals and providers in even more distant markets. For example, United Group Programs now covers procedures performed at the Bumrungrad Hospital in Thailand.<sup>167</sup> Blue Cross Blue Shield and the British insurer Bupa insure patients treated at the Wockhardt Hospitals in India.<sup>168</sup> The Henner Group, based in France, specializes in providing health care insurance to expatriates, multinational companies, and students studying overseas, with an international network of health care providers.<sup>169</sup> To make these arrangements work, participating hospitals and insurers must conform their practices and standards to at least some extent.

Some insurers like Blue Cross Blue Shield maintain extensive overseas provider networks, catering to customers that travel frequently. The company's BlueCard Worldwide program maintains a global network of hospitals, physicians, and other health care providers.<sup>170</sup> Aetna now provides a "Global Benefits" program that covers treatments overseas.<sup>171</sup> A brief survey shows that international health insurance plans are proliferating.<sup>172</sup> Again, an international network of providers requires participants to create some international standards for doing business.

These trends, although relatively new, suggest that companies in the hospital and insurance industries will increasingly do business overseas. Again, cross border business in these industries operates in tandem with the diffusion and harmonization of industry standards and practices. Companies are pushing de facto international standards, changing their practices to conform to requirements in other jurisdictions. Thus, market forces are encouraging convergence in these industries.

---

<sup>167</sup> Daniel Yi, *Overseas Surgery a Clamp on Costs*, L.A. TIMES, July 30, 2006, at A1.

<sup>168</sup> Ray Marcelo, *India Hopes to Foster Growing Business in "Medical Tourism,"* FIN. TIMES, July 2, 2003, at 10.

<sup>169</sup> See The Henner Group, GMC MedNet-The Medical Network, <http://resmed.henner.com/en> (last visited Oct. 27, 2008).

<sup>170</sup> BlueCard Worldwide – When Traveling Outside of the U.S., <http://www.bcbs.com/bluecardworldwide/index.html> (last visited Oct. 27, 2008); See Mattoo & Richardson, *supra* note 112, at 6 (explaining that the network is maintained by World Access Service Corporation); See generally Mondial Assistance USA–Health Care, <http://www.worldaccess.com/en/aboutus/products/health.htm> (last visited Oct. 27, 2008).

<sup>171</sup> Aetna, Aetna Global Benefits Homepage, <http://www.aetnaglobalbenefits.com/default.jsp> (last visited Oct. 27, 2008).

<sup>172</sup> See, for example, Global Insurance Net, <http://www.globalinsurancenet.com/Default.asp> (last visited Oct. 27, 2008).

## 3. CONVERGENCE AMONG MEDICAL PRODUCTS AND TECHNOLOGIES

International trends among medical products and technologies support the theory of market-driven convergence. In recent years, not only have the global markets for medical products surged, leading to their widespread diffusion, but several of these industries have succeeded in harmonizing international standards.

For example, the global pharmaceutical market both drives convergence and benefits from it. Recent sales figures reflect the broad diffusion of pharmaceuticals. The market grew by \$41 billion in just one year.<sup>173</sup> More importantly, since 2004, the primary increase in sales has been in developing countries, mainly in Latin America, Asia, and Africa, where markets have grown between 10 and 20 percent per year.<sup>174</sup> In 2006, the global market grew 12.7 percent in Latin America and 10.5 percent in Asia and Africa.<sup>175</sup> Two important markets, China and India, also grew significantly—sales in China jumped 20.5 percent in 2005 and 12.3 percent in 2006, and sales in India jumped 17.5 percent in 2006.<sup>176</sup> Overall, 27 percent of growth in the global pharmaceutical market now comes from countries with average annual incomes of less than \$20,000.<sup>177</sup>

The pharmaceutical industry's growth has been aided in part by a coordinated effort to harmonize international standards. In 1990, pharmaceutical regulators and industry organizations in the United States, Europe, and Japan established the International Conference on Harmonization (ICH) to harmonize drug development and regulatory approval standards.<sup>178</sup> ICH is composed of both regulators and industry representatives. The regulatory members are the European Medicines Agency (EMA), the Japanese Ministry of Health, Labor, and Welfare, and the

---

<sup>173</sup> Press Release, IMS Health, IMS Health Reports Global Pharmaceutical Market Grew 7.0 Percent in 2006, to \$643 billion (Mar. 20, 2007), <http://www.imshealth.com> (type in the title of the press release above in the search box, then click "search", then follow the first hyperlink) (the market grew from \$602 billion in 2005 to \$643 billion in 2006).

<sup>174</sup> Press Release, IMS Health, IMS Health Reports Global Pharmaceutical Market Grew 7.0 Percent in 2006, to \$643 billion (Mar. 21, 2006), <http://www.imshealth.com> (type in the title of the press release above in the search box, then click "search", then follow the first hyperlink).

<sup>175</sup> Press Release, IMS Health, *supra* note 173 (the Asian numbers exclude Japan, which is already the second largest pharmaceutical market in the world, behind the United States).

<sup>176</sup> *Id.*

<sup>177</sup> *Id.*

<sup>178</sup> International Conference on Harmonisation of Technical Requirements for Registration of Pharmaceuticals for Human Use (ICH), Homepage, <http://www.ich.org/cache/compo/276-254-1.html> (last visited Oct. 27, 2008).

U.S. Food and Drug Administration (FDA). The industry representatives include the Pharmaceutical Research and Manufacturers of America (PhRMA), the European Federation of Pharmaceutical Industries and Associations (EFPIA), and the Japanese Pharmaceutical Manufacturers Association (JPMA).

According to ICH, its purpose is “to achieve greater harmonization in the interpretation and application of technical guidelines and requirements for product registration in order to reduce or obviate the need to duplicate the testing carried out during the research and development of new medicines.”<sup>179</sup> Although the regulators in these regions certainly benefit from sharing information and harmonizing standards, it is the companies that primarily benefit—not only because they save millions upon millions in research expenses, but also because they can influence the drug development requirements.

ICH is interested in broadening both the scope of its activities<sup>180</sup> and its geographic reach. In 1999, ICH created the Global Cooperation Group to communicate with regional harmonization groups outside ICH.<sup>181</sup> For example, ICH has invited participation from the Asia-Pacific Economic Cooperation (APEC), the Association of Southeast Asian Nations (ASEAN), the Gulf Cooperation Countries (GCC), the Pan American Network on Drug Regulatory Harmonization (PANDRH), and the Southern African Development Community (SADC).<sup>182</sup> Additionally, the WHO and Health Canada, the central Canadian public health agency, are official observers to ICH.<sup>183</sup>

The pharmaceutical market also benefits from harmonization efforts by other quasi-governmental bodies and industry organizations, including the WHO’s PANDRH,<sup>184</sup> the Pharmaceutical Forum of the Americas,<sup>185</sup> the International Pharmaceutical Federation (FIP),<sup>186</sup> and the

---

<sup>179</sup> *Id.*

<sup>180</sup> ICH, History and Future of the ICH, <http://www.ich.org/cache/compo/276-254-1.html> (last visited Oct. 27, 2008).

<sup>181</sup> ICH, Frequently Asked Questions, <http://www.ich.org/cache/compo/2834-272-1.html#4> (last visited Oct. 27, 2008).

<sup>182</sup> ICH, ICH Global Cooperation Group, <http://www.ich.org/cache/compo/276-254-1.html> (last visited Oct. 27, 2008).

<sup>183</sup> ICH, *supra* note 181.

<sup>184</sup> Pan American Network for Drug Regulatory Harmonization (PANDRH), <http://www.panho.org/english/ad/thse/ev/RedParf-home.htm> (last visited Oct. 27, 2008).

<sup>185</sup> Pharmaceutical Forum of the Americas, <http://www.paho.org/English/AD/THS/EV/ffa-home.htm> (last visited Oct. 27, 2008).

International Federation of Pharmaceutical Manufacturers Associations (IFPMA),<sup>187</sup> among others.

The global medical device market has enjoyed a similar trajectory, both in terms of sales and industry cooperation. The WHO predicted that the medical device market would nearly double in just over five years, growing from \$145 billion in 2000 to over \$260 billion in 2006.<sup>188</sup> Several years ago, the rapid growth of the device market spawned an effort to harmonize standards, similar to what the ICH accomplished for pharmaceuticals.

In 1992, representatives from several regulators and industry organizations formed the Global Harmonization Task Force (GHTF) to harmonize the regulation of medical devices.<sup>189</sup> The Task Force includes representatives from the United States, the European Union, Canada, Australia, and Japan.<sup>190</sup> It also meets with three related organizations: the Asian Harmonization Working Party (AHWP), the International Organization for Standardization (ISO), and the International Electrotechnical Commission (IEC).<sup>191</sup> The stated purpose of the Task Force is to “encourage convergence in regulatory practices” in addition to “promoting technological innovation and facilitating international trade.”<sup>192</sup> The Task Force publishes standards for basic regulatory practices that serve as models for national regulators.<sup>193</sup>

These international drug and device organizations have followed the model of the ISO, an organization created in 1947 to develop worldwide industrial and commercial technical standards.<sup>194</sup> Technically, ISO is a non-governmental organization, but its standards often become law

---

<sup>186</sup> International Pharmaceutical Federation (FIP), <http://www.fip.org/www2> (last visited Oct. 27, 2008). FIP is a worldwide federation of professional and scientific pharmaceutical organizations, including those that represent pharmacists and pharmaceutical scientists. *Id.*

<sup>187</sup> International Federation of Pharmaceutical Manufacturers & Associations, <http://www.ifpma.org/> (last visited Oct. 27, 2008).

