Medial Tourism: Protecting Patients from Conflicts of Interest in Broker’s Fees Paid by Foreign Providers¹

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Introduction

Recognizing that medical tourism is a controversial topic, this article examines an important aspect of that substantial and growing industry: fees that foreign providers pay to brokers who bring them patients from the United States.³ These brokers—who prefer to be called "facilitators"⁴—are medical tourism companies that sometimes use glitzy websites and enticing language to solicit patients/customers.⁵ These fees can be

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³ See Angelesque Parsiyar, Note, Medical Tourism: The Commodification of Health Care in Latin America, 15 LAW & BUS. REV. AM. 379, 381 (Spring 2009) (“health tourism comprises $67 million [yearly], a figure that is growing at about 20 percent per annum”); Nathan Cortez, Patients Without Borders: The Emerging Global Market for Patients and the Evolution of Modern Health Care, 83 IND. L. J. 71, 75 (Winter 2008) (noting “valid concerns are counterbalanced both by considerations of equity as between medical tourists and citizens in other countries, and by the autonomy interests of individual patients”).
⁴ See Medical Tourism Association, Certification, http://www.medicaltourismassociation.com/certification.html (last visited Feb. 17, 2010). “Facilitators” is the term used by the Medical Tourism Association, which has instituted a certification process for medical tourism companies/brokers. Id.
thousands of dollars, and they are often not disclosed to patients. The medical tourism companies, moreover, might have greater expertise in tourism than in medical affairs, and in many cases, they might not have any medical expertise or personnel. This use of broker’s fees, which may also be called finder’s fees, kickbacks, fee splits, or referral fees, might seem odd given that legal and ethical precepts in the United States bar licensed physicians, actors with medical expertise, arguably enabling them best to identify referee providers, from paying or receiving referral fees. In fact, referral fees are roundly condemned in the United States’ medical industry, and it is a felony in the U.S. for anybody to pay or receive compensation for referring a patient to receive any good or service for which Medicare or Medicaid might pay. The ethical prohibitions on referral fees in the U.S. apply with extra force when the fees are paid to non-physicians because


See Medical Tourism Association, Compare Cost, http://medicaltourism.com/compare-cost.php?lang=en (last visited Feb. 17, 2010) (detailing costs of typical surgeries in six popular medical tourism destinations); see also E-mail with Jonathan Edelheit, infra note 15 (citing email interview with CEO of Medical Tourism Association who acknowledges it is common practice not to disclose fees).

See Cortez, supra note 3, at 118 (explaining that most medial tourism “brokers” are neither regulated nor licensed); The Medical Tourism Association implicitly recommends some medical expertise by inclusion of certain questions in its survey instrument for applications for facilitator certification, Medical Tourism Facilitator Certification 2009-2010 4 (2008) [hereinafter MTA Certification Evaluation Form], http://www.medicaltourismassociation.com/Certification%20Evaluation%20Form.PDF. Some of the yes or no questions are phrased as follows: “Applicant has described company’s experience in health care”; “Applicant has adequately described how they will be able to promote medical treatment procedures”; “Applicant has adequately described how do you answer medical-related questions from patient referrals”; “Applicant has a Medical Advisor”; “Applicant has provided a copy of said Advisor’s CV and indicated whether the Advisor is full time or part time staff and whether Advisor is compensated on a per patient basis”; “Applicant has listed any other medical professionals involved in the organization”; “Applicant has listed what languages staff speaks and in what language they provide the patient documents.” Id. See also PlacidWay, Terms and Conditions, http://www.placidway.com/terms conditions.php (last visited Feb. 17, 2010) (exampleing website’s lack of actual medical expertise). PlacidWay states it does not “provide health care and we do not provide any medical advice regarding the nature of health care treatment available in any location . . . . Please consult with your health care professional before using the services of any professional, facility or service that you learn about via our site.” Id.


Hall, Referral Fee Statutes, supra note 8, at 623 (citing 42 U.S.C. § 1320a-7b(b) (1982)).
such payments arguably encourage the lay entities or persons who receive the fees to make unwarranted claims about the care that will be given or to exert pressure on the professionals who pay the fees.  

The fees paid by foreign providers to medical tourism companies are analogous to the referral fees that are prohibited in the domestic realm, and they are of the especially disfavored genre of fees paid to non-physicians. As such, they might conjure up notions of trading in and commodification of patients, leading to commercialization and debasement of medical professionals. Nevertheless, thousands of U.S. patients need care that they are not able to afford unless they obtain it in another country, where the costs are a fraction of what they would be in the U.S.  

Many of these patients, moreover, would have no idea of whether or where they might obtain needed care without the involvement of medical tourism companies. These companies can only exist if they are adequately funded, and broker’s fees might be the only practical way that a sufficient number of companies will be adequately funded.

An inquiry into the nature and legal, economic, moral, and policy implications of medical tourism broker’s fees should be illuminated by examining prior consideration of and responses to referral fees between or from domestic medical providers. First, there will be a brief description of the workings of and economic justifications for medical tourism brokers and their compensation arrangements. The article will then examine, as well as compare and contrast, the analogous context of referral fees between or from domestic medical providers.

Medical tourism broker’s fees should not be prohibited (assuming that goal could practicably be achieved), but they should be disclosed before any agreements

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10 See American Medical Association Council on Ethical and Judicial Affairs, Code of Medical Ethics: Current Opinions with Annotations 6.021 (2008) (explaining physicians should not offer financial incentives or other valuable consideration to patients in exchange for recruitment of other patients). "Such incentives can distort the information that patients provide to potential patients, thus distorting the expectation of potential patients and compromising the trust that is the foundation of the patient-physician relationship." Id.


12 See text accompanying notes 31-60 (discussing economic justification for medical tourism broker’s fees).
between the brokers and potential patients are made and again by the providers when contact is consummated in the foreign venue. This will prevent abuse, foster competition, and preserve trust in the valuable institution of medical tourism and the brokers and foreign medical providers who help make it possible. Direct statutory commands would be difficult or impossible to enforce against foreign actors and, in practice, would discriminate against U.S.-based medical tourism companies. Therefore, these restrictions should be implemented through ethical codes and guidelines of professional bodies such as the Joint Commission International (the international counterpart of the Joint Commission for the Accreditation of Health Care Organizations that accredits U.S. medical institutions), the Medical Tourism Association, and the American Medical Association.13


To raise awareness of the high level of quality healthcare available in various countries.
To promote transparency in quality, pricing and patient safety in regards to the providing of international healthcare services.
To provide an unbiased source of information and education for patients, insurance companies and employers about top hospitals, their quality of care and outcomes.
To foster a stable forum for the communication for [sic] industry participants.

Medical Tourism Association, http://www.medicaltourismassociation.com/ (last visited Mar. 1, 2010). The American Medical Association has already promulgated guidelines regarding certain aspects of medical tourism. See New AMA Guidelines on Medical Tourism, AMER. MED. ASS'N, http://www.ama-assn.org/ama1/pub/upload/mm/31/medicaltourism.pdf (last visited Mar. 1, 2010). Glenn Cohen notes that "U.S. governments lack the direct power to force foreign hospitals to disclose information." Glenn Cohen, Protecting Patients With Passports: Medical Tourism and the Patient Protective-Argument, 95 IOWA L. REV. (forthcoming 2010). Cohen discusses, however, various mechanisms through which the U.S. government might bridle medical tourism entities: (1) U.S. governmental warnings regarding gathering and publishing data about medical tourism entities; (2) voluntary disclosures by medical tourism entities to earn "certifications"; (3) making it a crime to become a medical tourist; (4) making medical tourists ineligible for benefits such as Medicare, Medicaid, or the protections of the Emergency Medical Treatment and Active Labor Act (EMTALA); and (5) disallowing tax deductions for monies spent on medical tourism. Id. He further argues that a medical tourism ban "is unlikely to violate the U.S. federal Constitution," and that "[w]hile there is a well-established right to interstate travel protected by the Constitution, the right to travel abroad is on a very different, and much less certain, footing." Id. This overlooks the distinct possibility of a right to purchase standard care to which a person
Providers and patients should generally be left free to transact with each other. Legal and ethical interventions should only be ventured if they are justified by market failures or demonstrable threats to important values. It concludes that there does not appear to be a strong justification for the prohibition on referral fees between or from domestic medical providers and that there is certainly no reason to prohibit medical tourism broker's fees. On the other hand, markets have failed to consistently disclose broker's fees and that disclosure should be mandated by professional guidelines to provide patients with information they should rightfully have. Disclosure is not only morally proper, but it should encourage competition and foster trust.

