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Global Health Care Financing Law: A Useful Concept?

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INTRODUCTION

A primary concern of the O'Neill Institute is global health.[1]

The website of the Georgetown University Law Center asserts the importance of global health law, claiming that:

> Health laws and policies are increasingly transnational in the modern era. Trade, commerce, travel, environment, war, and terrorism transcend boundaries and profoundly impact individual and communal health. Protecting the public's health and improving individual health outcomes increasingly involve national and international innovation and collaboration through legal systems.[2]

A second focus of the O'Neill Institute is health care financing and organization.[3] The mission of the Institute's Financing and Organization Center is to "improve health care systems by focusing on the inefficiencies associated with existing organizational, financing and regulatory structures."[4] The Center's use of the term "health care systems" suggests that its focus is not narrowly domestic, but that it might address health care financing and organization more

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1. *See* O'Neill Institute for National and Global Health Law, http://www.law.georgetown.edu/oneillinstitute/centers.html (last visited Oct. 25, 2007).

2. Master of Laws: Global Health Law, http://www.law.georgetown.edu/graduate/globalhealth.htm (last visited Oct. 25, 2007).

3. O'Neill Institute for National and Global Health Law, *supra* note 1.

4. *Id.*

broadly.

The question addressed by this Essay is whether synergy is possible between these research concentrations. Is it useful to think about global health care financing law? The conclusion of this Essay is that law can in fact make a modest contribution at the global level to addressing the issues that face health care financing systems. This contribution is limited, however, first, because health care financing systems are peculiarly national rather than global in their orientation, and second, because even at the domestic level, law has only a secondary role to play in the design, operation, and reform of health care financing systems.

I. GLOBAL HEALTH LAW AND HEALTH CARE FINANCE

The global reach of other forms of health law studied by the Center is obvious. The application of the notion of global health law to public health law, for example, seems quite straightforward. Epidemics and hazardous products move easily across national boundaries. International conventions, such as the International Health Regulations, exist to permit countries to work together in addressing these threats.[5] Some forms of health care regulation also take place at the global level. Regulation of drugs, for example, is increasingly coordinated through the International Conference on Harmonization of Technical Requirements for Registration of Pharmaceuticals for Human Use (ICH) guidelines,[6] while regulation of biomedical research looks to international standards like the Declaration of Helsinki or the Council for International Organizations of Medical Sciences (CIOMS) guidelines.[7]

It is more difficult, however, to describe the meaning of global health law for health care financing systems. Health care financing is indisputably of great importance. The United States spent almost one sixth of its Gross Domestic Product (GDP) on health care in 2003; this was more than it spent on food, transportation, housing, or any other expenditure.[8] Even with this level of spending, 47 million Americans—15.8% of the population—did not have health

5. *See* David P. Fidler & Lawrence O. Gostin, *The New International Health Regulations: An Historic Development for International Law and Public Health*, 34 J.L. MED. & ETHICS 85, 86, 93 (2006) (asserting that "[t]he transformational nature of the new [International Health Regulations] create[s] a regime that has the potential to contribute significantly to the general global governance mission of improving national and international health," but recognizing that that new regulations are not a "'magic bullet' for global health problems").

6. *See* International Conference on Harmonization of Technical Requirements for Registration of Pharmaceuticals, Revised ICH Terms of Reference, http://www.ich.org/cache/html/581-272-1.html (last visited Aug. 20, 2007).

7. *See* THE ETHICS OF RESEARCH INVOLVING HUMAN SUBJECTS: FACING THE 21ST CENTURY 433, 501 (Harold Y. Vanderpool ed., 1996).

8. Gerard F. Anderson et al., *Health Care Spending and Use of Information Technology in OECD Countries*, 25 HEALTH AFF. 819, 819, 820 exhibit 1 (2006); U.S. CENSUS BUREAU, STATISTICAL ABSTRACT OF THE UNITED STATES, 2007, at 435 tbl.656 (126th ed. 2006), *available at* http://www.census.gov/statab/www/.

insurance in 2006.[9] The United States spends more on health care than does any other country, though health care costs are a major concern in virtually all countries. The median OECD country spent 8.4% of its GDP on health care in 2003, while several countries, including France, Germany, and Switzerland now spend 10% or more of their GDP on health care.[10] In every OECD country, health care spending is increasing at a rate that exceeds GDP growth.[11] While all other OECD countries provide universal or nearly universal access to health insurance, prompt access to some services is a real problem in a number of countries.[12] Developing countries spend less of their GDP on health care, but face severe problems of access to health care, including access to basic health care and services and public health protection.[13]

It would seem, therefore, that a global collaboration to study law as it concerns health care financing could be valuable in addressing common concerns. From the outset, however, this field of study faces two problems: the peculiarly domestic nature of health care financing systems and the limited role of law in health care finance.