<sup>188</sup> WHO, *Medical Device Regulations: Global Overview and Guiding Principles*, at v, at [http://www.who.int/medical\\_devices/publications/en/MD\\_Regulations.pdf](http://www.who.int/medical_devices/publications/en/MD_Regulations.pdf) (2003) (calling medical devices “one of the fastest growing industries”).

<sup>189</sup> Global Harmonization Task Force: About GHTF, <http://www.ghtf.org/about/> (last visited Oct. 27, 2008).

<sup>190</sup> *Id.*

<sup>191</sup> *Id.* “ISO” is not an acronym for the International Organization for Standardization, but refers to the Greek word ‘isos’, which means ‘equal’. See ISO—Discover ISO: ISO’s Name, [http://www.iso.org/iso/about/discover-iso\\_isos-name.htm](http://www.iso.org/iso/about/discover-iso_isos-name.htm) (last visited Oct. 27, 2008).

<sup>192</sup> Global Harmonization Task Force, *supra* note 189.

<sup>193</sup> *Id.*

<sup>194</sup> ISO—Discover ISO: ISO’s Origins, [http://www.iso.org/iso/about/discover-iso\\_isos-origins.htm](http://www.iso.org/iso/about/discover-iso_isos-origins.htm) (last visited Oct. 27, 2008).

domestically through treaties or other legal vehicles.<sup>195</sup> Currently, 157 of 192 countries in the world are members.<sup>196</sup> On its web site, ISO explains how and why it established international standards:

When the large majority of products or services in a particular business or industry sector conform to International Standards, a state of industry wide standardization can be said to exist. This is achieved through consensus agreements between national delegations representing all the economic stakeholders concerned—suppliers, users and, often, governments. They agree on specifications and criteria to be applied consistently in the classification of materials, the manufacture of products and the provision of services. In this way, International Standards provide a reference framework, or a common technological language, between suppliers and their customers—which facilitates trade and the transfer of technology.<sup>197</sup>

Beyond drugs and devices, the markets for other medical products and technologies are similarly bullish and may be ripe for industry driven standardization. For example, the global market for “telemedicine” and “telehealth” is estimated to be \$1.25 trillion and growing.<sup>198</sup> This market is made possible by cross border cooperation between health care providers. Standardization might increase competition among telemedicine providers. Similarly, rapid growth in related industries, such as private health insurance,<sup>199</sup> managed care,<sup>200</sup> insurance claims

---

<sup>195</sup> Naomi Roht-Arriaza, *Shifting the Point of Regulation: The International Organization for Standardization and Global Lawmaking on Trade and the Environment*, 22 *ECOLOGY LAW QUARTERLY* 479, 490 (1995).

<sup>196</sup> ISO—ISO Members, [http://www.iso.org/iso/about/iso\\_members.htm](http://www.iso.org/iso/about/iso_members.htm) (last visited Oct. 27, 2008).

<sup>197</sup> International Organization for Standardization, FAQs - General Information on ISO, [http://www.iso.org/iso/support/faqs/faqs\\_general\\_information\\_on\\_iso.htm](http://www.iso.org/iso/support/faqs/faqs_general_information_on_iso.htm) (last visited October 21, 2008).

<sup>198</sup> Ian S. Mutchnick, David T. Stern, & Cheryl A. Moyer, *Trading Health Services Across Borders: GATS, Markets, and Caveats*, 24 *HEALTH AFF.* W5-42, W5-45 (2005) (web exclusive), <http://content.healthaffairs.org/cgi/reprint/hlthaff.w5.42v1.pdf>; Chanda, *supra* note 110, at 5. This market includes “direct clinical services of \$804.2 billion, professional back up services of \$22.5 billion, consumer health information related services of \$21.6 billion, continuing professional education services of \$3.9 billion, and management of health care delivery services of \$235.5 billion.” *Id.*

<sup>199</sup> *See supra* Part II.B.2. Some predict that the market for private insurance in developing countries will “increase as more people move into income brackets that allow them to purchase private health insurance.” Mutchnick et al., *supra* note 198, at W5-47. *See* World Health Organization [WHO], Commission on Macroeconomics and Health [CMH], Working Paper Series, *Trade Liberalization in Health Insurance: Opportunities and Challenges: The Potential Impact of Introducing or Expanding the Availability of Private Health Insurance within Low or Middle Income Countries*, at 2, Paper No. WG 4:6 (Dec. 2000) (prepared by John A. Sbarbaro), [www.emro.who.int/cbi/PDF/HealthInsurance.pdf](http://www.emro.who.int/cbi/PDF/HealthInsurance.pdf).

<sup>200</sup> For example, by 1999, CIGNA covered 2.6 million people in Brazil, Chile, and Guatemala. Aetna operates in Brazil via Sul America Seguros, which generated over \$1 billion in revenues in

processing,<sup>201</sup> and clinical trials,<sup>202</sup> may lead to other coordinated efforts to harmonize industry standards.

Of course, harmonization and convergence do not fully explain why these industries have grown so dramatically. Another explanation is that companies constantly introduce new products and technologies into our health care systems.<sup>203</sup> Typically, these new products are expensive.<sup>204</sup> Again, the pharmaceutical industry is instructive. A recent study found that the United States not only spends much more per capita on pharmaceuticals than several peer countries, but also uses newer drugs at a much higher rate than most other countries that tend to rely on older drugs with expired patents.<sup>205</sup>

The industries themselves benefit from these trends. They are sustained by significant embedded interests, such as universities, medical research centers, the medical professions, and of course, the manufacturers.<sup>206</sup> A common criticism of these industries is that they artificially drive demand for their products.<sup>207</sup> For instance, some scholars have noted that the pharmaceutical and medical device industries “encourag[e] rapid adoption often before efficacy or cost effectiveness has been demonstrated.”<sup>208</sup> Mechanic and Rochefort note that physicians and other health care professionals often have strong incentives to use new technologies because they can generate additional income through higher reimbursement and quicker amortization rates.<sup>209</sup> They also note that patients and consumers in highly industrialized countries, particularly in the United States and the European Union, also highly value the use of new technologies.<sup>210</sup>

---

1996. Mutchnick et al., *supra* note 198, at W5-47. See Karen Stocker et al., *The Exportation of Managed Care in Latin America*, 340 (14) NEW ENG. J. MED. 1131, 1133 (1999), <http://content.nejm.org/cgi/reprint/340/14/1131.pdf>.

<sup>201</sup> Chanda, *supra* note 110, at 6 n.5.

<sup>202</sup> Richard A. Rettig, *The Industrialization of Clinical Research*, HEALTH AFF., Mar./Apr. 2000, at 129, 131, <http://content.healthaffairs.org/cgi/reprint/19/2/129.pdf>.

<sup>203</sup> Field, *supra* note 3, at 39.

<sup>204</sup> *Id.*

<sup>205</sup> Patricia M. Danzon & Michael F. Furukawa, *International Prices and Availability of Pharmaceuticals in 2005*, 27 (1) HEALTH AFF. 221, 221, 224 (2008), <http://content.healthaffairs.org/cgi/reprint/27/1/221.pdf>.

<sup>206</sup> Mechanic & Rochefort, *supra* note 4, at 243-44.

<sup>207</sup> *See id.*; see Mechanic, *supra* note 2, at 46.

<sup>208</sup> Mechanic & Rochefort, *supra* note 4, at 243.

<sup>209</sup> *Id.* at 243-44.

<sup>210</sup> *See id.* at 244.

Some developing countries have followed this trend. Many middle-income countries now offer advanced medical procedures and technologies, including some that have yet to be approved by Western regulators like the U.S. Food and Drug Administration (FDA).<sup>211</sup> Several developing countries now boast state-of-the-art hospitals that compete to attract foreign patients known as “medical tourists.”<sup>212</sup> Many of these hospitals conduct research to improve biotechnology products sold by Western manufacturers.<sup>213</sup>

To attract patients, hospitals advertise the technologies they can offer. For example, Wockhardt Hospitals in India advertises that it uses “top of the line medical/diagnostic equipment” just like “hospitals in New York, London, or Sydney.”<sup>214</sup> Penang Adventist Hospital in Malaysia is General Electric’s Southeast Asia test facility, “one of only a handful of facilities around the globe that receives the next generation of imaging equipment before the rest of the medical world.”<sup>215</sup> Thus, even developing countries use some of the same advanced medical technologies that were once offered solely by advanced industrialized nations.

In summary, some hospitals in developing countries now use the same pharmaceuticals and devices used by elite Western hospitals. It is a cyclical process. Manufacturers push for harmonization and convergence to do business overseas and open new markets for their products. In turn, developing economies seek to compete by adopting international standards.

#### 4. PRIVATIZATION, COMMERCIALIZATION, AND AMERICAN MEDICINE

Finally, three related trends support the theory of market-driven convergence. First, health care has become more privatized around the world. Second, health care goods and services have become more commercialized. And third, American medicine has exported itself particularly well. Together, these trends have allowed the private sector to exert more influence in creating international practices and standards. In this

---

<sup>211</sup> See Linda F. Powers, *Leveraging Medical Tourism*, THE SCIENTIST, Mar. 2006, at 79 (noting that many patients are seeking stem cell and cancer treatments overseas that have not been approved by FDA).

<sup>212</sup> Nathan Cortez, *Patients Without Borders: The Emerging Global Market for Patients and the Evolution of Modern Health Care*, 83 IND. L.J. 71, 82-85 (2008).

<sup>213</sup> Powers, *supra* note 211, at 79.

<sup>214</sup> Wockhardt Hospitals, International Patient Services, [http://www.wockhardthospitals.net/general/int\\_patients.asp](http://www.wockhardthospitals.net/general/int_patients.asp) (last visited Oct. 22, 2008).

<sup>215</sup> Eric P. Erickson, *Over the Ocean, Under the Knife*, CHI. SUN TIMES, Nov. 27, 2005, at C1.

section, I discuss how these three related trends have driven convergence.