It is important to explain that this article focuses on what is probably the most typical genre of medical tourism: the market involving uninsured or underinsured patients who are seeking a specific surgery or treatment outside the U.S. because they cannot obtain it in the U.S. at a price they are able or willing to pay. There are at least four other genres of medical tourism: (1) an emerging, limited, but potentially large market in which insurers provide at least some coverage for treatment outside the U.S.; (2) the wellness, spa, or alternative medicine market in which the emphasis is on well being and enhancement as much or more than on treatment for specific diseases; (3) the market for procedures or treatments that have not been approved as safe and effective in the U.S. and are, therefore, only available here, if at all, as part of experimental protocols; and (4) a market for transplant procedures that might involve attempts to avoid shortages of organs and protocols for distribution of scarce organs in the U.S.14

I. THE NATURE OF AND ECONOMIC JUSTIFICATION FOR MEDICAL TOURISM BROKER'S FEES

Medical tourism broker's fees range from 8% to 15% of the cost of care provided to the referred patient.15 Costs of care range from a few thousand dollars to

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14 See Cortez, supra note 3, at 99-100 (concerning category 1); see also Parsiyar, supra note 3, at 381 (regarding category 2); Kevin O'Reilly, Guidelines Target Stem Cell Medical Tourism, AM. MED. NEWS, Feb. 2, 2009, at 9, available at www.ama-assn.org/amednews/2009/02/02/prsb0202.htm (commenting many clinics abroad are marketing unproven, costly stem cell therapies to medical tourists); Erica Roberts, Comment, When The Storehouse Is Empty, Unconscionable Contracts Abound: Why Transplant Tourism Should Not Be Ignored, 52 HOW. L.J. 747, 750 (2009) (calling for U.S. legislation prohibiting transplant tourism).
15 It is important to note that this article relies heavily on the author's interviews of personnel at
tens of thousands of dollars. Therefore, the fees range from hundreds to thousands of dollars. For example, a heart bypass operation—a fairly common procedure—costs approximately $25,000 in Costa Rica, and a 10% referral fee therefore would be $2,500. To compare, a heart bypass operation in the U.S. costs approximately $144,000. Perhaps the most costly procedure available in the medical tourism market is a liver transplant, which the Medical Tourism Association indicates is available for $134,000 in Asia. Broker’s fees are commonly not disclosed to the patients, and patients might reasonably believe there are no such fees. This may be because of the non-profit designations of some medical tourism companies, the false assumption that a for-profit company is a non-profit company, the erroneous belief that fees charged by the medical tourism company for ancillary services such as arranging travel or lodging are all inclusive, or the misconception that the broker is actually part of a partnership that provides both the medical care and ancillary services, such as arranging air flights, excursions, and hotel and rehabilitation housing bookings.

Internationally accredited hospitals in Costa Rica and the top medical tourism hospital in Panama as well as correspondence with the head of the Medical Tourism Association. Interview with Sally Hernandez, Medical Tourism Director and Carla Isabella Stanziola N., Special Projects Manager of Hospital Punta Pacifica, in Panama City, Panama (Sept. 27, 2008); Interview with Dr. Jorge Cortes Rodriguez, Director of General Medicine, Clinica Biblica Hospital, in San Jose, Costa Rica (Nov. 6, 2008); Interview with Angela Lara, Nursing Coordinator and Medical Tourism Staff, CIMA Hospital, in Escazu, Costa Rica (Nov. 28, 2008); E-mail with Jonathan Edelheit, Chief Executive Officer of the Medical Tourism Association (Mar. 14, 2009) [hereinafter Email with Jonathan Edelheit]. The personnel at Clinica Biblica and CIMA would not disclose the amount of broker’s fees they pay, but those at Punta Pacifica were willing to disclose their practice. Interviews with Sally Hernandez and Carla Isabella Stanziola N., Special Projects Manager of Hospital Punta Pacifica, in Panama City, Panama (Sept. 27, 2008). They said they preferred to limit broker’s fees to 12%. Mr. Edelheit noted that fees can go up to 15%. E-mail with Jonathan Edelheit. None of the hospitals disclosed its fees to patients, and Mr. Edelheit noted that although the Medical Tourism Association believes in transparency and is working on a disclosure policy, it is common for fees not to be disclosed. Id.

See Medical Tourism Association, supra note 6. This list includes treatments as inexpensive as $2,600 breast implants in Colombia and treatments as expensive as $134,000 liver transplants in Asia. See id.

See id.

See id.

See id.

See id.

The foreign providers advertise through the internet and various print and broadcast media, which allows a patient not to have to use a broker. There are, however, almost two million entries under “medical tourism” in Google and patients often work through medical tourism brokers rather than attempt to find their way directly to a foreign provider. Medical tourism companies offer a variety of services. Some companies actually advertise medical interventions and rates so the consumer can sign up online to purchase the desired care. This direct purchasing approach is decried by the Medical Tourism Association. It takes the position that medical tourism companies should have direct contact with potential patients, have some medical expertise in-house, and put the patient directly in dialogue with the foreign medical provider before any surgery.

Whether there is a medical tourism company holding itself out as a seemingly direct seller of medical services or, instead, a company presenting itself frankly as a broker, the company can arrange solely for the desired medical intervention or, in addition, for a range of ancillary services. These ancillary services can include...

MEDICAL TRAVEL (Healthy Travel Media, 2d ed. 2008).

21 See, e.g., Woodman, supra note 20.


24 See, e.g., Planet Hospital, Procedures, http://www.planethospital.com/index.php?page=procedure_home (last visited Feb. 17, 2010). Planet Hospital’s website states: “After selecting a procedure from the list below, you will be able to choose the surgeons that are right for you, book an appointment, upload medical records and book your flights, all from one site. Or talk to a real doctor at no charge 24/7.” Id.

25 See MTA Certification Evaluation Form, supra note 7, at 8. The Medical Tourism Association’s position against direct purchasing is indicated by the question on its certification form: “Applicant does not sell packages to patients from their website that patients can purchase electronically without consultation.” Id.

26 See id. at 8. In regard to physician consultation prior to surgery, the Association’s certification questionnaire asks whether: “Applicant has adequately described practices they have in place for communication between the patient and the surgeon prior to surgery.” Id. at 10.

arranging travel to and from the provider’s country, travel to and from the airport, housing with or without a range of nursing or medically related services prior to or after hospital care is provided, and travel to tourist destinations to exotic locations prior to or after the relevant medical regimen.\(^{28}\)

Regardless of the form or content of the services provided, the consumer might not be aware of a broker’s fee or even that he is dealing with a broker. For example, if a medical tourism company’s website lists medical interventions and prices therefor, indicating that the services can be directly contracted for by filling out a form on the website, the consumer might reasonably believe that he is purchasing care from the company, even if the company states that the care will be provided at its “partners” facilities.\(^{29}\) If the medical tourism company clearly advertises that it will put the patient in contact with a foreign medical provider, the company does not advertise a non-profit designation (which might suggest it is funded by donations and, therefore charges no fees to anybody), and there is no fee paid by the consumer to the medical tourism company, the patient might reasonably assume that there is some sort of brokerage payment from the provider to the medical tourism company—which will in turn be reflected in the price of medical services.\(^{30}\) Logistically, there is no other way the company could survive. However, even if in this particular context the consumer should realize that there is a fee, he or she is unlikely to know the magnitude of the fee.

The various arrangements among consumers, medical tourism companies, and foreign providers, as well as connections among actors in somewhat analogous fields such as financial services and real estate, reflect the relative complexity of modern medicine and of these other industries.\(^{31}\) These fields often involve multiple providers but compensated directly by the patient; the facility in turn would pay a broker’s fee to the medical tourism company. *Id.*


\(^{29}\) See Medical Tourism Partners (“MTP”), http://medicaltourismpartners.com (last visited Feb. 17, 2010) (example of broker advertising services provided by “partner” healthcare providers overseas).

\(^{30}\) See Medical Nomad, Step by Step Guide, http://www.medicalnomad.com/StepByStep.jsp (last visited Feb. 17, 2010) (distinguishing between healthcare providers and brokers); Posting of Jessica Johnson to http://medicaltourismcity.com/profiles/blogs/looking-abroad-for-health (Nov. 9, 2009, 11:56 EST) (articulating medical tourism is encouraged by domestic broker). Medical tourism brokers have become numerous and help guide patients through the process of obtaining sought after health care services overseas. *Id.*

\(^{31}\) See Colwell & Kahn, *supra* note 27, at 267. As the field of medicine becomes more complex, the role of middlemen will become more crucial to the efficient operation of the field itself. *See*
and complex transactions. In such a milieu, intermediaries or middlemen can facilitate complex transactions by bundling services and bringing buyers in contact with sellers.\textsuperscript{32} These intermediaries perform various services for providers as well as consumers, and their compensation can appear in the form of referral fees from the providers.\textsuperscript{33} In some fields, referral fees are not questioned, while in other endeavors they can be deemed unethical or illegal.\textsuperscript{34}

Economists note that referral fees are found in markets in which there is not complete information about various sellers and buyers.\textsuperscript{35} They also observe that a good test as to the social value of referral fees is whether they persist despite requirements that they be disclosed.\textsuperscript{36} In a perfect market there would be complete information and thus no costs to the participants in finding each other.\textsuperscript{37} Usually there is no such complete information, and this is certainly the case with medical tourism.\textsuperscript{38} Both