II. GLOBAL HEALTH CARE FINANCING? HEALTH CARE FINANCING LAW?

Health care financing systems are peculiarly national in their orientation. Indeed, many systems, like our Medicaid program or the Canadian or Swiss health care systems, are even administered primarily at subnational regional levels.[14] National systems can, of course, be classified for analytic purposes—for example as social insurance or as general revenue-funded national health service systems.[15] But the French, German, and Dutch systems, traditionally classified as social insurance systems, are almost as unlike each other as they are unlike the Swedish, Canadian, Spanish, Irish, and English general revenue-

9. CARMEN DENAVAS-WALT, BERNADETTE D. PROCTOR & JESSICA SMITH, U.S. CENSUS BUREAU, INCOME, POVERTY, AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2006, at 18 (2007), *available at* http://www.census.gov/prod/2007pubs/p60-233.pdf.

10. Anderson et al., *supra* note 8, at 820.

11. Chapin White, *Health Care Spending Growth: How Different Is the United States from the Rest of the OECD?*, 26 HEALTH AFF. 154, 154, 157 exhibit 2 (2007).

12. *See* KAREN DAVIS ET AL., THE COMMONWEALTH FUND, MIRROR, MIRROR ON THE WALL: AN INTERNATIONAL UPDATE ON THE COMPARATIVE PERFORMANCE OF AMERICAN HEALTH CARE 15 (2007), *available at* http://www.commonwealthfund.org/usr_doc/1027_Davis_mirror_mirror_international_update_final.pdf?section=4039.

13. *See* Symposium, *Global Health Financing*, 26 HEALTH AFF. 918 (2007); George Schieber & Akiko Maeda, *Health Care Financing and Delivery in Developing Countries*, 18 HEALTH AFF. 193, 198 & exhibit 4 (1999).

14. *See* EUROPEAN OBSERVATORY ON HEALTH CARE SYS., HEALTH CARE SYSTEMS IN TRANSITION: SWITZERLAND 14–15 (2000); GREGORY P. MARCHILDON, EUROPEAN OBSERVATORY ON HEALTH SYS. & POLICIES, HEALTH SYSTEMS IN TRANSITION: CANADA 26–27 (Sara Allin & Elias Mossialos eds., 2005).

15. *See* TIMOTHY STOLTZFUS JOST, HEALTH CARE AT RISK: A CRITIQUE OF THE CONSUMER-DRIVEN MOVEMENT 167–71 (2007) (stating that "[m]ost attempts to categorize the world's various systems begin with a division between social insurance and national health service models," but finding that "[t]his traditional approach to classification is problematic").

funded national health service systems, which are also each unique.[16] Indeed, the provincial health care system of Ontario differs in significant ways from that of Quebec,[17] as does the national health service of Scotland from that of England.[18] The health care systems of developing countries also differ significantly among themselves. The United States, of course, is absolutely sui generis. Each nation's health care system is the product of that nation's peculiar history and politics.[19]

A second and in some ways more significant issue is the minimal role that law generally plays in health care finance systems. If health care financing systems are primarily products of the unique history and politics of particular countries, the most useful disciplines for understanding how health care systems have evolved would seem to be history and political science. The most useful disciplines for considering how to improve the functioning of health care systems, on the other hand, are arguably health economics, health services research, and health policy. But what is the role of law? Do—or can—law, lawyers, or legal institutions make any significant contribution to the organization or reform of health care finance?