But first, it is first important to note that market-driven convergence is part of a self-reinforcing cycle. The more countries privatize and commercialize their health care sectors, the more the private sector can influence industry methods, practices, and standards. And the more the private sector, rather than the public sector, influences methods, practices, and standards, the more health care becomes privatized and commercialized.

Although the trends of privatization and commercialization are incredibly broad, they are not accidental. They reflect the various successes of (1) free market economists, (2) pro-capitalism organizations in the United States, (3) international organizations like the World Bank, WTO, and OECD that push for trade liberalization, (4) private industry, and (5) groups in developing countries that wish to open their health sectors to foreign investment.

None of these phenomena are new. Over the last few decades, neoclassical economics has greatly influenced health care systems around the world,<sup>216</sup> responding to the growing challenge of controlling health care spending.<sup>217</sup> As modern welfare states matured,<sup>218</sup> and as conservative parties gained power and communist systems collapsed, theories of market based competition played a more direct role in influencing health care policies.<sup>219</sup>

In the United States in the 1970s and 1980s, pro-market economists gained influence once health care spending rose as a proportion of gross domestic product (GDP).<sup>220</sup> Theorists and policymakers began arguing under the guise of “consumer sovereignty” that patients should share a higher burden of their medical bills.<sup>221</sup> Theories of managed care tried to constrain the spending by providers.<sup>222</sup> Antitrust efforts tried to reduce the market power of providers and encourage more pure competition.<sup>223</sup> Physicians became regarded as “providers,” patients became “consumers,” and health care became just another business.<sup>224</sup>

---

<sup>216</sup> Wessen, *supra* note 84, at 376.

<sup>217</sup> Chernichovsky, *supra* note 18, at 344; Moran, *supra* note 84, at 17.

<sup>218</sup> Marmor, *supra* note 134, at 7, 11.

<sup>219</sup> Wessen, *supra* note 84, at 376.

<sup>220</sup> See Marmor, *supra* note 84, at 54, 54-55.

<sup>221</sup> *Id.* at 56.

<sup>222</sup> *Id.*

<sup>223</sup> *Id.* at 56-57.

<sup>224</sup> *Id.* at 57-60.

Coinciding with the market-based revolution was the cumulative influence of the American medical system.<sup>225</sup> For example, other developed countries have widely adopted pro-market inventions from the United States, such as the use of diagnosis-related groups (DRGs) to determine the cost of hospital visits.<sup>226</sup> Britain, Sweden, and Germany each reformed their systems based on theories of market competition and efficiency.<sup>227</sup> In Europe, these trends accelerated with directives imposed by the European Commission.

Some observers found this trend to be ironic given the United States' inability to control its own health care spending.<sup>228</sup> In many European health care systems, policymakers have been reluctant to surrender completely to market competition, given the high priority of protecting universal access to health care.<sup>229</sup>

At the same time, multinational institutions like the World Bank, WTO, WHO, and OECD have played a role in promoting greater privatization and commercialization in health care. For example, the WTO has long sought to privatize and deregulate the health care sectors in many countries, particularly in the developing world.<sup>230</sup> The WTO advocates eradicating trade barriers, opening health sectors to foreign direct investment (FDI), and eliminating market failures to encourage competition.<sup>231</sup> It has also tried to convince countries to reduce trade barriers in health care by making commitments under the General Agreement on Trade in Services (GATS).<sup>232</sup> Only a fraction of GATS signatories have made such commitments in health care, primarily because they view health care as a public good.<sup>233</sup>

Perhaps unsurprisingly, multinational organizations like the World Bank, OECD, and WHO favor convergence theories in health care, particularly theories that predict countries will move towards market competition.<sup>234</sup> But these positions have been criticized. Some have

---

<sup>225</sup> Wessen, *supra* note 84, at 376.

<sup>226</sup> *Id.* at 377 (citing Kimberly, de Pourville, & Associates, 1993).

<sup>227</sup> *Id.*

<sup>228</sup> *Id.*

<sup>229</sup> *Id.* at 379.

<sup>230</sup> See, e.g., Council for Trade in Services, *Background Note by the Secretariat: Health and Social Services*, S/C/W/50 (Sep. 18, 1998), available at [http://www.wto.org/english/tratop\\_e/serv\\_e/w50.doc](http://www.wto.org/english/tratop_e/serv_e/w50.doc).

<sup>231</sup> *Id.*

<sup>232</sup> David Price, Allyson M. Pollock, & Jean Shaoul, *How the World Trade Organization Is Shaping Domestic Policies in Health Care*, 354 LANCET 1889, 1890 (1999).

<sup>233</sup> See Chanda, *supra* note 110, at 29.

<sup>234</sup> Lian, *supra* note 104, at 307.

described WTO trade agreements as a “bill of rights for corporate business.”<sup>235</sup>

In the United States, organizations like the Department of Commerce, the U.S. Trade Representative (USTR), and the Coalition of Service Industries continue to push foreign health care sectors to privatize and remove trade barriers.<sup>236</sup> Other powerful institutions such as the U.S. Centers for Medicare and Medicaid Services (CMS) and the World Bank have been lead by pro-market health economists.<sup>237</sup> The United States has been the leading source for advocating markets in health care:

The policy history of recent years amounts to “Americanization.” Theories of planned markets, for instance, emerged out of policy debates created by the chaos of the American health care system. Three decades ago the United States was the “laggard” looking to Europe for reform inspiration; in the 1990s the traffic has been in the other direction . . .<sup>238</sup>

Yet, the American system has proven ineffective at using market mechanisms to control costs. Ted Marmor warns that, “[i]t is not clear what American experience (lagging as it is on coverage and cost control) can teach others about economy and effectiveness in the delivery of medical care.”<sup>239</sup> Michael Moran goes further, suggesting that, “[t]aking lessons in health care policy from the United States is like receiving instruction in seamanship from the crew of the *Titanic*.”<sup>240</sup> Indeed, some believe that developing countries have been pushed by American economists working for international organizations to adopt pro-competitive health care markets, leading to reforms that have only widened disparities in access to health care.<sup>241</sup>

But the privatization and commercialization of health care is much more than ideology.<sup>242</sup> Health care is a major industry in virtually every developed country and is becoming a major industry in many developing countries.<sup>243</sup> The products and services that comprise the health

---

<sup>235</sup> Price et al., *supra* note 232, at 1889.

<sup>236</sup> *Id.* at 1889-90; Council for Trade in Services, *supra* note 230, at 6, 9.

<sup>237</sup> Ranade, *supra* note 84, at 11.

<sup>238</sup> Moran, *supra* note 217, at 18.

<sup>239</sup> Marmor, *supra* note 218, at 7, 12.

<sup>240</sup> Moran, *supra* note 217, at 19.

<sup>241</sup> Mechanic & Rochefort, *supra* note 4, at 245.

<sup>242</sup> Moran, *supra* note 217, at 19.

<sup>243</sup> See generally Anne Mills, Ruairi Brugha, Kara Hanson & Barbara McPake, *What Can Be Done about the Private Health Sector in Low-Income Countries?*, 80 BULLETIN OF THE WORLD

care industry are themselves massive industries, like the pharmaceutical and medical device industries.<sup>244</sup> Indeed, some commentators have called health care “the world’s biggest industry.”<sup>245</sup> Furthermore, it is one of the most rapidly growing industries in the world.<sup>246</sup> Experts expected worldwide health care spending to grow by \$800 billion between 2002 and 2005—from \$3.2 trillion to \$4 trillion.<sup>247</sup> To use one foreboding example, as of 2006 the United States spends \$2.1 trillion per year on health care, but is expected to spend \$4.1 trillion per year by 2016.<sup>248</sup>

Of course, the private sector not only benefits from these trends, but promotes them. Moran describes the health technology industry as a major driver of markets in the health care sector in the last fifty years.<sup>249</sup> He points to the “historical alliance of scientific medicine and industrial capitalism” that encourages competition through innovation.<sup>250</sup> In health care, the predicate for success is research and development, without regard to how expensive the new technologies will be.<sup>251</sup> Because governments have had difficulty curbing technological innovation, particularly when it generates income for domestic companies, governments may have no choice but to embrace at least some forms of commercializa-

---

HEALTH ORGANIZATION 325 (2002) (discussing the “very large” private health care sectors in low-income countries).

<sup>244</sup> See *supra* Part II.B.3; Moran, *supra* note 217, at 20 (emphasizing the magnitude and strategic importance of health care products and services industries).

<sup>245</sup> Moran, *supra* note 217, at 21 (quoting Stephen Jencks & George Schieber, *Containing U.S. Health Costs: What Bullet to Bite?*, HEALTH CARE FINANCING REVIEW 1 (Supp. 1991)).

<sup>246</sup> Chanda, *supra* note 110, at 158.

<sup>247</sup> The World Bank estimated that global health spending was \$3.2 trillion in 2002. PABLO GOTTRÉT & GEORGE SCHIEBER, WORLD BANK, HEALTH FINANCING REVISITED: A PRACTITIONER’S GUIDE 3 (2006), <http://siteresources.worldbank.org/INTHSD/Resources/topics/Health-Financing/HFRFull.pdf>. Current estimates surpass \$4 trillion. Christine Borger, Sheila Smith, Christopher Truffer, Sean Keehan, Andrea Sisko, John Poisal & M. Kent Clemens, *Health Spending Projections Through 2015: Changes on the Horizon*, 25 HEALTH AFFAIRS w61 (2006), <http://content.healthaffairs.org/cgi/content/abstract/25/2/w61>; Chanda, *supra* note 110, at 158.

