

GLOBALIZATION, HEALTH AND THE LAW

DEVELOPMENTS IN THE UK

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I INTRODUCTION

Globalization is transforming health care delivery and regulation.¹ This comment examines British legal responses to globalization. It concentrates on two controversial issues: the criminalization of organ trafficking and the development of health tourism within the European Union. Both are controversies over regulation: how to respond at national level to the cross-border marketization of health care. Both demonstrate how globalization corrodes the basis of national health care systems based on solidarity and the promotion of shared ethical values.

II GLOBALIZATION, HEALTH CARE AND THE LAW

Globalization is a much abused term. It is often falsely described as a natural force responsible all by itself for social change. In truth globalization is shorthand for the restructured capitalist regime which emerged from the economic crises of the 1970s.² Via the Thatcher and Reagan governments, as well as the international financial institutions, capital shook off the

¹ J Harrington, 'Editorial. Towards a Global Health Law' [2004] 1 Law, Social Justice and Global Development. = elj.warwick.ac.uk/global/issue/2004-1/editorial.html

² EM Wood, Empire of Capital (London: Verso 2002).

restrictions imposed upon its accumulation by the welfare state in the first world and by the 'developmental' states of the third world. Taxes were lowered, social provision cut back and trade restrictions abolished.³ Capital now moves freely in and out of almost all states of the world. It enters the health system through outright privatization of service delivery or through lucrative public-private partnerships. It penetrates the taboos around the human body, commodifying organs, gametes and other body parts.

Globalization involves the recomposition of space and time by capital. The (uneven) spread of health technology across the globe allows nomadic patients to outflank national waiting lists and ethical restrictions. At home wealthier patients take advantage of tax cuts to switch to the private sector, where they increasingly encounter foreign multinational insurers and care providers.⁴ The network is underpinned by international economic law. States are obliged by treaty to permit free movement of capital; they are compelled to enforce drug company patents. The World Bank actively invests in private medicine in the Third World. The European Union's monetary and fiscal rules entail cuts in social spending.⁵

Convergence between national legal systems is greatest when economic interests are at stake. Moral and ethical convergence outside the sphere of capital is much slower: patent rules can be harmonized where the law on stem cell research cannot. National identity is often encoded in medico-legal rules, such as the Irish constitutional ban on abortion, or the criminal prohibition of euthanasia in Germany. Yet even these particularities are affected by deepening capitalist globalization. Cheap air travel and technical standardization mean that more Irish women than ever seek terminations in Britain, and that terminally and chronically ill Germans can journey to Switzerland for assistance in committing suicide. One way or another, all that is solid melts into air.

³ S Amin, Capitalism in the Age of Globalization (London: Zed 1997).

⁴ C Leys, Market-Driven Politics. Neoliberal Democracy and the Public Interest (London: Verso 2001) 81ff.

⁵ S Sexton, Trading Health Care Away? GATS, Public Services and Privatisation. Corner House Briefing No. 23 (London: The Corner House 2001).

III GLOBAL HEALTH TOURISM: ORGAN TRAFFICKING

The UK Human Organ Transplantation Act 1989 was passed in response to a scandal involving the extraction of organs from Turkish men for the benefit of British patients. It prohibits commercial dealings in organs including trafficking between other countries and Britain. This position is reflected in the European Convention on Human Rights and Biomedicine, as well as in resolutions of the World Medical Association and the World Health Organization. At present the British Parliament is considering a Human Trafficking Bill to update the law in this area. It would keep the prohibitions in the 1989 Act, criminalizing sales, brokering and advertising subject to a punishment of up to one year in prison.

Notwithstanding these measures, organ tourism from Britain to Third World countries is flourishing. Precise statistics are unavailable, but there is plenty of anecdotal evidence. In August 2002 a Coventry general practitioner was struck off the register by the General Medical Council. He had responded to the request of an undercover journalist for a kidney transplant, with an offer to procure an operation in India.⁶ A fellow doctor in the Midlands was suspended for the same offence two months later. Following up the story, the BBC reported on an impoverished quarter of the Indian city of Chennai (Madras), known as 'Kidney District' because of the high number of residents who had sold organs. One poor woman had earned \$750 for a kidney. The ultimate recipient a Singaporean, paid \$37,000 for it, most of which went to a middleman.⁷ The British (and indeed Indian) legal bans on organ trading seem to be irrelevant when well financed need meets absolute poverty by way of enterprising market makers.

⁶ 'Organ trade GP struck off', BBC News Online, 30 August, 2002 = <http://news.bbc.co.uk/2/hi/health/2225357.stm>

⁷ 'Indians Selling Human Organs', BBC News Online, 15 October, 2002 = news.bbc.co.uk/2/hi/health/2331341.stm

Pro-market ethicists and lawyers portray organ scarcity as a natural phenomenon rather than a product of conscious choices at global level to invest in transplantation facilities rather than basic public health and to privilege the lives of a wealthy minority over the needs of the masses. They focus almost exclusively on the reality of the organ provider's consent at the time of transplantation, ignoring the structural inequalities which drive the disadvantaged to donate.⁸ Organ sales, they argue, provide at least some income for the poorest; a point more or less analogous to the defence of Third World sweatshops in the manufacturing sector. Admittedly, more thoughtful writers would limit organ markets to single developed nations like the UK, or regions like the European Union.⁹ True consent may be possible in these areas, but not in third world nations with high levels of relative and absolute poverty. Moreover, since British or European markets are unlikely to meet the growing demand, organ tourism to poor countries is likely to continue in any case.