Public health care systems are, of course, constructed on legal frameworks—

16. *See, e.g.*, Special Issue, *Analysing the Impact of Health System Changes in the EU Member States*, 14 HEALTH ECON. S1 (2005) (describing the health care systems of a variety of European countries). The primary difference between the social insurance model of health care finance and the general revenue-funded model is that social insurance systems are generally funded by employee (and often employer) "contributions," essentially payroll taxes, while general revenue-funded national health services are funded by income, consumption, or other general taxes. JOST, *supra* note 15, at 168. Beyond this, financing is often administered in social insurance systems by "quasi-public social insurance funds," and services are more likely to be provided by private professionals and providers. *Id.* National health insurance funds are more likely to be administered by the government and at least some services are likely to be publicly provided. *Id.* Region-based national health services systems like those of Canada or the Scandinavian countries operate quite differently from more centralized systems like that of England. Social insurance systems also differ in important respects, such as in the degree to which the program is in fact funded by general taxes or the degree of independence and the number of governing sickness funds. *See* Rienhard Busse, Richard B. Saltman & Hans F.W. Dubois, *Organization and Financing of Social Health Insurance Systems: Current Status and Recent Policy Developments*, *in* SOCIAL HEALTH INSURANCE SYSTEMS IN WESTERN EUROPE 33, 33–40, 47–50 (Richard B. Saltman, Reinhard Busse & Josep Figueras eds., 2004) (describing the variety of social insurance systems). *See generally* Robert G. Evans, *Financing Health Care: Taxation and the Alternatives*, *in* FUNDING HEALTH CARE: OPTIONS FOR EUROPE 31 (Elias Mossialos et al. eds., 2002) (describing general revenue funding systems).

17. For a comparison of the Canadian provincial health care systems, see HEALTH CAN., CANADA HEALTH ACT ANNUAL REPORT, 2005–2006, at 15–193 (2006). Although all Canadian provinces cover hospital care and physicians' services, they vary significantly in their coverage of pharmaceuticals. *See* VALERIE PARIS & ELIZABETH DOCTEUR, OECD, PHARMACEUTICAL PRICING AND REIMBURSEMENT POLICIES IN CANADA 17–20 (2007). All residents of Quebec who do not have private drug coverage must sign up for the public plan, while in Ontario, coverage is much more limited. *See id.* at 20.

18. *See* SCOTT L. GREER, TERRITORIAL POLITICS AND HEALTH POLICY: UK HEALTH POLICY IN COMPARATIVE PERSPECTIVE 63–71 (2004).

19. *See* Special Issue, *Legacies and Latitude in European Health Policy*, 30 J. HEALTH POL. POL'Y & L. 1 (2005).

Chapter V of the German Social Code,[20] for example, or the Canada Health Act,[21] or Titles XVIII and XIX of the Social Security Act in the United States,[22] or the British National Health Services Act of 2006.[23] These framework laws are operationalized by more specific regulations and guidelines, such as Chapter 42 of the Code of Federal Regulations or the Medicare manuals in the United States.[24]

These statutes, regulations, and guidelines, however, are often quite different than criminal or regulatory public law. On the one hand, they include broad statements of policy that rarely present justiciable issues, such as the non-interference provision of the Medicare statute[25] or the "comprehensive health service" requirement of the National Health Services Act.[26] On the other hand, these statutes and regulations also contain detailed provisions governing program eligibility or payment for or coverage of products and services that may or may not create legal rights or obligations, but are primarily directed at guiding program administration.[27] In most instances they are interpreted and applied by civil servants rather than lawyers.

Other bodies of domestic law also govern health care systems. Competition or antitrust law plays an important role in many countries,[28] as does private health insurance regulation.[29] Fraud and abuse law is very important in a few countries and probably should be more important in others.[30] Tax subsidies play a major role in the United States health care system,[31] and a lesser but not

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20. Sozialgesetzbuch Gesetzliche Krankenversicherung V [SGB V] [Social Insurance Code] Dec. 20, 1988, Bundesgesetzblatt, Teil I [BGBl. I].

21. Canada Health Act, R.S.C., ch. C 6 (1985).

22. 42 U.S.C. §§ 1395–1396v (2000 & Supp. IV 2004).