<sup>248</sup> NAT’L HEALTH STATISTICS GROUP ET AL., NATIONAL HEALTH EXPENDITURES AGGREGATE, PER CAPITA AMOUNTS, PERCENT DISTRIBUTION, AND AVERAGE ANNUAL PERCENT GROWTH, BY SOURCE OF FUNDS: SELECTED CALENDAR YEARS 1960–2006 I, available at <http://www.cms.hhs.gov/NationalHealthExpendData/downloads/tables.pdf>; John A. Poisal, Christopher Truffer, Sheila Smith, Andrea Sisko, Cathy Cowan, Sean Keehan, Bridget Dickensheets, Nat’l Health Expenditure Accounts Projections Team, *Health Spending Projections Through 2016: Modest Changes Obscure Part D’s Impact*, 26 HEALTH AFFAIRS w242 (Feb. 21, 2007), <http://content.healthaffairs.org/cgi/content/abstract/26/2/w242>.

<sup>249</sup> Moran, *supra* note 217, at 24–25.

<sup>250</sup> *Id.* at 25.

<sup>251</sup> *Id.*

tion.<sup>252</sup> Moreover, as Moran notes, these new technology markets have been global, while health care systems remained largely domestic.<sup>253</sup> Medical technology companies, broadly defined, are but one of several key interests that have appropriated and promoted market ideology in the health care sector.<sup>254</sup> Because most of the health care sector is now global, these pro-market forces feel even more inevitable.

These forces have manifested themselves in domestic policy-making. In the last several years, an unprecedented number of countries, at all levels of development, have reformed their health care systems.<sup>255</sup> Many have reduced the government's role in providing health care.<sup>256</sup> Public programs have gradually reduced health spending, and some are selling their facilities to private entities.<sup>257</sup> Many governments are inviting more private sector participation.<sup>258</sup>

A growing number of developing countries also view their domestic health care industries as potentially lucrative sources of income.<sup>259</sup> For instance, private firms are investing money to increase the number of private beds in public hospitals.<sup>260</sup> As a result, many of these countries are opening their health care sectors to foreign direct investment for the first time.<sup>261</sup> They are removing traditional barriers to investment, such as limiting foreign equity participation, imposing discriminatory taxes, and enforcing restrictive competition policies.<sup>262</sup> Instead, countries have begun to privatize their health sectors in order to upgrade and modernize their infrastructure.<sup>263</sup> For example, India, Indonesia, Nepal, Maldives, Sri Lanka, and Thailand have recently opened their health care markets to foreign investment,<sup>264</sup> which has generated new hospitals, clinics, diagnostic centers, nursing homes, and treatment centers.<sup>265</sup>

---

<sup>252</sup> *Id.* at 26.

<sup>253</sup> *Id.* at 26-27.

<sup>254</sup> *Id.* at 30.

<sup>255</sup> Benavides, *supra* note 158, at 53.

<sup>256</sup> *Id.* at 58.

<sup>257</sup> *Id.* at 54; Chanda, *supra* note 110, at 159.

<sup>258</sup> Benavides, *supra* note 158, at 54.

<sup>259</sup> *Id.* at 55.

<sup>260</sup> *Id.* at 65-66.

<sup>261</sup> Chanda, *supra* note 110, at 159.

<sup>262</sup> *Id.* at 159, 161.

<sup>263</sup> Richard D. Smith, *Foreign Direct Investment and Trade in Health Services: A Review of the Literature*, 59 SOC. SCI. & MED. 2313, 2315 (2004); Chanda, *supra* note 110, at 158.

<sup>264</sup> Chanda, *supra* note 110, at 159.

<sup>265</sup> *Id.*

All these trends are not only evidence of market-driven convergence, but they also create an atmosphere that allows the private sector to exert greater influence in health care. Thus, privatization and commercialization feed a self-reinforcing cycle of market-driven convergence.<sup>266</sup> The more health care becomes private and commercial, the more likely the private sector will generate international standards. The more these standards emerge, the more opportunities the private sector has to further privatize and commercialize health care.

### C. THE ARGUMENTS AGAINST CONVERGENCE

Although health care convergence may be “intuitively attractive,”<sup>267</sup> its critics argue that convergence theories tend to oversimplify the issues, underestimate existing levels of divergence, ignore local conditions, and rely on selective evidence.<sup>268</sup> They argue that, notwithstanding the influence of modern science, the practice of medicine still differs between countries in various ways.<sup>269</sup> Although “medicine benefits from a certain amount of scientific input, culture intervenes at every step of the way.”<sup>270</sup> As Lynn Payer notes, “the choice of diagnoses and treatments is *not* a science . . . the weighing of those benefits and risks will always be made on a cultural scale.”<sup>271</sup>

Critics also worry that if the public and private sectors view convergence as inevitable, or even desirable in and of itself, then they might feel compelled to fall in line, even when convergence is counterproductive.<sup>272</sup> Indeed, convergence “might be a self-fulfilling prophecy” that

---

<sup>266</sup> Of course, international competition may also create incentives for providers to differentiate their products and services in the market. For example, health care providers in China and India still market traditional healing techniques that are more difficult to obtain elsewhere. Thus, international competition may lead to market segmentation even while standards and practices among Western-style providers gradually converge.

<sup>267</sup> Blank & Burau, *supra* note 6, at 267.

<sup>268</sup> MICHAEL HOWLETT & M. RAMESH, *STUDYING PUBLIC POLICY: POLICY CYCLES AND POLICY SUBSYSTEMS* 107 (1995); Blank & Burau, *supra* note 6, at 267; Christopher Pollitt, *Is the Emperor in His Underwear? An Analysis of the Impacts of Public Management Reform*, 2 *PUB. MGMT.* 181 (2000); *see generally* Alan Jacobs, *Seeing Difference: Market Health Reform in Europe*, 23 *J. HEALTH POL. POL'Y & L.* 1 (1998).

<sup>269</sup> Field, *supra* note 3, at 40.

<sup>270</sup> LYNN PAYER, *MEDICINE & CULTURE: VARIETIES OF TREATMENT IN THE UNITED STATES, ENGLAND, WEST GERMANY, AND FRANCE* 26 (1988); Field, *supra* note 3, at 40.

<sup>271</sup> PAYER, *supra* note 270, at 154.

<sup>272</sup> Blank & Burau, *supra* note 6, at 265.

countries pursue to their detriment.<sup>273</sup> Critics caution that one size does not fit all.

Each of these critiques contains a kernel of truth. Convergence is not inevitable. Diverging practices and standards will always remain. Evidence of convergence can always be countered by evidence of continuing divergence. Local cultures do matter.

One poignant example is United HealthCare's effort to export its managed care programs to South Africa.<sup>274</sup> In 1996, the American company entered into a joint venture with a South African company to offer managed care plans.<sup>275</sup> By 1998, United had discontinued operations and divested its share in the joint venture, partly because it mishandled relations with black physicians there, and partly due to a media backlash against the United States' negative experience with managed care.<sup>276</sup> In fact, the joint venture was accused of "medical imperialism" and "medical apartheid."<sup>277</sup> Thus, although there were strong market incentives for both United HealthCare and local companies, the joint venture failed for political and cultural reasons.<sup>278</sup> In Mexico, a similarly ambitious HMO venture led by a group from Harvard University failed as well.<sup>279</sup>

Nevertheless, the convergence hypothesis was never meant to ignore local conditions or to imply that unique cultures and histories do not matter.<sup>280</sup> As demonstrated by United HealthCare's experience in South Africa, local conditions will always affect how health care systems operate<sup>281</sup> and there will always remain some degree of divergence. Most convergence hypotheses simply suggest that macro trends cause specific activities to converge.<sup>282</sup> For example, after United HealthCare's failed joint venture, a separate local company created a successful managed care business in South Africa.<sup>283</sup>

Likewise, convergence theories are not meant to be absolute. Continuing divergence does not have to negate broader trends of convergence. Convergence does not have to be inevitable. In the long term,

---

<sup>273</sup> *Id.*

<sup>274</sup> Gould, *supra* note 134, at 52.

<sup>275</sup> *Id.* at 61.

<sup>276</sup> *Id.* at 64-65.

<sup>277</sup> *Id.* at 61.

<sup>278</sup> *See generally id.*

<sup>279</sup> *See* Batchelder & McGriff, *supra* note 134, at 263.

<sup>280</sup> Mechanic & Rochefort, *supra* note 4, at 242.

<sup>281</sup> *Id.*

<sup>282</sup> *Id.*

<sup>283</sup> Gould, *supra* note 274, at 65.

public programs may successfully counter the trends of privatization and commercialization. However, recent and ongoing trends reveal that the private sector is driving international practices and standards to converge in various health related industries.

Finally, market-driven convergence would not be possible without public sector participation. For example, ICH is a collaboration between the pharmaceutical industry and government regulators. Medical education is being standardized at both public and private medical schools. Supra-governmental organizations like the WHO publish international practice guidelines representing current best practices for surgeries, for example.<sup>284</sup> JCI accreditation would not carry the same weight if Congress had never made JCAHO accreditation a prerequisite for hospital reimbursement under Medicare. Regulators and policymakers have helped make market-driven convergence possible.

Yet, in spite of all these counterpoints, there remains significant evidence of market-driven convergence. Even though it is not inevitable, or absolute, or purely private in all respects, convergence persists in an environment characterized by constant improvements in communications and travel, and sustained efforts to privatize and commercialize health care.

### **III. THE BENEFITS AND BURDENS OF MARKET-DRIVEN CONVERGENCE**

What are the implications of market-driven convergence in health care? And what are the distinct benefits and burdens of convergence driven by the private rather than the public sector? Part III explores these questions. I begin in Section A by exploring the benefits of market-driven convergence before assessing the burdens in Section B.