\textsuperscript{32} Id. at 267-68. The reason for the multiple providers and complex transactions is because the professional services themselves have become more complex. \textit{Id.} at 267.
\textsuperscript{33} Id. at 267-68. \textquote{Referrals and referral fees emerge in markets in which there is less than full information about diverse customers and service providers.} \textit{See id.} at 268.
\textsuperscript{34} Id. \textquote{In some markets, referral fees are an accepted and uncontroversial party of the institutional landscape. In other markets and institutional settings they may be illegal, unethical, or economically inefficient.} \textit{Id.} Employee contracts are generally undesirable because they are created in such a way to prohibit employer's business associates from paying the employee. \textit{See id.}
\textsuperscript{35} \textit{See Colwell & Kahn, supra} note 27, at 268. Customers will bypass the use of middlemen when they are confident that their own expertise will direct them to an appropriate service provider. \textit{See id.} at 270.
\textsuperscript{36} Id. at 268. Colwell and Kahn argue that \textquote{there are still situations in which it is socially desirable to permit the middleman not to reveal whether a referral fee has been given in any particular instance.} \textit{Id.} This statement does not apply to the context of medical tourism companies. \textit{See generally id.} at 267-96.
\textsuperscript{37} \textit{See id.} at 268-69. Within the market there are costs that participants pay while finding one another; \textquote{the nature of these costs and the ways in which middle men can reduce them} determines their value. \textit{See id.} at 268.
\textsuperscript{38} \textit{See id.} at 268-69. The Medical Tourism Association ("Medical Travel Association"), also known as the Global Healthcare Association, is the first international non-profit association. Medical Tourism Association, About Us, http://www.medicaltourismassociation.com/aboutus.html (last visited Feb. 17, 2010) [hereinafter Medical Tourism Association, About Us]. The Association is made up of the top international hospitals, healthcare providers, medical travel facilitators, and insurance companies with the common goal of promoting the highest level of quality of healthcare to patients in a global environment. \textit{Id.} \textit{See also Offshore Living, Medical Tourism,} http://offshoreliving.typepad.com/medical_tourism/ (last visited Feb. 17, 2010) (stating task of becoming medical tourist would be greatly simplified through creation of comprehensive and complex Medical Tourism Database).
providers and patients lack information about each other. In this context, medical tourism companies can perform a marketing function for the various medical providers. If there are several providers involved, say a hospital, a travel or excursion company, and a pre- or post-hospital housing facility, there can be savings through economies of scope with the medical tourism company acting for each of the companies. Even if only direct medical care is involved, advertisements are likely to be inadequate. Rather, medical care is sufficiently complex to necessitate some direct communications between the consumer and the provider or its surrogate and the medical tourism company, even in the initial stages of the medical transaction.

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40 See Medical Tourism Association, About Us, supra note 38 (claiming goal is “[T]o promote and provide a forum for communication and to increase connectivity between patients, healthcare providers, and insurance companies”).

41 See Colwell & Kahn, supra note 27, at 269 (referring to real estate brokers and discussing how a customer saves by working in a single channel for marketing services).

42 See Medical Tourism Association, About Us, supra note 38. Although advertisements serve to raise awareness of the high level of quality healthcare available in various countries, medical tourism companies provide an unbiased source of information for patients, insurance companies and employers about top hospitals, their quality of care and outcomes. Id. Medical tourism companies serve as a valuable tool in this respect to further educate potential patients on all the consequences of seeking health care outside the U.S. because of the incomplete information advertisements provide. See Press Release, American College of Surgeons, Patients Safety Issues Prompt American College of Surgeons to Release Statement on Medical and Surgical Tourism (May 8, 2009), available at http://www.facs.org/news/surgtourism.html (discussing importance of individuals considering health care services outside of U.S. be informed of all potential risks and complications that may arise, as well as medical, social, cultural and legal implications of seeking health care elsewhere).

43 See Colwell & Kahn, supra note 27, at 270 (discussing possible complications in arranging package deal for a particular client). There are occasions when “customers will bypass the middleman to deal directly with the specialist service providers.” Id. See also Medical Tourism Association, About Us, supra note 38 (providing abstract price range for association users); Leigh Turner, ‘First World Health Care at Third World Prices’: Globalization, Bioethics and Medical Tourism, 2 BIODISCIPLINES 303, 306 (2007) (discussing how medical tourism agencies link international health care facilities to prospective clients). In addition, Turner argues that “since organizing health care in other countries requires purchasing airline tickets, finding an appropriate medical facility and suitably qualified physicians, reserving hotel accommodations for accompanying travelers, negotiating prices and arranging payment, and transferring medical records . . . ‘medical tourism agencies’ . . . bridge the gap between clients and caregivers.” Id.
The medical tourism company can also perform a screening function for the medical providers. They might lack capacity to travel, to consent to treatment, to undergo treatment, or to pay for treatment. The treatment they seek might be inappropriate for them, or they might not even need treatment. These deficiencies might be so salient that they can be screened for by an educated lay person.

It is likely that many persons would refuse to pay a fee to a company for the sole purpose of being screened for financial and other suitability for possible treatment. The reason that it is likely that many potential patients would refuse to pay for screening services becomes evident by analogy to a similar analysis ventured as to screening by personal injury lawyers, domestic medical specialists, and private investigators, as explained in detail below:

Although screening is a service to the customer, it is a service for which it is usually infeasible to have the customer pay directly. If customers

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44 See Council for Korean Medicine Overseas Promotion, http://www.koreahealthtour.co.kr/eng/pages/korea-medical-tourism/health-screening.jsp (last visited Feb. 17, 2010) (offering health screening before medical procedures take place in Korea); see also Colwell & Kahn, supra note 27, at 260 (noting middleman can perform preliminary screening functions before proceeding with purchase).
46 See Colwell & Kahn, supra note 27, at 269-71; see also Thomas R. McLean, Telemedicine and the Comoditization of Medical Services, 10 DePaul J. Health Care L. 131, at 162-63 (2007). Notably, changes in health insurance have precipitated the immediate growth of medical tourism as an industry. McLean, supra, at 163. However, insurance companies view this development, and their choice to cover such expenses, as empowering the patient's choice. Id. It is arguably a better investment for insurance companies to save money if the patient chooses a less expensive foreign provider, but many patients will not have the appropriate insurance coverage in the first place. Id. Additionally, some patients may not want to travel long distances simply for medical care. Id.
47 See Colwell & Kahn, supra note 27, at 269. The medical tourism company to this end serves as an intermediary between the patient and the foreign medical care provider ensuring that the proper medical services are arranged. See Levi Burkett, Commentary, Medical Tourism: Concerns, Benefits, and the American Legal Perspective, 28 J. Legal Med. 223, 229 (2007).
48 See Colwell & Kahn, supra note 27, at 270. In such situations, the customer is knowledgeable with respect to these deficiencies and may not even seek an initial screening. Id.
49 See id. at 269-70. As such, most professionals provide free initial consultations to encourage consumers to pursue the service. Id. at 270.
typically paid for the process of the initial screening to determine whether they were qualified to proceed further with a transaction, middlemen would have an incentive to set up operations to entice clearly unqualified individuals to pay for the screening and subsequently to reject them. Similarly, since rejecting an applicant is less costly than accepting one and going through the further work necessary, middlemen could be tempted to accept up-front payments and then reject customers without adequate screening. In other words, it is rational for customers to be wary of incentives for moral hazard.

To forestall such fears on the part of uninformed customers, professionals—notably personal injury lawyers, medical specialists, and private investigators—frequently arrange their business in such a way that initial consultations are free. At the initial consultation, a determination is made as to whether it makes sense to proceed with the services. The professional thus absorbs the cost of the initial consultation—that is to say; in the long run it is folded into the payment for subsequent provision of services. Thus, those customers who pass the initial screening end up bearing the [sic] all the screening costs, including costs from those who were rejected in the screening.50

In the medical tourism context, the providers do not have as wide initial access to consumers as do domestic personal injury lawyers, medical specialists, or private investigators.51 Thus, they often need agents, the medical tourism companies, to perform the initial screening services.52 Nevertheless, in this context many consumers

50 See id. at 269-70. Although the quoted language refers to initial screenings by professionals who go on to charge fees once an ongoing relationship is established, the medical tourism company stands in the shoes of the medical care provider and performs the initial screening with payment through a broker's fee only if an ongoing relationship is established with a foreign medical provider. Id. at 270.

51 Id. Furthermore, the actual value of the medical tourism company depends on whether the customer chooses to bypass the middleman. Id. Customers in specific circumstances may make their own appointments with the various medical providers, hotels, airlines, and purchase an extensive insurance policy independent of the medical tourism company. Id. When these situations arise, medical tourism companies simply serve as an informational tool for the clients that then use this information to establish their own package. Id.

52 See Colwell & Kahn, supra note 27, at 269. Employing a middleman, such as a medical tourism company, further reduces the costs of marketing and leads to a cost reduction. Id. Additionally, middlemen, as opposed to an advertisement, serve as a medium to better educate the customer and explain the details and desirability of the service. Id. These initial screening services allow the middlemen to screen out ineligible customers and determine whether the customer is
would also be wary of moral hazard were there a fee for the initial screening. The medical tourism companies might encourage unqualified applicants to apply and pay fees or might quickly disqualify qualified applicants after receiving fees, thereby avoiding further work.

Once a consumer is screened and found to be a qualified candidate for medical care, there remains a matching function that can be performed by the medical tourism company. The medical tourism company will ask whether the customer wants just medical care or medical care plus one or more of the ancillary services mentioned above. The company may also ask if the customer wants the least expensive care, the highest rated quality of care, or a mixture of the two.

preparing to move forward with the international medical process. Id.

53 Id. "Moral hazard . . . may be seen as a problem of information—about the risk-affecting behavior of individuals who have laid off risks on another. Essentially, the difficulty arises because the presence of insurance (or risk sharing of any other kind) reduces the care taken by the insured individual to avert the hazard. Where insurance covers the costs of repairing the possible damage, the moral hazard also encompasses the tendency of the party seeking repair not to economize." See CLARK C. HAVIGHURST, JAMES F. BLUMSTEIN & TROYEN A. BRENNA, HEALTH CARE LAW AND POLICY 165 (Foundation Press 2d ed. 1998) [hereinafter HAVIGHURST ET AL.].

54 See Colwell & Kahn, supra note 27, at 269. While screening is meant to benefit customers in determining whether this particular service is advantageous to them after considering the options, this policy of rejecting applicants, but still requiring them to pay for the screening, is financially tempting for the middlemen—a form of moral hazard. Id.