23. National Health Services Act, 2006, c. 41 (Eng.), *available at* http://www.opsi.gov.uk/ACTS/acts2006/20060041.htm.

24. *See* CENTERS FOR MEDICARE AND MEDICAID SERVICES, INTERNET-ONLY MANUALS (IOMS) (2007), http://www.cms.hhs.gov/Manuals/IOM/list.asp.

25. "Nothing in this title . . . shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided . . . ." 42 U.S.C. § 1395 (2000).

26. "The Secretary of State must continue the promotion in England of a comprehensive health service designed to secure improvement—(a) in the physical and mental health of the people of England, and (b) in the prevention, diagnosis and treatment of illness." National Health Services Act, 2006, c. 41 § 1 (Eng.).

27. *See, e.g.*, 42 U.S.C. § 1395ww(d)(7) (2000) (specifying that administrative and judicial review are not available for certain inpatient hospital prospective payment determinations made under the Medicare statute).

28. *See, e.g.*, Timothy Stoltzfus Jost, Diane Dawson & André den Exter, *The Role of Competition in Health Care: A Western European Perspective*, 31 J. HEALTH POL. POL'Y & L. 687 (2006).

29. *See* 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 (2001).

30. *See generally* Niteesh K. Choudhry, Adalsteinn D. Brown & Sujit Choudhry, Health Care Fraud and Gaming (unpublished manuscript, on file with author).

31. TIMOTHY STOLTZFUS JOST, DISENTITLEMENT? THE THREATS FACING OUR PUBLIC HEALTH-CARE PROGRAMS AND A RIGHTS-BASED RESPONSE 32–34 (2003).

insignificant role in other countries.[32]

But in general, lawyers and legal institutions, and more specifically the courts, play a marginal role in the organization and function of most health care financing systems. In only a few countries, notably Germany and the United States, and increasingly in England and in the European Union, is there a significant volume of litigation involving health care finance issues.[33] In most countries, complaints are presented through special complaint panels or through ombudspersons, and disputes are settled through arbitration or administrative tribunals.[34] Where legal challenges are brought, they are brought under administrative or constitutional law and are rarely successful.[35] The courts usually need say little more than that a particular financing decision is political or discretionary to end the matter.[36] Administrators and politicians run the system; lawyers and courts are at the periphery.

III. LAW'S CONTRIBUTION

If indeed law has little to contribute to the design, organization, or reform of health care financing, this would not, of course, in itself stop law professors

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32. *See* Elias Mossialos & Sarah M.S. Thomson, *Voluntary Health Insurance in the European Union*, *in* FUNDING HEALTH CARE: OPTIONS FOR EUROPE 134–135 (Elias Mossialos et al. eds., 2002). Australia, by contrast, imposes a tax penalty on wealthy persons who fail to purchase private health insurance. *See* MELISSA HILLESS & JUDITH HEALY, HEALTH CARE SYSTEMS IN TRANSITION: AUSTRALIA 37 (2001).

33. *See* André den Exter, *Patient Mobility in the European Union*, *in* JUST MEDICARE: WHAT'S IN, WHAT'S OUT, HOW WE DECIDE 335 (Colleen M. Flood ed., 2006) [hereinafter JUST MEDICARE]; Timothy Stoltzfus Jost, *Health Care Rationing in the Courts: A Comparative Study*, 21 HASTINGS INT'L & COMP. L. REV. 639 (1998); Christopher Newdick, *Judicial Supervision of Health Resource Allocation—English Experience*, *in* READINGS IN COMPARATIVE HEALTH LAW AND BIOETHICS 59, 59 (Timothy Stoltzfus Jost ed., 2d ed. 2007).

34. *See, e.g.*, JUDITH ALLSOP & LINDA MULCAHY, REGULATING MEDICAL WORK, FORMAL AND INFORMAL CONTROLS (1996); Diane Longley, *Complaints After Wilson; Another Case of Too Little Too Late*?, 5 MED. L. REV. 172, 175–76 (1997); Vyonne Göricke Nordlund & Lars Edgren, *Patient Complaint Systems in Health Care: A Comparative Study Between the Netherlands and Sweden*, 6 EUR. J. HEALTH L. 133 (1999).