I conclude that although market-driven convergence can be quite alluring, particularly as countries enjoy new health care resources, technologies, and other tangible benefits, policymakers should pay close attention to the perils of further privatizing and commercializing their health sectors. I also assess the unique position of developing countries that may confront more acute opportunities and risks when attempting to conform to foreign standards.

---

<sup>284</sup> Lawrence K. Altman, *W.H.O. Issues a Checklist to Make Operations Safer*, N.Y. TIMES, June 25, 2008, <http://www.nytimes.com/2008/06/25/health/25surgery.html>.

### A. THE BENEFITS OF MARKET-DRIVEN CONVERGENCE

Market-driven convergence in health care is capable of generating several tangible benefits. First, it can improve efficiency in certain health care markets and amplify the gains from international trade. Second, it can improve the quality of health care goods and services by both accelerating and spreading advancements in medical care. Third, convergence may give developing countries the rare opportunity to attract new resources into their health care sectors, which they can use to build infrastructure. Finally, market-driven convergence can enhance some patients' access to health care goods and services, which may improve patients' choice and autonomy.

#### 1. INCREASED EFFICIENCY AND GAINS FROM TRADE

Converging methods, practices, and standards in the private health care sector may not only allow various markets to operate more efficiently, but may reduce barriers to trade and encourage more international competition. As Bennett explains, actors often harmonize their conduct when they acknowledge that they are mutually interdependent and that everyone benefits by avoiding unnecessary inconsistencies.<sup>285</sup> Bennett argues in the context of policy convergence that harmonization is often driven by intergovernmental and supra-national institutions.<sup>286</sup> But in the private sector, this is not necessarily so.

Certainly, such institutions often encourage harmonization. Perhaps the best example is the International Conference on Harmonization (ICH), an organization created in 1990 by both pharmaceutical regulators and industry representatives in the United States, Europe, and Japan.<sup>287</sup> As I discuss above, the goal of ICH is to harmonize the scientific and technical aspects of drug development and regulatory approval.<sup>288</sup> Multi-national pharmaceutical companies have undoubtedly benefited from harmonized standards for clinical trials and marketing approvals in these jurisdictions. Similarly, the medical device industry has benefited from the activities of the Global Harmonization Task Force (GHTF), a parallel organization composed of regulators and industry representatives from

---

<sup>285</sup> Bennett, *supra* note 3, at 225.

<sup>286</sup> *Id.*

<sup>287</sup> Global Harmonization Task Force (GHTF), <http://www.ghtf.org/> (last visited Nov. 28, 2008).

<sup>288</sup> *Id.*

the United States, the European Union, Canada, Australia, and Japan.<sup>289</sup> Private industry representatives actively work with regulators to harmonize regulatory requirements and industry standards in these jurisdictions.

But harmonization also occurs among individual firms in the market. As Bennett might say, domestic companies sacrifice their short-term independence for long-term cooperation.<sup>290</sup> Indeed, entire industries have emerged from the demand for international standardization. For example, the contract research industry was created in part to meet the demand for international clinical trials that would satisfy multiple regulators. Contract research organizations (CROs) manage clinical trials for pharmaceutical companies and have tailored their practices to satisfy regulators from all over the world, which allows their clients to seek simultaneous marketing approvals.<sup>291</sup>

The contract research industry barely existed twenty years ago, but is now a lucrative industry unto itself.<sup>292</sup> Pharmaceutical companies have gradually outsourced their clinical trial functions to “manage costs by reducing jobs, centralizing R&D, and outsourcing to reduce fixed costs.”<sup>293</sup> Moreover, smaller biotechnology firms often lack the resources and internal expertise to manage clinical trials that would support marketing applications in multiple jurisdictions.<sup>294</sup> CROs save money for pharmaceutical and biotechnology companies by centrally housing expertise of the regulatory requirements in several countries. In turn, the largest CROs serve several multinational pharmaceutical companies, creating de facto industry standards. Thus, by outsourcing clinical trials, the pharmaceutical industry has driven convergence in the contract research industry. Multinational drug companies prefer harmonized standards because it saves them time and money during the drug development and approval processes, making the industry more efficient. The entire contract research industry emerged from this demand.

Another striking example of how market-driven convergence may improve efficiency and generate gains from trade is the growth of “medical tourism,” the phenomenon in which patients travel abroad for medical treatments.<sup>295</sup> Converging practices among physicians, hospitals,

---

<sup>289</sup> Global Harmonization Task Force (GHTF), <http://www.ghrf.org/> (last visited Nov. 28, 2008).

<sup>290</sup> Bennett, *supra* note 3, at 226.

<sup>291</sup> Rettig, *supra* note 202, at 129, 135.

<sup>292</sup> *Id.* at 131, 135-36.

<sup>293</sup> *Id.* at 135.

<sup>294</sup> *Id.*

<sup>295</sup> See generally Cortez, *supra* note 212, at 82.

and even insurers are encouraging patients to price shop for surgeries, mostly in developing countries.<sup>296</sup>

In 2005, Segouin observed that medical tourism would greatly expand “due to the development of global standards of quality and the rise of the processes of accreditation.”<sup>297</sup> That same year, a World Bank research paper announced that the United States could save at least \$1.4 billion annually if only 10 percent of patients traveled overseas for fifteen low risk surgeries.<sup>298</sup> The authors, Aaditya Mattoo and Randeep Rathindran, noted that “the upper end of the quality distribution of both professionals and hospitals in several developing countries lies well above the minimum acceptable standards in industrial countries.”<sup>299</sup> Thus, by conforming to Western medical standards, several developing countries now attract significant numbers of foreign patients.<sup>300</sup> As a result, some developing countries, such as India, Thailand, and Malaysia, are investing significant resources to attract customers.<sup>301</sup>

In fact, Mattoo and Rathindran observed that the lack of conformity in the insurance industry has been a major barrier to trade in the global market for patients.<sup>302</sup> Most private health insurance remains non-portable, which discourages patients from traveling overseas.<sup>303</sup> To date, most health insurers have been reluctant to pay for treatments overseas due to diverging standards for health care education, hospitals, medical licensure, and insurance.<sup>304</sup>

However, as convergence begins to affect these areas, some insurance companies are beginning to cover treatments at hospitals that conform to prevailing Western standards like international hospital accreditation.<sup>305</sup> Moreover, both the public and private health care sectors in destination countries are trying to eliminate barriers to trade by conforming their standards and practices.<sup>306</sup>

---

<sup>296</sup> *Id.*

<sup>297</sup> Segouin, *supra* note 122, at 277.

<sup>298</sup> Mattoo & Rathindran, *supra* note 112, at 1, 3.

<sup>299</sup> *Id.* at 13.

<sup>300</sup> *Id.* at 12.

<sup>301</sup> Cortez, *supra* note 212, at 90-93.

<sup>302</sup> See generally Mattoo & Rathindran, *supra* note 112; Aaditya Mattoo & Randeep Rathindran, *How Health Insurance Inhibits Trade in Health Care*, 25 HEALTH AFF. 358 (2006).

<sup>303</sup> Mattoo & Rathindran, *supra* note 112, at 3.

<sup>304</sup> See Cortez, *supra* note 212, at 82-85, 96-98.

<sup>305</sup> See *supra* Part II.B.2; Cortez, *supra* note 212, at 99-101.

<sup>306</sup> Cortez, *supra* note 212, at 82-85 (describing private sector initiatives), 89-95 (describing public sector initiatives).

The emerging medical tourism industry is instructive. Not only do converging practices and standards among providers encourage patients to price shop, but the potentially enormous gains from trade are encouraging providers to further harmonize their standards to attract foreign patients.<sup>307</sup> Recognizing how lucrative this market may become, several governments have partnered with local industry to attract patients.<sup>308</sup> For example, India, Malaysia, Singapore, and Thailand have used joint public-private partnerships to promote their medical tourism industries.<sup>309</sup> Thus, the private sector is responding quickly and decisively to patients' and insurers' demand for international standardization. And the market has even spurred the public sector to act.

Interestingly, the largest remaining barriers to the medical tourism market are things controlled mostly by governments. For example, patients may be reluctant to travel overseas if they do not trust foreign regulators to adequately oversee local providers.<sup>310</sup> Additionally, patients might not travel if they do not trust foreign courts to provide adequate legal recourse from medical negligence.<sup>311</sup> The lagging public sector may respond to these incentives. We might see increased regulation of facilities that attract medical tourists. One industry analyst reports that two Indian states, Madhya Pradesh and Kerala, have formed "public-private medical tourism councils to regulate the industry and provide a forum for addressing complaints and malpractices."<sup>312</sup> Indian hospitals and physicians may voluntarily accept more burdensome, Western-style regulation if it allows them to compete with foreign hospitals. Thus, private sector convergence may ultimately encourage the public sector to follow suit.

Scholars and policymakers should track whether these trends encourage a race to the top or a race to the bottom. In either case, market-driven convergence is making some health care goods and services more tradable, which should, in theory, reduce barriers to trade and facilitate international competition.

---

<sup>307</sup> See generally *id.* at 87.

<sup>308</sup> *Id.* at 89-95.

<sup>309</sup> *Id.*

<sup>310</sup> *Id.* at 104-106.

<sup>311</sup> *Id.* at 106-107.

<sup>312</sup> *Tourism Ministry Plans Price Cap for Foreigners*, FIN. EXPRESS, Mar. 24, 2005, ¶ 3.

## 2. HIGHER QUALITY GOODS AND SERVICES

The second potential benefit of market-driven convergence is that it may improve the quality of some health care goods and services. Industry catchphrases like “best practices” may strike many scholars as hollow business jargon, but in the health care sector, best practices and industry standards are more likely to be supported by scientific and clinical evidence than in other industries.