55 Michael Klaus, Outsourcing Vital Operations: What if U.S. Health Care Costs Drive Patients Overseas for Surgery? 9 QUINNIPIAC HEALTH L.J. 219, 227-28 (2005). Generally, medical tourism companies work with airlines, hospitals and hotels to provide for the patients. Id. at 227. The brokers specifically coordinate with the prospective patients to plan an appropriate medical trip based on their medical needs and budget. Id. In some instances, the medical tourism company provides a list of available physicians that meet the needs of the patient, and from this initial step on, the company works closely with the patient to ensure that their accommodations are secure and that the patient's medical needs are properly handled. Id. at 227-28.

56 See International Wellness and Healthcare Travel Association, supra note 20 and accompanying text (example of many ancillary services that medical tourism companies can provide).

In each case, the value of the middleman again depends on the existence of economies of scale and scope. These economies occur on both sides of the middleman. On the client's side, a single interview can provide information on several dimensions, enabling the middleman to put the appropriate package together more cheaply. On the service provider's side, a middleman can learn once about the various services available from various providers, evaluate them, and then use this information repeatedly when dealing with clients.
It is also unlikely that all qualified persons would pay a fee to a company for the sole purpose of advising them concerning various sources of foreign medical care. Medical tourism has been a robust phenomenon for years and, although there are some companies that charge set fees for locating foreign providers, others charge for specific travel-related or ancillary services. Some companies even state that they are free.

II. COMPARING AND CONTRASTING DOMESTIC REFERRAL FEES AND MEDICAL TOURISM BROKER'S FEES

This section will analyze, compare, and contrast referral fees between and from domestic medical providers and broker's fees paid by foreign providers to medical tourism companies. This section will also focus on the paradigm case of domestic physician referral fees involving physician-to-physician referral. As noted above, physicians are prohibited from paying referral fees whether the payments are made to physicians or lay persons. First, there will be a general comparison of the domestic and medical tourism settings with the goal of identifying: (1) types of regulations or interventions that are theoretically possible in the two contexts; and (2) existing mechanisms that already serve as possible checks on evils that might be argued to be

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58 See, e.g., MedRetreat, Medical Tourism Process, http://www.medretreat.com/medical_tourism/medical_tourism_process.html (last visited Feb. 17, 2010) (demonstrating company that charges fees). Its initial screening is done under a free registration. Id. However, in its “Medical Tourism Program Outline” it lists several initial screening steps such as exchange of “basic information relating to your case.” Id. Then it speaks of moving further “[o]nce you have made the decision to become a Gold Club Member and move forward . . . .” Id. Gold Club membership costs $195. Id.

59 See Parsiyar, supra note 3, at 383-84. PlanetHospital charges for various optional concierge services:

- Airport pick up and drop off
- Transport from hotel to hospital on days of treatment
- Hospital visits if required
- Notify friends and family of your surgical progress if required
- A mobile phone . . .
- Two hours of personal driving time for shopping, excursions, or other touring
- A personal [sic] who is a phone call away to assist you while you are in a foreign country and to take care of you in the event of an emergency, including rebooking your flights (often with no charge to you because of our relationships with local airlines)


60 See Healthbase, supra note 5. However, the only services advertised as free on this website are a free quote and free registration, which enable the user to access additional information. Id.

61 See Hall, Referral Fee Statutes, supra note 8, at 623.
associated with referral or broker's fees. This will require a listing of the evils that can be argued to be associated with domestic referral fees. Then, there will be a preliminary discussion on how to define physician "referral fees" within statutes that implement the wide-spread ban on domestic referral fees, which might help understand the causes of the wide-spread ban. The section will next consider a possible defense of domestic physician referral fees and will then consider more specifically each of the objections to such fees insofar as they might apply to both domestic referral and medical tourism broker's fees.

A. Possible Regulations or Interventions, and Existing Mechanisms, that Might Check the Negative Effects of Referral or Broker's Fees

It is necessary to list the evils that arguably may be associated with domestic referral fees in order to better understand possible interventions or existing mechanisms that might check those evils. These interrelated evils are: (1) paying windfalls to referring physicians; (2) encouraging unnecessary care; (3) increasing the cost of care; (4) encouraging referrals to providers who pay the highest referral fees rather than those who can give the best care; (5) encouraging providers who pay referral fees to cut corners in their care to recoup the costs of referral fees; (6) commodifying patients and commercializing and debasing providers; (7) undercutting societal and individual patient trust in providers; and (8) creating poorer patient outcomes because of the attenuation of trust.  

The possible forms of regulation or intervention concerning referral or broker's fees include, but are not limited to, prohibition, limitation as to amount, or disclosure regarding the fact or amount of the fees. Turning to comparison of the domestic referral fee and medical tourism broker's fees settings, it is obviously much easier for legislators, regulators, or professional bodies to wield their influence and directive powers over domestic actors, as opposed to foreign actors. Some medical tourism companies are based in the U.S., while others are foreign companies. Furthermore, the providers who pay broker's fees are located outside the U.S. Although some of the
physicians who provide care to medical tourists are certified by U.S. specialty boards, usually foreign hospitals or other institutions, which in turn have relationships with the individual providers, pay broker's fees.66

It is also important to recognize that there are many existing mechanisms that might limit abuses that could be associated with domestic referral fees or medical tourism broker's fees.67 It could be that these mechanisms are sufficient without any prohibition, mandatory disclosure, or other specific intervention concerning referral or broker's fees.68 Generally, the existing mechanisms might be more numerous or powerful in the domestic setting as compared to in many medical tourism destinations, but they are similar and substantial in both contexts. These mechanisms are internalized professional norms; market/reputational forces; quality assurance and utilization review by governmental, insurance, and professional bodies; and potential liability suits.69

Turning first to consideration of internalized professional norms, domestic physician referral fees involve a physician as either the recipient and/or payer of the referral fee.70 In the medical tourism context, however, various medical providers, usually hospitals or clinics as opposed to individual doctors, pay fees to a lay entity—the medical tourism company.71 These differences probably make it somewhat more likely that internalized professional and ethical norms will encourage proper behavior in the domestic, as opposed to the medical tourism context.72 Institutional providers, however, are often expected to adhere to certain elevated ethical standards, and there is some movement toward professionalizing medical tourism through certification of facilitators by the Medical Tourism Association.73

68 Id. at 209-10 (noting importance of and justification for incentive disclosure).
69 Id. at 210-22 (arguing against regulating mechanisms based on open market theories).
70 See Colwell & Kahn, supra note 27, at 267 (describing evolution of referral fees).
72 Id. at 3. Most patient referrals are physician to physician but about a third of physicians polled in this survey report receiving patients from internet advertising, social networking, and, in one case, from a medical equipment company. Id.
73 Medical Tourism Association, Certification, supra note 4. The Medical Tourism Association website boasts that it has launched a pilot program with the goal of certifying medical tourism facilitators and creating a system for which these providers can be judged against one another. Id.
Internalized professional and ethical norms are perhaps the most speculative of alternative mechanisms. Another informal, but likely more powerful, mechanism is the desire of domestic providers, foreign providers, and medical tourism companies to maintain their reputations as a way of competing in the medical market places. Domestic providers, foreign providers, and medical tourism companies are all likely to lose business if they develop reputations for participating in transactions that encourage unnecessary or bad practices or outcomes. The possibilities for exposure of abuses by both traditional media and communication among patients and other participants through websites, blogs, and chat rooms are substantial.

There is one reason that market controls of abuses might be less potent in the domestic context. Some have argued that patients would be outraged and may lose trust in their physicians if referral fees were allowed and became public knowledge. The reason this might not happen in many or most domestic transactions is that most care is paid for through government or private insurance. Patients would likely dismiss referral fees as just another expense for the insurance companies. In the medical tourism context addressed here, however, the very impetus for obtaining care outside the U.S. is the inability or unwillingness to pay U.S. prices. In this context, patients are more likely to call for curative action if there are unwarranted fees—fees that will come directly out of their pockets. As will be seen below, it is possible that patients would not learn about referral or broker's fees without mandatory disclosure policies. On the other hand, it is possible that they would be particularly upset and galvanized toward action if they found out about undisclosed, excessive fees on their own.

If domestic referral fees were allowed and led to unnecessary or bad care, existing government, institutional, and insurance company quality assurance and

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74 See id.
75 See generally JOSEF WOODMAN, PATIENTS BEYOND BORDERS: EVERYBODY'S GUIDE TO AFFORDABLE, WORLD-CLASS MEDICAL TRAVEL (Healthy Travel Media 2d ed. 2008).
76 See Hall, Theory, supra note 67, at 210.
77 See id.
78 See id.
79 See id. Part of the reason for the patient's inability or unwillingness to pay is because the patient's insurance provider is unwilling to cover, either partially or fully, the cost of the treatment, which sends patients to other locales where the same treatment can be obtained at a lower cost. Id. at 210.
80 See Hall, Theory, supra note 67, at 210.
81 See id. at 211-12 (arguing market forces could produce disclosure without government mandate if necessary). Consumer behavior and concern could divulge referral fees on their own. Id.
82 See id. at 223-24.
utilization review mechanisms that are designed to identify and root out such unnecessary or bad care would come into play. There is not much evidence concerning the nature and efficacy of such mechanisms in the various medical tourism markets, but the Joint Commission International has structured its most recent accreditation standards so as to focus on quality assurance mechanisms.