While systems for extracting and marketing organs have been successfully, if often illicitly reconstituted at global level, there has been no matching ethical and cultural convergence. The strength of taboos relating to organ removal still varies considerably as between countries and regions (eg. strong in Japan, less so in India).¹⁰ Enforcement capacities differ too. Furthermore the national consensus against commodification has come apart under pressure of the actually-existing market.¹¹ Despairing of their ability to protect the vulnerable through prohibitions, pro-marketeers prefer to settle for a lesser evil. They seek reform and adaptation rather than contest and transformation.¹²

⁸ N Scheper-Hughes, 'Commodity Fetishism in Organs Trafficking' (2001) 7 Body and Society 31-62.

⁹ SD Pattinson, 'Paying Living Organ Providers' [2003] 3 Web Journal of Current Legal Issues = webjcli.ncl.ac.uk/2003/issue3/pattinson3.html

¹⁰ N Scheper-Hughes, 'Keeping an Eye on the Global Traffic in Human Organs' (2003) 361 The Lancet 1645-1648.

¹¹ CA Erin & J Harris, 'An Ethical Market in Human Organs' (2003) 29 British Medical Journal 137-138.

¹² B de Sousa Santos, Toward a New Legal Common Sense. Law Globalization and Emancipation (2nd ed London: Butterworths 2002) 173.

IV HEALTH TOURISM IN THE EUROPEAN UNION

The 2004 case of Mrs Yvonne Watts is a British example of how transnational economic law tends to erode the basis of national health systems.¹³ Mrs Watts was told by her local Primary Care Trust (PCT) that she would have to wait twelve months for a total hip replacement operation. This was in line with the UK Department of Health's standard waiting times. Suffering great pain, she had the operation done in France instead. In court she claimed that the PCT was obliged by European Union law to pay for her treatment. Article 49 of the EC Treaty guarantees the right of businesses to provide services to nationals of other member states. The European Court of Justice (ECJ), has held that Article 49 also protects the right of consumers to cross borders to avail of these services within the EU.¹⁴ Mrs Watts also relied on a European Union Regulation of 1971 which obliges public health insurers to cover the costs of cross-border treatment where the patient would suffer 'undue delay' in accessing it at home. The regulation promotes the exercise of consumer freedoms under Article 49 of the EC Treaty and it is automatically enforceable in English law.

Had Mrs Watts suffered 'undue delay' in accessing treatment? In principle, the English Court of Appeal held that it was bound by ECJ case law to rule in her favour. For the ECJ what amounts to 'undue delay' is determined by the clinical needs of the particular patient, not by nationally agreed waiting times. The Department of Health sets these times with reference to the overall scarcity of resources within Britain's National Health Service (NHS). As a result the patient's needs may be subordinated to economic considerations. This conflict occurs because the NHS is a universal provider, drawing its funds directly from the taxpayer and offering care free at the point of use. A quarter century of underfunding has changed the Service from an admired system of socialized medicine, to a much criticized mechanism of health care

¹³ *Secretary of State for Health v R (on the Application of Watts)* [2004] EWCA Civ 166..

¹⁴ TK Hervey & JV McHale, *Health Law and the European Union* (Cambridge: Cambridge University Press 2004).

rationing. The British courts have traditionally upheld the rationing decisions of the NHS.¹⁵ As the Watts case shows, this deference is no longer possible under the impact of European law, itself a species of international economic law.

The Court of Appeal was acutely aware of the profound change which a decision for Mrs Watts would work upon the constitution of the NHS. Patients would be entitled to 'jump the queue' in Britain by travelling to another member state with the financial support of their local PCT. The effect of this according to Lord Justice May would be to

disrupt NHS budgets and planning and undermine any system of orderly waiting lists... [Furthermore] if the NHS were required to pay the costs of some of its patients having treatment abroad at a time earlier than they would receive it in the United Kingdom this would require additional resources.¹⁶

Given the nature of the NHS, this extra funding could only be obtained if

those who did not have treatment abroad received their treatment at a later time than they otherwise would or if the NHS ceased to provide some treatments that it currently does provide.¹⁷

The material basis of a universal free system of health care would be undermined. PCTs would be compelled to contract with private and public providers abroad, undermining capacity at home and turning the NHS as a whole into a purchaser rather than a provider of care. The ethos of national solidarity which has underpinned the System since its creation in 1948 would be dissolved. (Ultimately the Court decided to refer the case to the ECJ for an advisory ruling. Given the ECJ's track record it is hard to see how Mrs Watts can lose.) Of course the current Labour government in Britain has initiated some change of this sort already.¹⁸ The importance of Watts is that it demonstrates the legal compulsions driving the change. European Union law in this area anticipates at a regional level, the World Trade Organization's

¹⁵ C Newdick, Who Should We Treat? Law, Patients and Resources in the NHS (Oxford: Oxford University Press 1995).

¹⁶ Secretary of State for Health v R (on the Application of Watts) [2004] EWCA Civ 166 (Per May LJ at para 105).

¹⁷ Ibid.

much criticized General Agreement on Trade in Services, which has not yet been extended to health.

IV CONCLUSION

The contradictions and strains of globalization in the health care sector can be seen clearly in the legal issues raised by organ trafficking and health tourism. Legislation embodying particular national taboos is made obsolete by the development of cross-border trade in body parts. Case law supporting a nationally based rationing of health care is undone by the effect of international economic law. Non-market values, relating to the intrinsic dignity of the human body or the principle of social solidarity in health care provision, are swept away by capitalist globalization. Reformist responses are expressed as demands for partial regulation, of organ trade or of health tourism. The inadequacy of these responses may require us to consider more fundamental change.

¹⁸ A Pollock, NHS plc. The Privatisation of Our Health Care (London: Verso 2004).