Also, competition among private businesses may lead them to benchmark each others’ practices, creating de facto industry standards. Because quality matters in health care markets, conforming to industry standards may be required to compete effectively.

Finally, the diffusion of Western medicine might improve the overall quality of care in certain pockets of the health industry, particularly in places that do not have the infrastructure or scientific base to generate these advances alone. Thus, market-driven convergence may, in theory, improve the quality of certain health care goods and services.

## 3. UNIQUE OPPORTUNITIES FOR DEVELOPING COUNTRIES

How does market-driven convergence affect developing countries with vastly different health care systems and economies? I argue that convergence may present developing countries with several rare opportunities.

First, market-driven convergence may encourage some health care providers in developing countries to adopt modern medical practices and technologies. Local providers can essentially import time-tested, evidence based products and techniques from more advanced countries without sinking significant local resources into developing these advancements from scratch. That said, adopting standards and practices from advanced, modern health care systems may require significant investments in medical infrastructure. In short, market-driven convergence may be very expensive for developing countries with scarce health care resources.

Second, market-driven convergence may allow firms from developing countries to compete more effectively with firms from developed countries that have greater business expenses, including higher wages. For example, as I discuss above, the medical tourism industry is

booming precisely because a critical mass of providers in developing countries can offer Western-style health care at third-world prices.<sup>313</sup>

Third, market-driven convergence may encourage foreign investment in the health care sectors of developing countries. As mentioned above, several middle-income countries increasingly see the potential profits in their health sectors, which have led many governments to open their health sectors to foreign direct investment.<sup>314</sup> New investors may inject resources that developing countries can use to build medical infrastructure and modernize aspects of their health care systems. Of course, new resources may accrue disproportionately to private sector entities, ignoring the public sector providers that treat local patients.<sup>315</sup> According to the trickle-down theory by Alain Enthoven, gains by the more lucrative portions of the health sector used by rich patients will ultimately promote the quality and availability of goods and services used by the poor.<sup>316</sup> This debate has yet to be settled.

Nevertheless, the potential benefits of market-driven convergence in developing countries are far from certain. Indeed, developing countries are often lost in these discussions. The considerable body of comparative health policy literature has largely ignored developing countries—or has considered them only as an afterthought.<sup>317</sup> Those focusing on health care in developing countries often focus (justifiably) on urgent public health issues, such as HIV/AIDS, malaria, and tuberculosis. Fortunately, a growing number of researchers focus on the private health care sectors in these countries, including the relationships between the public and private sectors.<sup>318</sup>

The volatile nature of private health care markets in developing countries makes it exceedingly difficult to predict the effects of market-driven convergence. So what do we know at this point? In the early 1990s, studies began to show that private sector health care played a much larger role in developing countries than previous characterizations

---

<sup>313</sup> See *supra* Part III.A.1.

<sup>314</sup> See *supra* Part II.B.4.

<sup>315</sup> See, e.g., Cortez, *supra* note 212, at 109-10.

<sup>316</sup> Alain Enthoven, *On the Ideal Market Structure for Third-Party Purchasing of Health Care*, 39 SOC. SCI. AND MED. 1413, 1420 (1994).

<sup>317</sup> Barbara McPake & Anne Mills, *What Can We Learn from International Comparisons of Health Systems and Health System Reform?*, 78 BULL. WORLD HEALTH ORG. 811, 817 (2000).

<sup>318</sup> For example, Anne Mills and Barbara McPake at the Health Policy Unit in the London School of Hygiene and Tropical Medicine have published several studies examining private health care systems in developing countries. See, e.g., *id.*

suggested.<sup>319</sup> Although virtually every developing country with a functioning government uses some type of public system to finance health care, a very high proportion of total spending in these countries is paid out-of-pocket.<sup>320</sup> For example, 78 percent of health care spending in India is uninsured, private, and out-of-pocket.<sup>321</sup> By comparison, the proportion of out-of-pocket spending in the United States is only 13 percent.<sup>322</sup> A major reason for the prevalence of private out-of-pocket spending in developing countries is that their public health care systems have inadequate resources.<sup>323</sup> Thus, even though most developing countries purport to offer some sort of universal, comprehensive, and free health care coverage, the inadequacies of these public systems force private citizens to pick up the slack.<sup>324</sup>

Yet in developing countries, private sector health care goods and services may have several advantages over their public sector counterparts. First, private sector goods and services may be relatively inexpensive, particularly if providers must offer prices that are affordable to the local population.<sup>325</sup> Second, private sector goods and services may be more accessible. For example, local citizens that need drugs can simply buy them in retail shops.<sup>326</sup> However, as I discuss below, many of these private goods and services may be of low quality.<sup>327</sup> And of course, the distinction between “public” and “private” in health care is never neat, and there is often considerable overlap.<sup>328</sup>

But again, health care systems are not monolithic, especially among developing countries. In the health sphere, “[t]here are important distinctions between the very poor and the transitional, middle-income nations.”<sup>329</sup> For example, the World Bank distinguishes between: “Low Income Countries” (LICs), such as India and Nigeria, with per capita incomes of less than \$755; “Lower Middle Income Countries” (LMICs), such as China, Cuba, and Thailand, with per capita incomes between

---

<sup>319</sup> McPake & Mills, *supra* note 317, at 812.

<sup>320</sup> Mark V. Pauly, Peter Zweifel, Richard M. Scheffler, Alexander S. Preker & Mark Bassett, *Private Health Insurance in Developing Countries*, 25 HEALTH AFF. 369 (2006).

<sup>321</sup> *Id.* at 370.

<sup>322</sup> *Id.* at 371.

<sup>323</sup> *Id.*

<sup>324</sup> *Id.* at 370, 372.

<sup>325</sup> Mills, et al., *supra* note 243, at 326.

<sup>326</sup> *Id.*

<sup>327</sup> *Id.*

<sup>328</sup> *Id.* at 325.

<sup>329</sup> McPake & Mills, *supra* note 317, at 813.

\$756 and \$2,995; and “Upper Middle Income Countries” (UMICs), such as Brazil, Malaysia, Mexico, and Turkey, with per capita incomes between \$2,996 and \$9,265.<sup>330</sup> The latter countries obviously have higher income levels and larger middle classes, but also may have more sophisticated public health care sectors and more developed private sectors.<sup>331</sup> For example, higher density urban populations tend to reflect more developed private health care sectors.<sup>332</sup>

Thus, although market-driven convergence presents many potential benefits to developing countries, these benefits are highly uncertain. Indeed, the potential benefits may depend not only on each country’s specific level of development, but also on the public sector’s willingness to demand a share of the new profits and resources from the private sector. Moreover, if the private sector providers that benefit from convergence are willing to subsidize the public providers and share new resources, developing countries may capture some of the benefits of market-driven convergence.

#### 4. ENHANCED CHOICE AND AUTONOMY

What affect will convergence have on individual patients? Currently, health care in many countries is being influenced by patients’ demand to have greater choice among providers and treatment options.<sup>333</sup> Market-driven convergence may give patients greater choice and variety.

By making health care goods and services more tradable, convergence should, in theory, increase the number of providers both within and across jurisdictions. As a result, consumers should be able to shop among providers offering the same (or at least similar) goods and services based on price, quality, or both.<sup>334</sup> For example, the recent surge in medical tourism is due in part to increased international competition be-

---

<sup>330</sup> Miguel A. Gonzalez Block & Anne Mills, *Assessing Capacity for Health Policy and Systems Research in Low and Middle Income Countries*, HEALTH RES. POL’Y & SYS. (2003), <http://health-policy-systems.com/content/1/1/1>.

<sup>331</sup> McPake & Mills, *supra* note 317, at 813.

<sup>332</sup> *Id.*; I Inayat Thayer et al., *Private Practitioners in the Slums of Karachi: What Quality of Care Do They Offer?*, 46 SOC. SCI. & MED. 1441 (1998) (pointing to the proliferation of private doctors in the slums of Karachi, Pakistan).

<sup>333</sup> Mechanic & Rochefort, *supra* note 4, at 259.

<sup>334</sup> *See generally* Cortez, *supra* note 212.

tween providers that can offer roughly the same services.<sup>335</sup> Patients are more willing than ever to explore new treatment options overseas.<sup>336</sup>

Market-driven convergence may also enhance choice and autonomy for patients who face long waiting lists in countries with national or social health insurance systems.<sup>337</sup> For example, British patients now travel to India or to less developed European countries like Turkey for medical treatments.<sup>338</sup> Some public health systems have even embraced health travel. EU regulations require Member States to reimburse citizens for the medical treatments they receive in other Member States if there is an “undue delay” in obtaining the procedure domestically.<sup>339</sup> Under these regulations, the European Court of Justice recently required Britain’s National Health Service (NHS) to reimburse a British resident for a hip replacement she obtained in France, even though she did not receive prior approval from the NHS to seek treatment there.<sup>340</sup> In 2004, the NHS actually began sending patients to France, Spain, and Germany for certain surgeries to reduce waiting times.<sup>341</sup> Without at least some converging standards between these countries, such efforts would not be possible.

Finally, market-driven convergence may increase the autonomy of patients by allowing them to “vote with their feet.”<sup>342</sup> Local laws may ban certain medical treatments.<sup>343</sup> Local regulators may decide that a treatment is unsafe or not effective.<sup>344</sup> Or local providers may choose not

---

<sup>335</sup> See generally *id.*

<sup>336</sup> See generally *id.*

<sup>337</sup> *Id.* at 79, 111-13.

<sup>338</sup> *Record Numbers Go Abroad for Health Treatment with 70,000 Escaping NHS*, DAILY MAIL ONLINE (U.K.), Oct. 28, 2007, <http://www.dailymail.co.uk/news/article-490233/Record-numbers-abroad-health-treatment-70-000-escaping-NHS.html>.