35. *See, e.g.*, Colleen M. Flood, Mark Stabile & Carolyn Tuohy, *What Is in and out of Medicare? Who Decides?*, *in* JUST MEDICARE, *supra* note 33, at 15, 26–30 ("[B]etween 1985 and 2002 of the thirty-three cases that have challenged health care policy [under the equality provision of the Canadian Charter], only eleven have been successful. More specifically, of the cases that have challenged policies limiting insured medical services only one has been upheld at the Supreme Court level.").

36. Representative is the statement of Lord Justice Bridge in *Ex parte Hincks*, (1980) 1 B.M.L.R. 93, 97 (1980):

> I feel extremely sorry for the particular applicants in this case who have to wait a long time, not being emergency cases, for necessary surgery. They share that misfortune with thousands up and down the country. I only hope that they have not been encouraged to think that these proceedings offered any real prospects that this court could enhance the standards of the National Health Service, because any such encouragement would be based upon manifest illusion.

In fairness to the British courts, they have become somewhat more willing to intervene in Health Services decisions in recent years, *see* Newdick, *supra* note 33, at 67–68, but world-wide, courts still tend to see health services rationing decisions as largely nonjusticiable.

from weighing in on the subject. Law professors have little respect for the territorial boundaries of other disciplines. We are virtually all amateur economists; indeed some have made a career out of being amateur economists. Many of us are quite happy to pontificate on philosophy, history, sociology, and, above all, policy. One can easily imagine a law school program of study examining health care systems that rarely touched on law.

However, I believe that if we as legal academics are honest with ourselves, we do face the double conundrum just presented. First, does law make more than a marginal contribution to discussions of health care financing, and second, if it does, is this contribution solely at the domestic level?

I believe that law can contribute to the consideration of health care financing and that law can make a contribution at a global level. The areas of law where global law touches most directly on health care finance are international human rights law, international trade law, international pharmaceutical regulation, and comparative health law.

First, international human rights law speaks to issues of health care financing and provision. Article 25 of the 1948 Universal Declaration of Human Rights provides: "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of . . . sickness, [and] disability . . . ."[37]

The International Covenant on Economic, Social, and Cultural Rights (ICESCR) more specifically provides at Article 12: "The States Parties . . . recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health."[38] The steps that signatories commit themselves to taking to implement this right include public health protection measures and achieving: "[T]he creation of conditions which would assure to all medical service and medical attention in the event of sickness."[39]

The ICESCR has been adopted by approximately 150 countries (although it has not been ratified in the United States).[40] The Covenant, however, only requires each State Party "to take steps . . . to the maximum of its available resources, with a view to achieving progressively the full realization of the rights . . . ."[41] The ICESCR is also supplemented by other regional human rights conventions and conventions prohibiting discrimination against particular popu-

37. Universal Declaration of Human Rights, G.A. Res. 217A, at 71, U.N. GAOR, 3d Sess., 1st plen. mtg., U.N. Doc. A/810 (Dec. 12, 1948).

38. International Covenant on Economic, Social, and Cultural Rights, art. 12, Dec. 16, 1966, 993 U.N.T.S. 3 [hereinafter ICESCR].

39. *Id.* art. 12.2(d).

40. *See* OFFICE OF THE U.N. HIGH COMM'R FOR HUMAN RIGHTS, STATUS OF RATIFICATIONS OF THE PRINCIPAL HUMAN RIGHTS TREATIES AS OF 9 JUNE 2004 (2004), *available at* http://www.unhchr.ch/pdf/report.pdf.

41. ICESCR, *supra* note 38, at art. 2.1.

lations, such as women or children.[42]

What are the implications of human rights law for the financing of health care? The courts of several countries, including South Africa, India, and Venezuela, have in specific instances recognized an enforceable right to health care under their domestic constitution[43] and in some instances, the existence of a broader international human right to health care.[44] The human right to health care is also used rhetorically to argue for increased health care services. But I know of no international tribunal that has brought about the expansion of availability of health care services through the application of human rights law, or of a domestic court that has done so by relying solely on international, as opposed to domestic, human rights law.[45] Indeed, although approximately two-thirds of the world's constitutions recognize a right to health or health care, constitutional provisions seem to have little relationship with national commitments of resources to health care.[46]

Second, international trade law is having an increasingly significant influence on health care systems. This is most obviously true in the European Union, where a series of decisions of the European Court of Justice have allowed residents of one E.U. country to receive health care services in another member country at the cost of their own health care systems when those services are not adequately available in their own country.[47] European Union free trade and competition law is also increasingly constraining the ability of member nations to regulate private health insurance.[48]

While the European Union presents the most obvious example of international trade law influencing health care systems, it is not difficult to find other

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42. *See* Eleanor D. Kinney, *The International Human Right to Health: What Does This Mean for Our Nation and World?*, 34 IND. L. REV. 1457, 1460 (2001).