B. A Preliminary Look At How To Define Physician “Referral Fees” and Why They Are Condemned in the U.S.

One might imagine from the discussion about the economic justification for broker's fees in Section I that referral fees between professional service providers could be considered efficient and thus legal and ethical. While some industries and professions embrace referral fees, others severely limit or totally prohibit them. Although different dynamics among industries might logically explain the disparate approaches to referral fees, there does not seem to be a coherent economic or ethical analysis that explains the differences among the various professions. Representative of this apparent incoherence, the American Institute of Certified Public Accountants (“AICPA”) used to prohibit referral fees as unethical. It rescinded this policy in 1990, however, when the Federal Trade Commission charged that the policy was an anti-competitive device that violated antitrust laws.

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83 See id. at 238 (outlining utilization management and incentives for physicians to ensure quality assurance).
87 See id. at 29 (outlining prohibition of referral fees). The AICPA prohibited CPAs from accepting commissions for referring clients to products or services of non-CPA vendors, from paying a referral fee or accepting a referral fee from another CPA for a client, and accepting a fee contingent upon particular outcomes. Id.
88 See id. (noting AICPA agreement to relax the prohibitions in the field).
Referral fees might be thought of as particularly appropriate between health care providers.\textsuperscript{89} After all, health care providers are far better qualified than consumers to judge when and from whom additional medical care might be needed. Although referral fees are accepted within the medical field in some countries, they are roundly condemned as unethical and illegal in the United States.\textsuperscript{90} For example, the American Medical Association considers referral fees unethical.\textsuperscript{91} State statutes frequently define giving or accepting referral fees as unprofessional conduct worthy of professional discipline.\textsuperscript{92} Some states actually criminalize the practice.\textsuperscript{93} Arguably, the most serious referral fee prohibition is the federal Medicare/Medicaid fraud and abuse statute that, paraphrased, states:

\begin{quote}
[A]nyone who pays or receives any remuneration directly or indirectly, overtly or covertly, in cash or in kind for the referral of a patient to a person for the furnishing of any item or service for which payment may be made under Medicare or Medicaid is guilty of a felony punishable by five years imprisonment or $25,000, or both.\textsuperscript{94}
\end{quote}

\textsuperscript{89} See cf. Allen & Ng, supra note 86, at 29-35.
\textsuperscript{90} Lance Stell, \textit{Two Cheers for Physicians' Conflicts of Interest}, 71 MT. SINAI J. MED. 236, 38 (Sept. 2004) (referral fees common in Japan). \textit{See also} Cortez, supra note 3, at 90-96 (outlining medical tourism in various countries around the world); Allen & Ng, supra note 86, at 31-32 (discussing referral fees in United States).
\textsuperscript{91} \textit{See} American Medical Association, \textit{Code of Medical Ethics: Current Opinions with Annotations} 6.02 (2008-2009 ed.) (regarding fee splitting by or with a physician); \textit{see also id.} at 6.021 (regarding referral fees paid to patients); \textit{id.} at 6.03 (regarding referral fees paid to physicians by health care facilities).
\textsuperscript{92} \textit{See} Havighurst et al., supra note 53, at 446-450.
\textsuperscript{93} \textit{See id.} at 446-50 (discussing state statutes prohibiting fee-splitting and self-referrals for medical services); \textit{see also} N.Y. PUB. HEALTH LAW § 4500-03 (McKinney 2009), available at http://public.leginfo.state.ny.us/menugetf.cgi (making for-profit referrals for medical services a misdemeanor punishable by imprisonment for up to a year and subject to a fine of $5000); CAL. HEALTH & SAFETY CODE § 445 (West 2009), available at http://codes.lp.findlaw.com/ca/code/HSC/1/d1/1.9/s445 (same).
The broad language just quoted can be literally interpreted to criminalize a broad array of transactions—even physicians' waivers of deductibles and co-payments or a rural hospital's recruitment “of a badly needed specialist to the county.” The former “can be characterized as payments to refer one's patients to oneself for treatment.” A compensation package to the rural physician in the latter example could be deemed a payment to induce the physician to bring patients to the hospital rather than reasonable compensation for services provided. If the fraud and abuse statute did not just cover Medicare and Medicaid, it would clearly apply to U.S. health care providers paying broker's fees to medical tourism companies operating and referring within the confines of the United States, i.e., referring patients either to much cheaper providers outside their state of residence or from one cold, dreary state to providers in a “vacation paradise” state.

It is instructive here to consider part of a prior analysis of the general question of how to interpret vague referral fee statutes. Mark Hall, one of the nation's leading scholars in the areas of health care law and policy and medical bioethics, suggests that

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96 See Hall, Referral Fee Statutes, supra note 8, at 623-24. Although waiver of beneficiary cost sharing is no longer criminalized by the anti kickback statute, it might still be illegal under the Stark Law, 42 U.S.C. § 1395nn (2008), which prohibits physician self-referrals if the waiver is for the provision of a designated health service not provided personally or by a member of a physician group practice. See generally Medicare Fraud and Abuse; Physicians' Referrals to Health Care Entities with Which They Have Financial Relationships, 63 Fed Reg. 1659 (Jan. 9, 1998) (responding to comments regarding comparisons between Stark and anti-kickback statute). Under Stark, certain referrals are prohibited outright unless certain exceptions have been met; in contrast, the anti-kickback statute is a ban on the knowing and willful use of remunerations to induce future referrals—behavior must therefore be analyzed on a case by case basis. See HAVIGHURST ET AL., supra note 53, at 487.

97 See Hall, Referral Fee Statutes, supra note 8, at 623.

98 Cf. U.S. v. Cancer Treatment Centers of America, 2005 WL 2035567 (N.D. Ill. 2005); U.S. ex rel Poraless v. St. Margaret's Hosp., 243 F. Supp. 843, 848 (C.D. Ill. 2003) (anti-kickback statute regulates only referrals where federal funds are involved, such as Medicare and Medicaid). Likewise, the Stark Act only applies to physicians who refer Medicare or Medicaid beneficiaries to designated health services in which they have a financial interest. See 42 U.S.C.A § 1395nn(b)(1) (West Supp. 1998).

99 See Hall, Referral Fee Statutes, supra note 8, at 626-27 (distinguishing between OIG's current transactional model and proposed definitional model for determining criminality of referral fees).
the proper approach is not a transactional model that attempts to specify which categories of transactions are or are not covered. Instead, he suggests that a "definitional model—one that seeks to redefine the essence of the prohibited referral fee in a more limited manner before applying that definition to individual cases" is appropriate.

Hall's analysis will be drawn on below to suggest that medical tourism broker's fees should not be prohibited because they represent payments for actual services provided to both the tourists/patients and the foreign medical providers. In addition, Hall's analysis suggests another possible limitation on broker's fees: limiting them to amounts that represent reasonable compensation for the medical tourism companies' services. It will be argued below that it is unnecessary, too difficult and too intrusive to attempt to determine reasonable broker's fees among the plethora of medical tourism companies and their disparate packages of services. It is first necessary to further examine physician referral fees and to pursue their comparison to broker's fees.

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100 See id. at 628-29. In regard to this model, Hall has observed:

A superior definitional model can be found in state law interpretations of fee-splitting statutes. These interpretations have regularly grappled with the problem of subsidiary referral motivations that underlie payments for legitimate services. A classic situation is the rental of hospital space and equipment to in-house pharmacies and radiologists in exchange for a percentage of their gross receipts. Since hospital pharmacies and radiologists obtain their patients from the hospital, these rental payments have the clear potential to induce referrals. California courts and attorney general opinions analyzing this situation under the state's felony statute have developed a penetrating distinction between earned and unearned referral fees. Fees incidentally related to a referral are nevertheless valid if they are fully earned by legitimate non-referral services—that is, if they do not exceed the fair market value of necessary services bargained for at arm's length . . . .

Id. Hall has conducted extensive research on numerous topics in the health care field, including consumer-driven health care, doctor/patient trust, genetics and insurance regulation. Wake Forest University School of Law, Faculty Profiles, http://law.wfu.edu/faculty/profile/hallma/ (last visited Feb. 17, 2010).

101 See Hall, Referral Fee Statutes, supra note 8, at 626.

102 See infra notes 117-120. A charge for actual services incurred would, in this sense, impose a requirement of demonstrable harm prior to a charge of statutory violation. See HAVIGHURST ET AL., supra note 53, at 118.

103 See Hall, Referral Fee Statutes, supra note 8, at 629 (recommending fees, even if incidental to service performed, be considered valid if fully earned by legitimate non-referral services). Hall suggests that fair market value for necessary services bargained for at arm's length should be the key indicator of whether a fee should be subject to a criminal sanction. Id.

104 See discussion infra Part I.I.E.
C. A Possible Defense of Domestic Physician Referral Fees

The objections to referral fees listed above are not founded on firm empirical evidence and are subject to counter arguments. Mark Pauly, a Bendheim Professor and Chair of the Health Care Systems Department at the Wharton School of the University of Pennsylvania, focuses on two of the primary evils argued to be associated with referral fees in the domestic market: encouraging unnecessary referrals or referrals to the physicians who pay the highest referral fees rather than to those who can provide the best care. Pauly expounds on his reasons below:

In the best of all worlds (whether possible or not), fee splitting need not exist. Fee splitting is a symptom of a divergence of price from marginal cost. The most direct cure for fee splitting would be a readjustment of prices so that price would equal marginal cost. Failing this, kickbacks serve to bring the net price of specialist services, as perceived by the generalist, closer to something like the true marginal cost of such services. In a sense, this increases the incentive to the generalist to act as his patient’s perfect agent. But kickbacks also transfer some of the specialist’s monopoly profit from each referral to the generalist, and in this sense lead to perverse incentives. Nevertheless, one cannot be sure which effect is greater, and so it is impossible to find conclusive informative support for a ban on fee splitting.