<sup>339</sup> See Council Regulation 1408/71, art. 22, 1971 O.J. SPEC. ED. (L 149) 2; see generally Council Regulation 574/72, 1972 O.J. SPEC. ED. (L 74) 1 (the implementing regulation for 1408/71); Katrien Kesteloot, Sabrina Poceschi & Emmanuel van der Schueren, *The Reimbursement of the Expenses for Medical Treatment Received by “Transnational” Patients in EU-Countries*, 33 HEALTH POL’Y 43, 45 (1995).

<sup>340</sup> Case C-372/04, *The Queen v. Bedford Primary Care Trust & Sec’y of State for Health*, 2006 E.C.R. I-4376; see Mattoo & Rathindran, *supra* note 112, at 6.

<sup>341</sup> Mattoo & Rathindran, *supra* note 112, at 12 (citing data from the U.K. Dep’t of Health, <http://www.performance.doh.gov.uk/waitingtimes/index.htm>).

<sup>342</sup> Cortez, *supra* note 212, at 111-113. Although this phrase is most often associated with the Tiebout Hypothesis, it does not come from Tiebout himself. See Christopher Serkin, *Big Differences for Small Governments: Local Governments and the Takings Clause*, 81 N.Y.U. L. REV. 1624, 1662 n.147 (2006) (citing Todd E. Pettys, *The Mobility Paradox*, 92 GEO. L.J. 481, 482 n.10 (2004)).

<sup>343</sup> Cortez, *supra* note 212, at 77.

<sup>344</sup> *Id.* at 77-78.

to provide certain treatments for moral or ethical reasons.<sup>345</sup> Market-driven convergence gives patients the option of obtaining these treatments in other jurisdictions, enhancing their autonomy by allowing them to vote with their feet.<sup>346</sup>

### B. THE BURDENS OF MARKET-DRIVEN CONVERGENCE

Despite the tangible benefits of market-driven convergence, there are usually risks in relinquishing control to private markets in health care. Health care is not like other goods or services. There will almost never be “perfect” competition in health care markets.<sup>347</sup> Health care is beset by market failures, some of which are unique to health care, and some of which cannot be easily cured by government intervention. For example, most countries view health care as a “public good” not suitable for privatization or commercialization.<sup>348</sup> Health care is also notorious for the information asymmetries between patients, providers, and insurers that distort competition.<sup>349</sup> Monopolies and monopsonies further distort prices and incentives.<sup>350</sup> Thus, if health care practices and standards are converging, and if this is indeed being driven by markets, then we should be aware of how the market often fails in health care.

This section analyzes two separate dangers of market-driven convergence. First, convergence may have negative distributive consequences, particularly in developing countries. And second, market-driven convergence may actually depress the quality of goods and services available to low-income patients.

---

<sup>345</sup> *Id.* at 78.

<sup>346</sup> *Id.* at 111-13.

<sup>347</sup> Council for Trade in Services, *Background Note by the Secretariat: Health and Social Services*, S/C/W/50 (Sept. 18, 1998), [http://www.wto.org/english/tratop\\_e/serv\\_e/w50.doc](http://www.wto.org/english/tratop_e/serv_e/w50.doc) (even the pro-market World Trade Organization acknowledges the inherent market failures in health care: “Health services are normally provided in an environment significantly different from the textbook ideal of a market economy. A host of imperfections, distortions and information problems may prevent consumers and producers from contracting on an equal basis, in full knowledge of, and financial responsibility for, the ensuing results.”).

<sup>348</sup> Chanda, *supra* note 110, at 29.

<sup>349</sup> Chernichovsky, *supra* note 18, at 344-45; Hall & Schneider, *supra* note 91, at 647-48.

<sup>350</sup> Chernichovsky, *supra* note 18, at 344-45; Hall & Schneider, *supra* note 91, at 647-48. A “monopsony” is a market dominated by a single buyer, or a single source of demand, and is the counterpart to a “monopoly,” which is a market dominated by a single seller, or a single source of supply. BLACK’S LAW DICTIONARY, 1028 (8th ed. 2004).

### 1. CONVERGENCE MAY HAVE NEGATIVE DISTRIBUTIVE CONSEQUENCES

Perhaps the most obvious danger of market-driven convergence is that increased privatization and commercialization in health care will exacerbate unequal access to care and other distributive concerns. Although countries looking to conform to international standards might be justifiably proud to generate new revenues, build new facilities, and offer new technologies, these countries should consider the risks of further privatizing and commercializing their health sectors.<sup>351</sup>

The risks may be particularly acute for developing countries with less robust public health care systems. Developing countries may be more desperate to attract new financial resources or find new ways to provide health care to their citizens. A major risk is that conforming to international practices will exacerbate the two tiered health care systems in some countries, with separate systems for the wealthy and the poor.<sup>352</sup> Market-driven convergence may cause more resources to be devoted to private sector providers that cater to wealthier populations, resulting in fewer resources being dedicated to the public facilities that treat most citizens. For example, private hospitals in developing countries increasingly capture high revenue patients, leaving public hospitals with fewer resources to care for those who can't afford private hospitals.<sup>353</sup> In Brazil, the private sector uses 120,000 physicians to treat 25 percent of Brazil's population; the public sector uses less than 70,000 physicians to treat the remaining 75 percent of the population.<sup>354</sup>

Health insurance is also susceptible to this public-private imbalance. Private health insurers may "cream-skim."<sup>355</sup> When public insurers have to compete with private insurers for patients, the private sector tends to gobble up the "healthier and wealthier," while the public sector is left to care for the poorest and sickest.<sup>356</sup> In many countries, the pri-

---

<sup>351</sup> Smith, *supra* note 263, at 2320.

<sup>352</sup> Mechanic & Rochefort, *supra* note 4, at 249.

<sup>353</sup> Sarah Sexton, *Trading Health Care Away: GATS, Public Services, and Privatisation*, CORNER HOUSE BRIEFING 1, 19-20 (2001), <http://www.thecornerhouse.org.uk/pdf/briefing/23gats.pdf>.

<sup>354</sup> *Id.* at 28.

<sup>355</sup> Wynand P.M.M. van de Ven et al., *Access to Coverage for High-Risks in a Competitive Individual Health Insurance Market: Via Premium Rate Restrictions or Risk-Adjusted Premium Subsidies?*, 19 J. HEALTH ECON. 311, 316 (2000) (defining the practice of cream skinning); Timothy Stoltzfus Jost, *Private or Public Approaches to Insuring the Uninsured: Lessons from International Experience with Private Insurance*, 76 N.Y.U. L. REV. 419, 458-59 (2001).

<sup>356</sup> Sexton, *supra* note 353, at 25.

ivate sector benefits from the public safety net catching the least profitable patients.

The second danger of market-driven convergence is that market failures may be more severe in lesser developed countries. For example, information asymmetries may be much more pronounced in poorer countries,<sup>357</sup> where consumers may be less educated and may have less access to information. Many local citizens in developing countries may lack basic knowledge about diseases and treatment options, which can artificially depress demand for beneficial treatments.<sup>358</sup> Some observers warn that because such citizens depend greatly on their health care providers for information, they are particularly vulnerable to “self-interested behavior by providers.”<sup>359</sup>

Notwithstanding these unique difficulties, international organizations have long encouraged developing countries to further privatize and commercialize their health care sectors. The World Bank and the International Monetary Fund (IMF) have been criticized for forcing developing countries to privatize their health care sectors.<sup>360</sup> Sarah Sexton argues that World Bank and IMF reforms:

have helped commercial interests to cater to wealthier people in developing countries through private health care insurance and private hospitals. Most people are left dependent on a poorly equipped, shrinking public sector; it is the affluent who call upon rapidly expanding and increasingly high-cost private services.<sup>361</sup>

Moreover, although free trade agreements, such as GATS, appear to have minimal impact in the health sector,<sup>362</sup> some worry that GATS could be used to force developing countries to align their health policies at the expense of domestic needs.<sup>363</sup> For example, GATS encourages WTO members to liberalize free trade by requiring each WTO country to treat all countries alike (so-called “most favored nation” sta-

---

<sup>357</sup> McPake & Mills, *supra* note 317, at 813 (noting the prevalence of information asymmetries in health care).

<sup>358</sup> Mills et al., *supra* note 243, at 326.

<sup>359</sup> *Id.*

<sup>360</sup> Sexton, *supra* note 353, at 14; Kasturi Sen & Meri Koivusalo, *Health Care Reforms and Developing Countries—A Critical Overview*, 13 INT’L J. HEALTH PLAN. & MGMT. 199-215 (1998); see generally Mechanic & Rochefort, *supra* note 4, at 251.

<sup>361</sup> Sexton, *supra* note 353, at 15.

<sup>362</sup> *Id.* at 14 (noting that many countries have not committed to liberalizing trade in their health care sectors under GATS).