43. *See* State of West Bengal [W.B.] v. Paschim Banga Khet Mazdoor Samity, 1996 A.I.R. 2426 (S.C.) (India) (right to provision of "adequate medical facilities"); *Minister of Health & Others v Treatment Action Campaign & Others* (2002) (5) SA 721 (CC) (S. Afr.) (obligation of government to provide medication that prevents mother-to-child transmission of AIDS); Bermúdez v. Ministerio de Sanidad y Asistencia Social, Case No. 15.789, Decision No. 916 (Venez. 1999) (access to antiretroviral drugs); *see also* Lisa Forman, *Ensuring Reasonable Health: Health Rights, the Judiciary, and South African HIV/AIDS Policy*, 33 J.L. MED. & ETHICS 711 (2005).

44. Both *Bermúdez* and the Treatment Action Campaign cases, for example, refer to the ICESCR. *See supra* note 43.

45. The U.N. Human Rights Commission, interpreting the ICESCR's companion, the International Covenant on Civil and Political Rights (ICCPR), Dec. 16, 1966, 999 U.N.T.S. 171, has held that the Peruvian law prohibiting abortion violated the ICCPR, U.N. Human Rights Comm., Comm'n on *K.N.L.H. v. Peru*, ¶¶ 2.1–2.3, 6.5–6.6, U.N. Doc. A/61/40 (II) (Nov. 13, 2002), while the European Court of Human Rights, applying the Council of Europe's Convention for the Protection of Human Rights and Fundamental Freedoms, Nov. 4, 1950, 213 U.N.T.S. 221, recently ruled that Poland had an obligation to provide a means of reviewing a denial of abortion for health reasons, Tysiąc v. Poland, App. No. 5410/03, Eur. Ct. H.R. (2007), *available at* http://www.echr.coe.int/eng. Neither case establishes a broader right to health care financing.

46. *See* Eleanor D. Kinney & Brian Alexander Clark, *Provisions for Health and Health Care in the Constitutions of the Countries of the World*, 37 CORNELL INT'L L.J. 285, 291, 295 (2004).

47. *See* den Exter, *supra* note 33.

48. *See* Jost, Dawson & den Exter, *supra* note 28, at 695–99.

examples. The protections offered to drug patents by the 1994 Trade-Related Aspects of Intellectual Property Rights (TRIPS) agreement, for example, have created a major barrier to access to affordable pharmaceuticals for developing countries, which was only partially addressed by the Doha agreement.[49] The Australia-United States Free Trade Agreement provides United States drug companies with the right to challenge decisions of the Australian Pharmaceutical Benefits Scheme, which has raised concerns about the ability of Australia to control drug prices.[50] The implications of NAFTA for the regulation of private health insurance in Canada following the 2005 *Chaoulli* decision, which found a right to purchase private health insurance under the Quebec Charter,[51] is a source of concern for Canadian legal commentators.[52]

Third, and closely related, regulation of the sale of pharmaceuticals is increasingly taking place on an international scale. While this is primarily an issue of health care regulation rather than the financing of health care, it is ultimately likely to have implications for the ability of countries to control a major segment of their health care expenditures. For example, when the European Medicines Agency approved Viagra in 1998, the British National Health Service was caught by surprise and, in its hurry to develop a coverage policy, ended up being sued by Pfizer under domestic and European law.[53]

Fourth, perhaps the most useful contribution of global law to this area will be through comparative rather than international law. Two years ago, I led a team of scholars from eight nations who examined health care coverage determinations in the public health care systems of their countries, one goal of which was to examine the role that administrative procedure played in these determinations.[54] Our conclusion was that the role of legal institutions and procedure is