There appears to be a fundamental confusion as to what ethics might involve. The ideally ethical behavior for the physician is the behavior which maximizes his patient’s welfare, and the ethical physician would be one who chooses that course of action no matter what. With or without fee splitting, the physician will be faced with financial incentives to depart from this course. With fee splitting, there is an incentive to refer inappropriately, or to inappropriate persons. Without fee splitting, there is an incentive not to refer even where referral would be appropriate [because the patient and revenue from him might be lost]. What is desirable here is not eradication of kickbacks per se, but rather appropriate referral behavior. It is not obvious that referral behavior is more appropriate when kickbacks are prohibited. It is obvious that

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referral behavior is better when specialist prices are set appropriately [at
the specialists' marginal costs]. If those prices are not appropriate, then
the splitting of fees may produce a result that is more in the patients' 
interest.\textsuperscript{106}

\section*{D. Considering Each Specific Objection To Physician Referral Fees As
It Might Apply In The Domestic And Medical Tourism Contexts}

Domestic referral fees have been prohibited in the U.S.; therefore, there is no
good evidence as to what effects they would actually have in our domestic medical
market.\textsuperscript{107} The objections considered throughout this paper and in this section are
subject to limitation by the existing checking mechanisms discussed above.\textsuperscript{108} It is
important to note that the discussion concerning domestic referral fees is perforce
speculative.

With these caveats in mind, first consider the objection that referral fees lead to
windfalls to the referring person or entity.\textsuperscript{109} The transactional setting for the domestic
physician supposes that he already has an established relationship with the patient that
requires, as a matter of both law and ethics, that he refer the patient if necessary.\textsuperscript{110} The
physician has ready access to the identities and reputations of specialists, and exercising
this access should take little time and effort.\textsuperscript{111} The patient may not realize that he needs
additional care that the referring physician either cannot supply or lacks comparable
expertise concerning. In this situation, it might seem unfair to the patient for the
physician to receive a referral fee for simply complying with his legal and ethical duties
concerning referrals. The most direct way to vitiate this unfairness is to prohibit referral
fees, but this does not remedy any unfairness to patients because specialists charge these

\begin{flushright}
\textsuperscript{106} \textit{Id.} at 351-52 (bracketed material added).
\textsuperscript{107} \textit{See} Robert Gatter, \textit{Walking the Talk of Trust in Human Subjects Research: The Challenge of Regulating
\textsuperscript{108} \textit{See} discussion \textit{supra} Part II.A (discussing mechanisms).
\textsuperscript{109} \textit{See} Pauly, \textit{supra} note 105, at 344-52 (noting financial incentive to refer inappropriately as a
result of fee splitting).
\textsuperscript{110} \textit{See id.} at 344-45. Pauly compares the legal and ethical responsibility of physicians to the law of
agency, explaining that medical care is among the goods and services in which consumers “often
use an \textit{agent} as a proxy decisionmaker.” \textit{Id.} at 344.
\textsuperscript{111} \textit{See id.} at 345. If it is an extraordinary case, he can charge a fee for doing special research
concerning referral alternatives. \textit{Id.} In the agency/principal relationship, the patient, acting as a
principal, will consult a physician who will recommend action possibly in the form of a specialist.
\textit{Id.} at 345.
\end{flushright}
patients more than the specialists' marginal costs. Yet, if the ability and thus necessity to pay referral fees is removed, it is at least theoretically possible that some specialists will pass the savings on to patients.

In the medical tourism transactional context, the patient usually already knows that he needs or desires care but also knows that, domestically, he either cannot afford that care or that he can only obtain it at a price that he considers excessive. His domestic health care providers are presumably not likely to make a referral to a foreign provider because they are not knowledgeable about those providers, they have a fear of liability for making a referral to a provider of unproven quality, or are opposed to the prospect of widening the sphere of competition among medical providers to the entire globe. Medical tourism companies step into this situation and offer information and services to consumers so they can obtain care at a cost they can or are willing to handle. As pointed out above, this also appears to be a context within which at least some consumers are either not able or not willing to pay companies a direct fee, or a sufficiently large direct fee, for researching the mere possibility that they might be able to find and qualify for access to an acceptable foreign medical alternative.

It is an important point that, as discussed in the previous paragraph, medical tourism broker's fees represent bona fide services provided by the medical tourism companies. Recall the discussion of Hall's analysis in which he argues that fees paid by pharmacies for rental of hospital space based on the number of patients seen within the hospital should not even be considered referral fees if they represent reasonable

112 See id. "If prices for other providers' services differ from marginal cost, either because of insurer reimbursement policy or because of monopoly, and if the agent's price is given, prohibiting fee splitting does not necessarily improve welfare. The outcome when fee splitting is permitted can actually be more socially efficient." Id.

113 See Pauly, supra note 105, at 345 (stating "[i]f the agent's price is variable, fee splitting can be a device for reducing monopoly power").

114 See id. at 345. Even more so than the possibility of liability for domestic referrals, the possibility of malpractice action in medical tourism does make the nominal cost to the referring physician "depend on outcome if the actual outcome deviates to a sufficient extent from the expected outcome." Id. at 345.

115 Cortez, supra note 3, at 75 ("valid concerns are counterbalanced both by considerations of equity as between medical tourists and citizens in other countries, and by the autonomy interests of individual patients").

116 See Colwell & Kahn, supra note 27, at 267-96.

117 But see E-mail with Jonathan Edelheit, supra note 15 (explaining that typical broker's fees range between 12% to 15%). Additionally, although the Medical Tourism Association believes in transparency and is working on a disclosure policy, it is common for fees not to be disclosed. See id.
rental payments. In that case, the payments will be prohibited if they are deemed to be referral fees because of the domestic laws against referral fees. Notably, the payments should not be prohibited if they represent bona fide compensation as part of a legitimate economic transaction. Medical tourism broker's fees fulfill an important economic function; therefore, they should not be prohibited.

There is an argument that even if fees paid to medical tourism companies are defensible to an extent, the actual fees are more likely to be disproportionate compared to physician-to-physician referral fees because of a total or relative lack of valuable medical expertise involved in the transactions. This objection is offset by the proposal below to require disclosure of the fact and amount of medical tourism broker's fees. Disclosure is likely to spur monitoring and competition, which could reduce excessive fees. It is also partially “offset” in a more fundamental way: these brokers do not have to be full-fledged medical experts (maybe not even partially-fledged)—their function is to bring parties together to transact. Lay persons are presumed capable of finding competent local medical care on their own; lay persons in medical tourism companies similarly should be capable of finding competent medical care abroad, for a fee, if patients do not want to or do not have the resources to do it themselves.

Consider an analogy to travel brokers. Although the internet is available for most

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118 See Hall, Referral Fee Statutes, supra note 8, at 623-28 and accompanying text (discussing 42 U.S.C. § 1320a-7b(b) (1982)).
119 See id. at 623-29.
120 See BestMed Journeys, supra note 27 (explaining how broker’s fees include ancillary services such as travel, lodging and rehabilitation services).
121 See Arthur R. Derse et al., Medical Tourism: Ethical Pitfalls of Seeking Health Care Overseas, AHC Media LLC, Nov. 2007, available at http://www.ahcpub.com/hot_topics/?htid=1&httid=1874 (noting that, as policy matter, lawmakers may not want patients to travel overseas for medical care because countries to which they go may engage in “dangerous, morally questionable procedures to attract patients”).
122 See infra notes 179-80 and accompanying text; see also Cortez, supra note 3, at 124-25 (explaining similar disclosure requirements would enable patients, employers, and policymakers to compare quality of treatment patient would receive in different countries).
124 Derse, supra note 121 (explaining because medical tourism brokers are lay individuals, potential patients are encouraged to “do his or her homework”).
125 See id. There may, however, be legal concerns regarding the liability of medical tourism brokers should malpractice occur. Id.
people to make their own travel arrangements fairly economically and conveniently, many consumers still use travel agents. Even though travel prices are higher due to the travel broker's fees, consumers use travel agents to reduce uncertainty and risks, save time, and reduce transaction costs in general.

The second objection to referral fees, insofar as it might apply to the domestic and medical tourism contexts, is whether the fees encourage unnecessary care. In the domestic setting, there are incentives for unnecessary referrals even without referral fees. Physicians, as a group, insist that they are forced by fear of unjustifiable liability suits to make unnecessary referrals for, among other interventions, diagnostic tests and specialist physician examinations. There is reason to doubt at least the extent of this supposed "defensive medicine" phenomenon, but it is a risk, and undoubtedly, there are at least some unnecessary referrals because of liability concerns. Physicians are also likely to make referrals simply because they want their patients to have every possible benefit of medical science even if the marginal utility of an intervention exceeds its marginal costs. To a large extent, physicians and patients can have an attitude in favor of purchasing care that has any possible benefit, even if its costs exceed its marginal benefits, because most care is paid for by public or private insurance.

