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Comparative and International Health Law

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AS MANY AUTHORS in this symposium note, the growth and elaboration of health care law has been one of the most notable developments in the past half century in legal scholarship, education, and practice, and indeed in the law itself. Another equally, if not more dramatic, development has been in the growth of international and comparative law. A recent study of new courses in the second and third years of law school, for example, found that the greatest area of growth in new offerings in the mid-1990s was in international and comparative law, where 265 new courses and seminars were added between 1994 and 1997 (compared to 126 in health law).[1] Comparative and international law has also been an important growth area in legal practice, with many firms adding new international law departments, or even overseas offices. It would be surprising, therefore, if we did not witness at the intersection of these two trends the development of international and comparative health law.

In fact health law, and health law scholarship, remain predominantly domestic in their concerns. Health care is peculiarly and tenaciously local in its character. Whereas we purchase automobiles from Japan, computers from Korea, toys from China, and clothes from Bangladesh, when we get sick we go to the doctor in our neighborhood or the hospital downtown. Doctors and nurses cannot even practice in the next state without getting a license from that state, and drugs and devices available in Europe cannot be used in the United States unless they are approved by our own Food and Drug Administration. Health law practice is primarily concerned with state law, supplemented by federal Medicare and Medicaid, antitrust, tax, and fraud and abuse law. It is likely that many health law practitioners get through their entire career without giving a thought to international or comparative law.

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[1] Deborah Jones Merritt & Jennifer Cihon, *New Course Offerings in the Upper-Level Curriculum: Report of an AALS Survey*, 47 J. LEGAL EDUC. 524, 537 (1997) (analyzing the distribution of 1,574 new course offerings in the upper-level curricula of law schools nationwide based on reports from 83 law schools).

Nevertheless, comparative and international health law has been around for much of the history of health law and has been growing modestly for the past decade and a half. The first volume of the *Journal of Health Politics, Policy and Law* (JHPPL) included an article on comparative health policy,[2] and JHPPL has regularly over the years published many articles[3] and symposia[4] on comparative health policy and law. The American Journal of Law and Medicine added a panel of international editors in 1987, and its parent organization, the American Society of Law, Medicine and Ethics, sponsored three international conferences on law and medicine in the late 1980s and early 1990s. The Society's annual health law teachers' conference has had presentations on international and comparative topics for most years since 1990, and two in 1995.[5] Loyola University Chicago sponsored five international comparative conferences in the early 1990s, which were published in its *Annals of Health Law*.[6] This journal, *Health Matrix*, published two important symposia on international health policy in 1994, one dealing with Justice and Health Care,[7] the other with Justice and Child Health.[8] One of these *Health Matrix* symposia was published separately as a book, which remains one of the few books available on comparative health law.[9] I also have edited a collection of readings in comparative health law that has been used by a number of law schools for teaching comparative health law, mainly in seminars and summer programs.[10]

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[2] David J. Falcone, *The Challenge of Comparative Health Policy for Political Science*, 1 J. HEALTH POL. POL'Y & L. 196 (1976).

[3] *E.g.*, Constance A. Nathanson, *The Skeptic's Guide to a Movement for Universal Health Insurance*, 28 J. HEALTH POL. POL'Y & L. 443 (2003) (discussing the strategy needed to achieve universal health care in the United States and using Canada's health care structure as a model).

[4] *E.g.*, Symposium, *Learning from Experience*, 20 J. HEALTH POL. POL'Y & L. 1 (1995) (containing a collection of articles that generate ideas for health care reform based on the experience of the United States and other countries).

[5] Personal Communication with Victoria Stratton, American Society of Law, Medicine & Ethics, July 7, 2003.

[6] *E.g.*, Nicholas Bala, *Child Sexual Abuse Prosecutions in Canada: A Measure of Progress*, 1 ANNALS HEALTH L. 177 (1992) (discussing the history of child abuse laws in Canada and how recent changes to the legal system have begun to help decrease its occurrence).