<sup>363</sup> Blank & Burau, *supra* note 6, at 267; Leah Belsky et al., *The General Agreement on Trade in Services: Implications for Health Policymakers*, HEALTH AFF. May-June 2004, at 137, 137-38; see generally Sexton, *supra* note 353, at 1, 16, 18-20.

tus) and to treat foreign companies as if they were domestic (“national treatment”).<sup>364</sup> As a result, local health care providers may struggle to compete with foreign providers for scarce resources. Other critics of GATS worry that market-driven health care systems reduce widespread access to health care, as observed in the United States and in many Latin American countries.<sup>365</sup>

In fact, several international observers worry that these market reforms will create international convergence towards the U.S. health care system, which is dominated by for-profit, private sector companies.<sup>366</sup> It is easy to understand the cause for concern. The U.S. health care system is famous for its spending, accounting for roughly half of the \$4 trillion spent on health care each year worldwide.<sup>367</sup> But by most estimates, Americans are neither healthier nor happier with their health care system than citizens in peer countries.<sup>368</sup> Moreover, the United States has not proven that market mechanisms can effectively control health care spending.<sup>369</sup>

American medicine is exceptional in other ways that developing countries might not want to emulate. It is aggressive.<sup>370</sup> For example, American physicians order several times as many hysterectomies, cesarean sections, and coronary bypasses than their counterparts in other industrialized countries.<sup>371</sup> American medicine is extremely specialized. Specialty providers in the United States have proliferated,<sup>372</sup> and some worry that American medicine has become too specialized and relies too heavily on “high technology.”<sup>373</sup> Mark Field quotes a British physician who calls Americans “Godsakers,” which means: “For God’s sake, do

---

<sup>364</sup> Uruguay Round Agreement: General Agreement on Trade in Services, Annex 1B, Apr. 15, 1994, 1869 U.N.T.S. 183 (most-favored nation provisions are located at GATS Article II, and national treatment provisions are located at Article XVII); Sexton, *supra* note 353, at 4.

<sup>365</sup> Sexton, *supra* note 353, at 1.

<sup>366</sup> *Id.* at 20.

<sup>367</sup> *Id.* at 27.

<sup>368</sup> Gerard F. Anderson et al., *It's the Prices Stupid: Why the United States Is So Different from Other Countries*, HEALTH AFF., May-June 2003, at 89, 103; Timothy Stolfus Jost, *Our Broken Health Care System and How to Fix It: An Essay on Health Law and Policy*, 41 WAKE FOREST L. REV. 537, 538 (2006); Gerard F. Anderson et al., *Health Spending in the United States and the Rest of the Industrialized World*, 24 HEALTH AFF. 903, 909 (2005).

<sup>369</sup> Moran, *supra* note 217, at 19.

<sup>370</sup> Field, *supra* note 3, at 41.

<sup>371</sup> *Id.* at 40-41.

<sup>372</sup> *Id.* at 39.

<sup>373</sup> John D. Stoeckle, *The Citadel Cannot Hold: Technologies Go Outside the Hospital, Patients, and Doctors Too*, MILBANK Q., 1995, at 3, 3-4.

something!”<sup>374</sup> More than in other countries, American physicians and patients tend to think that more medical intervention is usually better.<sup>375</sup>

Ironically, evidence is emerging that increasingly expensive private insurance in the United States is driving people into public programs, even if they remain eligible for private, employer sponsored insurance.<sup>376</sup> Thus, market-driven convergence may Americanize health care in countries that can least afford it. Policymakers in these countries might consider limiting public expenditures on unproven new technologies or investing more resources into basic, primary care services. Policymakers might also permit aggressive new technologies in the private sector but find ways to cross subsidize basic care in the public sector.

Finally, market-driven convergence may be a self-reinforcing cycle that tends to promote further privatization and commercialization in health care, which may not be sustainable for many countries. A growing consensus recognizes that public health care systems get more bang for their buck, tend to be more equitable, and are generally superior at controlling costs than private systems.<sup>377</sup> Dov Chernichovsky notes that “[a]lthough private enterprises may have greater incentive to operate more efficiently than their public counterparts,” they also tend to generate monopolies, prevent economies of scale, and impose “high information and transactional costs on the consumers, insurers, and even the care providers.”<sup>378</sup>

Everyone in a private system has to fend for herself. Consumers must either pay out of pocket or choose among different health insurance premiums, deductibles, and a maze of insurer specific rules. Consumers must also choose providers, research treatment options, and budget their present and future spending. Insurers must contract with providers, determine what services they will pay for, negotiate prices, and navigate a complex web of national and local regulations. Finally, health care providers must negotiate with payors and comply with increasingly complex regulatory schemes. Not all of these hurdles disappear in a public system, particularly in models that publicly finance private providers. But a substantial chunk of these hurdles do subside in the public realm. Mar-

---

<sup>374</sup> Field, *supra* note 3, at 41.

<sup>375</sup> *Id.*

<sup>376</sup> Jessica P. Vistnes & Barbara S. Schone, *Pathways to Coverage: The Changing Roles of Public and Private Sources*, 27 HEALTH AFF. 44, 45-46 (2008).

<sup>377</sup> Chernichovsky, *supra* note 18, at 344.

<sup>378</sup> *Id.* at 345.

ket-driven convergence might exacerbate these inefficiencies by shifting more activities to the private sector.

The trick for policymakers is capturing the tangible benefits of market-driven convergence without exacerbating existing inequalities and inefficiencies. Recognizing where and how the market fails is crucial. Again, policymakers in nearly all jurisdictions are struggling to find the right balance.

## 2. CONVERGENCE MAY LOWER THE QUALITY OF HEALTH CARE

Critics of privatization argue that for-profit health care is not only more expensive and less efficient than publicly provided care, but that it is also of lesser quality.<sup>379</sup> A common criticism is that companies create artificial demand for their medical goods and services, even though new products may provide little if any marginal benefit over previous technologies and may also pose unknown risks.<sup>380</sup>

Of course, there are several reasons why private sector health care goods and services may be of relatively poor quality in developing countries. First, observers have already found that the quality of private health care goods and services in developing countries can be low.<sup>381</sup> For example, many citizens in developing countries pay for most of their health care services out-of-pocket, and these transactions have been associated with “adverse health and financial consequences.”<sup>382</sup> Second, many lower tiered private providers receive no guidance from the public sector on how to diagnose or treat common ailments, so their practices may be influenced more by information distributed by self-interested parties, such as pharmaceutical companies.<sup>383</sup> Third, lower tier private providers may also lack access to adequate resources, such as essential diagnostic or treatment equipment.<sup>384</sup> It is not uncommon for local providers to use treatments that they know are ineffective because uninformed local citizens demand them.<sup>385</sup> Finally, many developing countries have witnessed the growth of relatively large “informal” private

---

<sup>379</sup> Sexton, *supra* note 353, at 25 (citing studies comparing public and private providers in the United States and other countries).

<sup>380</sup> Mechanic & Rochefort, *supra* note 4, at 243-44; Mechanic, *supra* note 2, at 46.

<sup>381</sup> Mills et al., *supra* note 243, at 326.

<sup>382</sup> Pauly et al., *supra* note 320, at 373.

<sup>383</sup> Mills et al., *supra* note 243, at 327.

<sup>384</sup> *Id.*

<sup>385</sup> *Id.*

health sectors, which are much less regulated and may offer products and services of widely varying quality.

Compounding these problems, few consumers in developing countries have the requisite knowledge or information to identify higher quality goods and services.<sup>386</sup> Wider information asymmetries between consumers and providers produce more dramatic market failures—consumers may neither seek nor receive high quality care.<sup>387</sup> Nevertheless, governments can help even a relatively uneducated population identify quality care by sponsoring educational campaigns and playing a role in accreditation and credentialing.<sup>388</sup>

Patients in developing countries may also lack adequate opportunities to seek redress when they have been harmed by health care providers or products.<sup>389</sup> For example, India created the Consumer Protection Act in 1986 to provide stronger remedies to consumers,<sup>390</sup> but many perceive these protections to be inadequate.<sup>391</sup> This may reflect similar sentiments in other jurisdictions. Yet, as the private health care sectors grow in these countries, it may become more difficult to regulate private providers. Researchers suggest that the window of opportunity may be small for developing countries to regulate the private sector effectively before it becomes too powerful economically and politically.<sup>392</sup> Market-driven convergence may not only accelerate the growth of the private sector, but might also empower foreign companies that can lobby more effectively to avoid stringent regulation.

In turn, there are several discrete risks in allowing the private sector to drive international standards and push for further privatization and commercialization in health care. Although immediate solutions may prove to be evasive, policymakers should think about how international market competition might affect their domestic health care programs. Finding ways to cross subsidize the public sector might be the best way to reap the tangible benefits of market-driven convergence without surrendering too much control to the private sector or allowing it to exacerbate existing inequalities.

---

<sup>386</sup> McPake & Mills, *supra* note 317, at 813; Mills et al., *supra* note 243, at 327.

<sup>387</sup> Mills et al., *supra* note 243, at 326.

<sup>388</sup> *Id.* at 327.

<sup>389</sup> *Id.*

<sup>390</sup> The Consumer Protection Act, 1986, No. 68, Acts of Parliament, 1986, available at <http://ncdc.nic.in>; Mills et al., *supra* note 243, at 327.

<sup>391</sup> Ramesh Bhat, *Regulating the Private Health Care Sector: The Case of the Indian Consumer Protection Act*, 11 HEALTH POL'Y & PLAN. 265, 272-275 (1996).

<sup>392</sup> Mills et al., *supra* note 243, at 328 (citing the experience in Thailand).

## CONCLUSION

In this article, I showed how recent international trends in health care derive in part from market-driven convergence—the process by which the private sector has encouraged methods, practices, and standards in the health care industry to become more alike across jurisdictions. Relying on over thirty years of scholarship, I explained how market-driven convergence is a dynamic, self-reinforcing process. I also showed how convergence allows physicians to migrate, hospitals to open branches overseas, pharmaceutical companies to sell prescription drugs around the world, and patients to travel for surgeries. These trends demonstrate not only the power of market-driven convergence, but also its self-reinforcing nature.

I also showed that though market-driven convergence may generate tangible benefits for many, these benefits tend to accrue disproportionately to the private sector and may undermine public health care programs. Finally, I demonstrated the perils of emulating the American health care system and adopting its market based principles, particularly for developing countries that may not only be more keen to adopt these approaches, but also more susceptible to their dangers. Policymakers in all countries should recognize the risks and byproducts of market-driven convergence.