For the foregoing reasons, the risks of over utilization are so strong in the domestic market that the government not only tolerates but sometimes encourages Managed Care Organization's use of anti-referral fees. These are financial incentives that are designed to reward physicians for frugal approaches to care or to punish them for being too "liberal" in their referral and utilization patterns. Given all the

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126 See Dayna Bowen Matthew, Tainted Prosecution of Tainted Claims: The Law, Economics, and Ethics of Fighting Medical Fraud Under the Civil False Claims Act, 76 IND. L.J. 525, 560-61 (2001) (noting legislators who pass antifraud legislation are oftentimes concerned with the costly overuse of unnecessary medical services); see also Hall, Institutional Control, supra note 94, at 497-98.
127 See Matthew, supra note 126, at 561-62.
129 See generally Kligman, supra note 128 (exploring various definitions of "defensive medicine," noting limitations of surveys as research tool and concluding defensive medicine exists to some extent in certain clinical situations but is not as prevalent or important as often claimed).
130 Kligman, supra note 128, at 119.
132 See Hall, Institutional Control, supra note 94, at 483-86.
133 See Hall, Theory, supra note 67, at 208-09 (mentioning incentives evolved from those solely targeting cost savings to mixed incentives targeting savings and patient care); Hall, Institutional Control, supra note 94, at 488-89 (using term "antireferral fees").
incentives for over-utilization, it is only reasonable to suspect that adding the possibility of receiving referral fees might encourage more referrals and sometimes work in conflict with anti-referral fees or other devices or policies meant to cabin escalating medical costs.\textsuperscript{134}

There is reason to believe that there is much less chance of broker's fees leading to unnecessary care in the medical tourism context. In this context, the most common interventions are surgeries or treatments for ailments that have already been diagnosed in the domestic market.\textsuperscript{135} The patient is most often seeking surgery or treatment because it is not covered by insurance and he is not able to afford to purchase it in the United States, at least for a price that he is willing to pay.\textsuperscript{136} The incentives for unnecessary care that exist in the dynamics of the domestic market, as explained in the preceding paragraph, simply do not appear to reside in the medical tourism setting. It is possible that medical tourism companies and foreign providers could attempt to oversell experimental services, such as stem cell therapy, but experimental medicine is in the periphery of and only a small portion of the medical tourism market.\textsuperscript{137} It is beyond the scope of this article to analyze medical tourism for experimental treatments, but it appears that this is an area subject to possible abuse.\textsuperscript{138} Possible abuse in this one area should not indict medical tourism generally.

The third objection to referral fees, insofar as it might apply in the domestic and medical tourism contexts, is that fees increase the costs of care.\textsuperscript{139} The objection here must be distinguished from the objection discussed above concerning encouragement of unnecessary care.\textsuperscript{140} Of course, if referral fees encourage unnecessary care, they will inflate the overall costs of medical care.\textsuperscript{141} The more precise objection considered here

\textsuperscript{134} See Hall, \textit{Institutional Control}, \textit{supra} note 94, at 492 ("Efficiency incentives combat precisely the evil that referral fee prohibitions target: inflated charges and overutilization").

\textsuperscript{135} See \textit{supra} notes 17-19 and accompanying text (discussing price disparities in surgery costs between the United States and other countries).

\textsuperscript{136} See \textit{supra} note 11 and accompanying text.

\textsuperscript{137} See O'Reilly, \textit{supra} note 14. "The number of patients who have traveled abroad for stem cell therapies is unknown, though experts said that anecdotally it appears to be in the thousands. That represents a sliver of the 750,000 Americans who left the U.S. for medical care last year, according to the Deloitte Center for Health Solutions." \textit{Id.}

\textsuperscript{138} See \textit{id.} and accompanying text (describing growing trend of stem cell clinics outside the U.S. providing medically uncertain and costly stem cell therapies to Americans who are not made aware of the risks of such therapies).

\textsuperscript{139} See \textit{supra} notes 29-32 and accompanying text.

\textsuperscript{140} See \textit{supra} notes 29-32 and accompanying text (discussing medical tourism companies which serve as paid intermediaries between foreign health care providers and American patients).

\textsuperscript{141} See Hall, \textit{Theory}, \textit{supra} note 67, at 208-09 (2002) (explaining antireferral fees are designed to
is that even if referral fees will not encourage unnecessary referrals, they will add to the cost of care provided by the referee physicians because those physicians will have to factor in the referral fees as part of their cost of doing business. Providers can only pay referral fees if the providers’ prices to patients exceed marginal costs. Prices can exceed marginal costs only if there is some market imperfection, such as providers’ inordinate market power. It is theoretically possible that domestic specialist providers would refrain from charging what their market power allows if they did not have to pay referral fees. As argued above, moreover, the generalists who might receive referral fees are probably receiving a windfall rather than compensation for value added beyond what they are expected to do regardless of referral fees. This makes a prohibition plausible in the domestic context. In the medical tourism context, the spread between prices and marginal costs is likely to be minimal because of the robust competition among a plethora of providers in many venues within and among countries all over the globe.

In addition, as discussed above, the medical tourism companies have grown to fill needed functions. They are not like domestic generalists who receive a windfall; rather, they might need broker’s fees to exist in sufficient numbers to service the growing number of medical tourists. If this is the case, broker’s fees, at least if reasonably limited, do not contribute to unnecessarily high prices. Instead, the fees are part of the necessary costs of an entire medical tourism transaction.

A legitimate question in need of further research is whether patients who go directly to a foreign provider and avoid a broker pay the same amount for care as do patients who work through a broker. If patients do pay the same amount for care, reduce costs of medical care).

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142 See supra notes 29-32 and accompanying text.
143 See generally Colwell & Kahn, supra note 27; Gloria Bazzoli, Medical Service Risk and the Evolution of Provider Compensation Arrangements, 26 J. HEALTH POL., POL’Y & LAW 1003 (2001); Hall, Referral Fee Statutes, supra note 8, at 627-28.
144 See Colwell & Kahn, supra note 27, at 268.
145 Id.
146 See supra note 109-113 and accompanying text.
149 See supra notes 120-131.
150 See Cortez, supra note 3 at 96 (proposing ways to minimize risk and gain access to opportunities available in medical tourism industry). See generally Bye, supra note 148.
this might indicate that the prices for care, albeit much lower than in the United States, might be somewhat inflated. On the other hand, if patients who do not use a broker are charged the same as patients who do, this might just indicate that the former patients are cross-subsidizing the latter patients, the entire group together paying what is necessary to sustain the arguably necessary functions of medical tourism companies. Moreover, the mandatory disclosure of the fact and amount of broker's fees recommended here can spur competition and monitoring that could curb unnecessary costs.

In regard to the fourth objection, that referral fees might affect the choice of provider, there is a possibility that domestic providers or medical tourism companies will refer patients to providers that pay the highest referral fees in lieu of those who give the most efficient or effective care. This risk is ameliorated by the likelihood that competition in the domestic specialist and medical tourism markets probably sets limits on the spread between providers' costs and prices they can charge patients and, consequently, caps the amount of referral fees that could or can be paid. This narrows the range of possible amounts of referral fees that might be paid by various providers, thus minimizing the chance for "off-the-chart" referral fees that might entice improper referrals. Based on the plethora of advertising and number of countries taking initiatives in the medical tourism markets, it appears that competition in the medical tourism market is fierce. It is also possible that, in both the domestic and medical tourism settings, the providers who pay the highest referral fees will be able to pay those high fees specifically because they are more skilled and efficient. In both contexts, the risks of non-optimum referrals seem speculative and should not justify

151 See Cortez, supra note 3, at 99.
152 See id.
153 See id.
154 See Pauly, supra note 105, at 347 (explaining economic incentives rather than medical efficiency might drive physician's choice to refer patient).
155 See id. at 348 (noting prohibition on referral fees would force physicians to be neutral and patient welfare would always take prominence over economic welfare).
156 Hall, Referral Fee Statutes, supra note 8 at 630 (where an example of an "off-the-chart" fee was paid to another physician in violation of 42. U.S.C. § 1320a-7b(b) (1982)).
157 Medic8, supra note 147. The Medic website links to the following countries as popular destinations for medical tourism: Argentina, Austria, Belgium, Jordan, Malaysia, Costa Rica, Czech Republic, Brazil, Poland, Lithuania, France, India, South Africa, Turkey, Switzerland, Spain, Thailand, Cyprus, Philippines, New Zealand, Egypt, Germany, Greece, Mexico, Italy and Hungary. Id.
158 See Pauly, supra note 105 at 349 (noting referral fees are generally paid by specialists to generalists, which supports claim high referral fees are paid by those who can provide special care to patients and actually improves patient welfare).
prohibition. In both contexts, moreover, disclosure of the fact and amount of referral fees should serve as an antiseptic against poor referrals.

A fifth objection, similar to the fourth objection just considered, is that the providers who pay the referral fees will not provide optimum inputs of time and resources because they will want to recoup the costs of the referral fees. One might argue that those who pay the highest referral fees will cut the most corners, providing the lowest standard of care. Although this is theoretically possible, it seems to require extremely corrupt and risk preferring providers. There is no proof that this would or has taken place, and it should not guide decision making concerning referral or broker's fees.