[7] Symposium, *Justice and Health Care: An International Perspective*, 4 HEALTH MATRIX 205, 205-95 (1994).

[8] Symposium, *Justice and Child Health: National and International Perspectives*, 4 HEALTH MATRIX 1, 1-152 (1994).

[9] JUSTICE AND HEALTH CARE: COMPARATIVE PERSPECTIVES (Andrew Grubb & Maxwell J. Mehlman eds., 1995).

[10] TIMOTHY STOLTZFUS JOST, READINGS IN COMPARATIVE HEALTH LAW AND BIOETHICS (2001).

If one looks beyond the United States, comparative and international health law is even more popular. The World Association for Medical Law has been in existence since 1967,[11] and in 2004 will sponsor its fifteenth biennial World Congress on Medical Law (in Sydney, Australia) to examine comparatively a variety of medical law topics.[12] A number of journals, including the *European Journal of Health Law*, *Medical Law International*, the *Medical Law Review*, and the *Journal of Law and Medicine*, publish health law scholarship from many countries, much of it comparative in nature. Finally, Kluwer's *International Encyclopedia of Medical Law*[13] now provides monographs allowing the reader to compare the health law from many countries.

Comparative health law serves a number of purposes. Bioethical issues can often benefit from comparative analysis. Though judicial decisions involving bioethical issues, such as access to abortion or the right to die, are primarily grounded in national law, they are also based in understandings about the nature and meaning of human life, autonomy, and community, that are, in turn, grounded in philosophical and religious traditions that transcend national boundaries. It is not coincidental that the great American Supreme Court decisions on bioethical issues, such as *Roe v. Wade*[14] or *Washington v. Glucksberg*,[15] at least glance beyond our national boundaries at the experience of other lands. Decisions from other countries, such as Canada[16] or Australia,[17] for example, do so to an even greater degree.

Not only can we learn from countries that share with us a common philosophical and religious tradition, we can also benefit from observing the experience of countries that approach bioethical decisions from radically different perspectives. For example, we in the United States seem to have arrived, at least for the moment, at a fairly general consensus that termination of nutrition and hydration for a

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[11] *See* The World Association for Medical Law, *at* http://waml.haifa.ac.il (last visited Jan. 10, 2004).

[12] Invitation to 15th World Congress on Medical Law, *available at* http://www.tourhosts.com.au/wcml/invit.asp (last visited Jan. 10, 2004).

[13] INTERNATIONAL ENCYCLOPEDIA OF LAWS, MEDICAL LAW (Herman Nys ed., 2003).

[14] 410 U.S. 113, 129–38 (1973) (examining historic treatment of abortion at the English common law).

[15] 521 U.S. 702, 718, n.16 (1997) (reviewing positions of other countries on euthanasia and assisted suicide).

[16] *E.g.*, Rodriguez v. British Columbia (Attorney General), [1993] 107 D.L.R. (4th) 342, 401-04 (comparing Canada's assisted suicide laws to those in other countries).

[17] *E.g.*, Rogers v. Whitaker (1992) 175 C.L.R. 479, 486 (discussing duty to warn cases in the US and Canada by the High Court of Australia).

patient in a persistent vegetative state is legally permissible—even if it results in the death of that patient—while giving the same patient an injection to immediately terminate life is not acceptable. The lower Japanese courts that have considered the matter, however, do not see such a sharp distinction between these two actions, and are more cautious about terminating treatment for patients in a persistent vegetative state on the one hand, while being somewhat more open to active euthanasia for terminal patients on the other.[18] Reflecting on the reasoning of these courts might make us more open to questioning our own assumptions.