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49. TRIPS is an international agreement administered by the World Trade Organization that imposes on its signatory countries obligations to protect intellectual property rights, including the patent rights of pharmaceutical companies. The modifications to the agreement reached in 2001 at a meeting at Doha gave developing countries greater flexibility in assuring their residents rights to essential medicines. *See* Frederick M. Abbott, *The WTO Medicines Decison: World Pharmaceutical Trade and the Protection of Public Health*, 99 AM. J. INT'L L. 317 (2005); M. Gregg Bloche & Elizabeth R. Jungman, *Health Policy and the WTO*, 31 J.L. MED. & ETHICS 529, 535–36 (2003); Kevin Outterson, *Pharmaceutical Arbitrage: Balancing Access and Innovation in International Prescription Drug Markets*, 5 YALE J. HEALTH POL'Y L. & ETHICS 193, 223–30 (2005).

50. *See* Peter Sainsbury, *Australia-United States Free Trade Agreement and the Australian Pharmaceutical Benefits Scheme*, 4 YALE J. HEALTH POL'Y L. & ETHICS 387 (2004).

51. Chaoulli v. Attorney General of Quebec, [2005] 1 S.C.R. 791, 2005 SCC 35 (Can.).

52. Tracey Epps & David Schneiderman, *Opening Medicare to Our Neighbours or Closing the Door on a Public System? International Trade Law Implications of* Chaoulli v. Quebec, *in* ACCESS TO CARE, ACCESS TO JUSTICE: THE LEGAL DEBATE OVER PRIVATE HEALTH INSURANCE IN CANADA 369 (Colleen M. Flood et al. eds., 2005); Mark Crawford, *Interactions: Trade Policy and Healthcare Reform After* Chaoulli v. Quebec, 1 HEALTHCARE POLICY / POLITIQUES DE SANTÉ (2), 90 (2006).

53. *Ex parte* Pfizer, Ltd., (1999) 3 C.M.L.R. 875 (Q.B.) (Eng.).

54. *See generally* HEALTH CARE COVERAGE DETERMINATIONS: AN INTERNATIONAL COMPARATIVE STUDY (Timothy Stoltzfus Jost ed., 2005) [Hereinafter HEALTH CARE COVERAGE].

significant.[55] A number of articles in a 2005 special issue of the *Journal of Law, Medicine and Ethics* edited by Colleen Flood, Lance Gable, and Larry Gostin on legislating and litigating health care rights also comparatively examined the role law plays in determining health care coverage in health care systems.[56] There is useful work being done and to be done in this area.

Moreover, the comparative study of health care systems is inherently of interest. It offers students a useful perspective from which to view our own badly flawed American health care system. Hopefully, as some of our students move on to become policy-makers, they will take these lessons with them. Lawyers also have skills that they can bring to comparative policy studies. Lawyers are trained to be experts in procedure, for example, and every health care system needs procedures for getting things done. Lawyers are taught to think clearly and logically about solving problems and are free of much of the jargon and ideological baggage that burdens other disciplines. Finally, lawyers are supposed to be concerned about justice, and every health care system can use more justice in addressing disparities between the rich and the poor, for example, or assuring equal access for racial and ethnic minorities.[57]

CONCLUSION

In the end, there are good reasons to conclude that a global health law program should address health care financing. Even though health care financing law is primarily domestic in its orientation and is not primarily driven by legal considerations, international human rights law, trade law, and pharmaceutical regulation, at least, do affect health care financing at a global level. Comparative examination of health care financing law is also inherently interesting and may make a contribution toward shaping domestic health policy.

We as lawyers, and this new program, do have a useful contribution, however modest, to make to the study of global health care organization and financing law.

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55. *See* Timothy Stolzfus Jost, *Conclusion* to HEALTH CARE COVERAGE, *supra* note 54, at 261–62. Legal rules, for example, determine who can initiate coverage determinations, appeal adverse determinations, and even have a seat at the table when determinations are made. These factors in turn affect the likelihood that coverage determinations will favor coverage of new technologies.

56. Symposium, *Legislating and Litigating Health Care Rights Around the World*, 33 J.L. MED. & ETHICS (SPECIAL ISSUE) 636–738 (2005).

57. *See* JOST, *supra* note 15, at 177–81.