Observing the experience of other countries might also make us more sensitive to the exceptional character of our American approach to financing health care. As every American health law scholar (and by now most informed Americans) knows, the United States is the only developed country without some form of universal health care coverage. It is important to avoid the illusion that we simply need to learn how others have done it and follow suit.[18] There were a great many comparative health systems articles written during the heyday of the Clinton plan, and they were largely ignored by American lawmakers and the American public. There are historical and political reasons for our American predicament and the situation may not change in our lifetime.[19] Understanding how universal health coverage works in other countries, however, may help us to understand how it could work in the United States: which approaches might be more compatible with our own peculiarities, and which approaches we might best leave alone. We may also be able to learn from technical approaches that others have taken to specific problems in health system design, such as how to adjust payments for risk or how to pay providers for particular services.[20] If nothing else, we should learn

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[18] Danuta Mendelson & Timothy Stoltzfus Jost, *A Comparative Study of the Law of Palliative Care and End-of-Life Treatment*, 31 J.L. MED. & ETHICS 130, 136-37 (2003) (discussing Japanese court decisions that distinguish between passive, indirect, and active euthanasia and demonstrating a greater openness to active euthanasia).

[18] *See* Theodore R. Marmor, *Comparing Global Health Systems: Lessons and Caveats, in* GLOBAL HEALTH CARE MARKETS: A COMPREHENSIVE GUIDE TO REGIONS, TRENDS, AND OPPORTUNITIES SHAPING THE INTERNATIONAL HEALTH ARENA 7, 8-9 (Walter W. Wieners ed., 2001) (arguing that health care models cannot simply be transplanted from one nation to another).

[19] The best exploration of this topic is probably CAROLYN HUGHES TUOHY, ACCIDENTAL LOGICS: THE DYNAMICS OF CHANGE IN THE HEALTH CARE ARENA IN THE UNITED STATES, BRITAIN, AND CANADA 74-85 (1999) (discussing the economical and political factors that prevented the enactment of the Clinton plan and the unlikely possibility that the window on change will open any time in the near future).

[20] *See* Timothy Stoltzfus Jost et al., *The British Health Care Reforms, The*

that a health care system designed around private insurance is very abnormal when judged by comparison to the rest of the world, and that, on the whole, our health care system performs worse than that of other nations by many measures (though it performs better by a few).[21]

We might also learn by observing the approaches that other nations have taken to other sorts of health law conundrums with which we struggle. Many articles have been written, for example, examining the no-fault systems of Sweden and New Zealand, and although we cannot simply adopt their solutions for our own problems, we might learn from them. We might also learn from how other countries deal with other common problems, like protecting the confidentiality of medical records or handling complaints against health care providers.

When we turn from comparative to international law, there is more to learn. For example, the relevance of international human rights law for health care has become increasingly apparent in recent years. A number of international conventions articulate a right to health or to health care.[22] The European Convention on Human Rights in Biomedicine has become an important basis for human rights in health in Europe, for example.[23] A number of scholars in the United States have also argued for greater awareness of international human rights to health,[24] while others have explored its concrete application in specific contexts.[25]

American Health Care Revolution, and Purchaser/Provider Contracts, 20 J. HEALTH POL. POL'Y & L. 885, 892 (1995) (comparing purchaser/provider contracts in the United States and the United Kingdom and noting that the UK's contracts specify what services are provided and at what cost, while this information is missing from the US's contracts).

[21] *See* WORLD HEALTH ORGANIZATION, THE WORLD HEALTH REPORT 2000 – HEALTH SYSTEMS: IMPROVING PERFORMANCE (2000) (analyzing the health systems statistics of its member states for 1997).

[22] *E.g.*, BRIGIT C.A. TOEBES, THE RIGHT TO HEALTH AS A HUMAN RIGHT IN INTERNATIONAL LAW (1999) (arguing that all people have a right to health services and that the state has a responsibility to help provide them).

[23] *See*, *e.g.*, DAS MENSCHENRECHTSÜBEREINKOMMEN ZUR BIOMEDIZIN DES EUROPARATES: TAUGLISCHES VORBILD FÜR EINE WELTWEIT GELTENDED REGELUNG? (2002).

[24] *E.g.*, Eleanor D. Kinney, *The International Human Right to Health: What Does this Mean for our Nation and World?*, 34 IND. L. REV. 1457 (2001) (arguing that international human rights law establishes a right to health services in nations and requires nations to take affirmative actions to protect that right).

[25] *E.g.*, REBECCA J. COOK ET AL., REPRODUCTIVE HEALTH AND HUMAN RIGHTS: INTEGRATING MEDICINE, ETHICS, AND LAW (2003) (explaining the global barriers to female reproductive health and using human rights principles to propose specific reforms); LAWRENCE O. GOSTIN & ZITA LAZZARINI, HUMAN RIGHTS AND PUBLIC HEALTH IN THE AIDS PANDEMIC (1997) (discussing the necessity of interna-

International law has a number of other practical applications as well. The outbreak of severe acute respiratory syndrome (SARS) in 2003 highlighted again a point that the AIDS epidemic (and, for that matter, the problem of tobacco addiction) had already made—that public health problems are international and must be addressed at the international level.[26] Though the World Health Organization has long been reluctant to pursue international law approaches to public health issues, a body of international law must be elaborated to assure international cooperation in addressing international public health problems.[27]

Finally, research involving human subjects today takes place throughout the world, and the drugs and devices that result from this research are marketed globally. The International Conference on Harmonization and the European Drug Management Agency represent two international models for opening a global market for pharmaceutical products. The World Trade Organization's international Trade-Related Aspects of Intellectual Property (TRIPS) agreement, on the other hand, has posed a barrier to availability of drugs in poor countries.[28] Finally, the Declaration of Helsinki[29] and the CIOMS guidelines[30] present models for establishing international ethical standards for clinical trials.

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tional human rights to health care in the fighting the AIDS virus).

[26] The most active scholar in this area is David Fidler, who has produced a torrent of scholarship addressing the issue. *See* DAVID P.FIDLER, INTERNATIONAL LAW AND INFECTIOUS DISEASES (1999) (focusing on the impact of infectious diseases on international legal issues); David P. Fidler, *A Globalized Theory of Public Health Law*, 30 J.L. MED & ETHICS 150 (2002) (discussing the relationship between national and international law with respect to public health); David P. Fidler, *International Law and Global Public Health*, 48 U. KAN. L. REV. 1 (1999) (explaining the increased interest in the intersection between international and public health law).

[27] *See* David P. Fidler, *The Future of the World Health Organization: What Role for International Law?*, 31 VAND. J. TRANSNAT'L L. 1079 (1998) (discussing how the WHO should be less reluctant to pursue international law when addressing health issues).

[28] *See* Margo A. Bagley, *Legal Movements in Intellectual Property: TRIPS, Unilateral Action, Bilateral Agreement and HIV/AIDS*, 17 EMORY INT'L. L. REV. 781 (2003) (discussing the effects of TRIPS on access to HIV/AIDS medications).

[29] *Ethical Principles for Medical Research Involving Human Subjects*, World Medical Association Declaration of Helsinki, June 1964 (as amended by 52nd WMA General Assembly, Edinburgh, Scotland, October 2000) (providing guidelines for medical professionals around the world who conduct experimental research with human subjects), *available at* http://www.wma.net/e/ (last visited 8/29/03).

[30] COUNCIL FOR INTERNATIONAL ORGANIZATIONS OF MEDICAL SCIENCES (CIOMS), INTERNATIONAL ETHICAL GUIDELINES FOR BIOMEDICAL RESEARCH INVOLVING HUMAN SUBJECTS (2002) (enumerating a set of ethical guidelines for biomedical research dealing with topics like confidentiality, informed consent, and

Comparative and international health law scholarship addressing these and other topics has become quite common in the United States during the past two decades. Perhaps it is time, however, to begin thinking more seriously about not just studying international and comparative health law ourselves, but also teaching it to our students. It is may already be the case that few students make it through law school without encountering law from beyond our shores in some law school course (or perhaps even in an international summer program). The time may soon arrive when an education in health law will also be seen to be deficient if it remains narrowly focused on the parochial concerns of domestic law, and does not offer the health law student the opportunity to think more broadly about the topics that health law addresses through the lens of international or comparative legal study.

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the duty to provide health services).