The final objections, a set of objections mentioned above, are interrelated and are primarily derivative of the other objections. The objections are that receiving windfalls, making unnecessary referrals, making non-optimum referrals, adding to the overall cost of medical care, or cutting corners to save money to pay referral fees will, individually or together, commodify patients and debase and commercialize physicians. This in turn could lead to societal and individual mistrust of physicians and subsequently harm the outcomes of patients who only fare best when they receive care from providers they can trust. An argument may be made that even if referral or broker's fees do not lead to any specific evils, the mere possibility that they might

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159 See id. (where referral fees entice physician to refer patient to specialist if generalist is unable to treat patient more effectively thus creating environment where referral fees lead to better care).
160 See id. (noting referral fees can be beneficial for patient welfare and if traditional market principles apply, the publication of referral fees would educate consumers about that physician's ability).
161 See id. at 349 (conflicting with author's contention legalization of referral fees would lead to efficiency in medical care if one accepts premise that resources will be wasted in effort to recoup costs of fees).
162 See 42 U.S.C. § 1320a-7b(b) (1982). The legislative intent behind the enactment of this statute was to ensure that patient welfare and efficiency in providing medical care takes precedence. See Hall, Referral Fee Statutes, supra note 8, at 623. The possible waste of resources or the potential to cut corners stands in contrast to Congress' intent when enacting the statute. See id.
163 See 42 U.S.C. § 1320a-7b(b) (where plausible argument could be made Congress' intended to prohibit referral fees out of fear it would create corrupt and risk preferring professionals in the field).
164 Pauly, supra note 105 at 352 (suggesting referral fees lead to more efficient and effective care only when physicians exercise appropriate referral behavior and refer patients only if another physician will provide better care for his or her patients).
165 See supra note 62.
166 See id.
undercut patient trust, especially given that trust (or its absence) is not a wholly rational phenomenon but can be based on misperception or exaggeration of risks.

The argument that patients will be commodified and physicians commercialized and debased is highly speculative and ultimately unpersuasive. It is similar to arguments made, much less now than decades ago, that for-profit medicine commodifies patients and debases physicians.\textsuperscript{167} The best view currently is that all for-profit and not-for-profit providers need aggressive business strategies to survive, that all providers must and should be subject to a healthy dose of market forces, and that market failures exist that even justify measures to influence physicians to reasonably limit the care they prescribe for patients.\textsuperscript{168}

The argument concerning loss of societal and individual patient trust must be considered in two dimensions. The first dimension concerns the effects of widespread practice and patient and societal knowledge concerning the use of referral or broker’s fees. The second dimension relates to the effects of patients finding out about referral or broker’s fees in the absence of widespread knowledge or individual disclosure. In the contexts of anti-referral fees and per capita enrollment fees paid by pharmaceutical companies and medical device manufacturers to researchers who sign patients up for clinical studies, some commentators argue that disclosures should not be made for the very reason that patient trust will be undercut by general or specific knowledge about the respective financial incentives.\textsuperscript{169} These objections are directly pertinent to the recommendations here concerning medical tourism broker’s fees. Answers to these objections will be discussed in the next subsection that summarizes this article’s recommendations.


\textsuperscript{168}Michael I. Sanders, Health Care Joint Ventures Between Tax-Exempt Organizations and For-Profit Entities, 15 Health Matrix 83, 86 (Winter 2005); Hall, Theory, supra note 67 at 234.

E. Responses Recommended Concerning Medical Tourism Broker's Fees

Some would argue that mandatory disclosure is not necessary because the market place will work to provide disclosure if information about broker’s fees is important to patients. It might also be argued that disclosure of “trade in patients” will undercut societal and individual trust in foreign providers who pay broker’s fees, thus leading to poorer outcomes for patients. 170 In regard to these two objections to mandatory disclosure, much can be learned from Mark Hall’s prior analysis of disclosure concerning anti-referral fees. 171 Hall explains that “[e]conomic theory predicts that properly functioning markets will produce roughly the types of information that consumers need in order to make adequately informed purchasing decisions.” 172 He notes three market imperfections indicate why anti-referral fees were uniformly not disclosed prior to specific legal mandates, and one of these imperfections—the so-called “lemons phenomenon”—applies in the medical tourism broker’s fees setting. Hall explains this imperfection: “whenever product information is difficult to verify independently . . . competitive markets tend to suppress rather than generate . . . information . . . because it is difficult for producers to convince consumers that they provide better value at a higher price.” 173 Providers might believe that they provide better services because they have better or no anti-referral fee mechanisms. This might require them to charge higher prices, but those prices are presumably justified because of their entire package of services. However, it is hard to verify what others are doing, explain this to consumers, and convince the consumers that their better practices justify different prices.

Similarly, medical tourism companies might believe that they could offer superior services by fashioning and disclosing superior broker’s fees practices. 174 They might have to charge consumers directly, but this might be justified by their better, unfettered practices. 175 The problem is that it is difficult to determine what other tourism companies are doing or to convince consumers that the differences in broker’s fees and practices, including the disclosure, signal any difference in the quality of

170 Hampson, supra note 169, at 2330-31.  
171 See Hall, Theory, supra note 67, at 211.  
172 Id. at 210.  
174 See Hall, Theory, supra note 67, at 209-10 (elaborating on benefits of mandatory disclosure).  
175 See id.
services provided.\textsuperscript{176} This problem works against companies trying to gain a competitive advantage by voluntarily limiting or disclosing their broker's fees practices.\textsuperscript{177} The lemons phenomenon arguably works against disclosure in the medical tourism context.\textsuperscript{178} In practice, in any event, it is apparent that there is a dearth of information about broker's fees.\textsuperscript{179} This market failure or imperfection justifies the proposal here to encourage disclosure of both the fact and amount of broker's fees through guidelines of professional bodies such as the Joint Commission International, the Medical Tourism Association, and the American Medical Association.\textsuperscript{180}

Hall's writings are also pertinent to the objection that disclosure might actually undercut patient trust, thereby worsening patient outcomes.\textsuperscript{181} He agrees that patient trust might be an important ingredient for maximizing patient welfare.\textsuperscript{182} He also argues that disclosures are not likely to undercut patient trust and are morally required.\textsuperscript{183} He has addressed current disclosure practices concerning anti-referral fees and the impact of disclosures concerning them, noting the four plan representatives involved in his study said disclosures have had virtually no impact.\textsuperscript{184} Hall also observes: "[U]nder the Medicare rules, regulators and plans reported that beneficiaries who are told that they have the right to request information about physician incentives rarely or never do

\begin{footnotesize}
\begin{enumerate}
\item[176] See id.
\item[177] See id.
\item[178] See generally Emmons & Sheldon, supra note 173.
\item[179] See supra note 20 and accompanying text (information on cost available online is limited to procedure prices and does not mention fee costs).
\item[183] See Hall, Theory, supra note 67, at 209, 231-32 (proposing layered disclosure approached as remedy to ethical dilemma incentives create in managed care context).
\item[184] See id. at 229 (citing results from qualitative study on impacts of incentive disclosure); Mark Hall, et al., \textit{Disclosure of Physician Incentives: Do Practices Satisfy Purposes?}, 19 HEALTH AFF. 156 (2000).
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Furthermore, in a quantitative part of research Hall helped conduct, a detailed disclosure statement (although simpler than existing statements) was mailed to members.\textsuperscript{186} It “was followed by a phone call in which the statement was read aloud and repeated if subjects failed to correctly answer simple comprehension questions immediately after the first reading. Despite a fifty percent increase in knowledge of incentives, one month following the disclosure, the majority of subjects were not able to correctly recall the answers to more than half the comprehension questions, and fourteen percent had no correct responses.”\textsuperscript{187}

Although disclosures have limited impact and some argue that they might confuse patients and undermine trust, Hall nevertheless observes:

This does not mean . . . that disclosure is pointless. Surveys show that people are interested in learning about physician incentives. Even if the information does not change many people’s decisions, people still have good reason to want to know. And, even if the information is rarely actually read, the integrity of the relationships among patients, physicians, and health plans requires that this information be made available for those who do want to know it.\textsuperscript{188}

Hall’s observations concerning disclosure of anti-referral fees are instructive in terms of disclosure of medical tourism broker’s fees.\textsuperscript{189} First, if disclosure of anti-referral fees has “limited or no impact on patient trust of physicians and health plans, and may actually have a positive effect,” it is likely that disclosure of broker’s fees will

\textsuperscript{185} Hall, \textit{Theory}, supra note 67, at 209, 229.

\textsuperscript{186} \textit{Id.} (discussing methodology of quantitative study).

\textsuperscript{187} See \textit{id.} at 229-30 (summarizing results of study). Hall writes:

This result is consistent with a focus group study that found that some people have great difficulty grasping the notion that different payment structures might affect physicians’ behavior. We should expect that more realistic disclosure methods than those used in these artificial studies will be even less successful in conveying basic understanding. Communication theory and research establish that the success of information disclosure depends on the amount and complexity of information, the recipient’s prior familiarity with the information, and the information’s salience. None of these conditions lends itself to easy comprehension of physician incentives.

\textit{Id.} at 230. Although “[c]ritics of physician incentives claim that disclosing them will undermine trust . . . disclosing incentives appears to have limited or no impact on patient trust of physicians and health plans, and may actually have a positive effect.” \textit{Id.}

\textsuperscript{188} \textit{Id.} at 231.

\textsuperscript{189} See generally Hall, \textit{Theory}, supra note 67, at 231 (discussing disclosures of anti-referral fees).
not undercut patient trust in medical tourism companies or foreign providers. A bigger risk may be that patients find out on their own about undisclosed fees and lose trust in medical tourism companies and foreign providers. Second, just as disclosure concerning anti-referral fees might not affect patient behavior, revelation of broker’s fees might not influence medical tourist’s behavior. In both cases, however, “people still have good reason to want to know” and disclosure is necessary “to the integrity of the relationships.”

Disclosure would be even more beneficial in the medical tourism context than in relation to anti-referral fees. Disclosures concerning anti-referral fees are very difficult for patients to understand because anti-referral fee programs are relatively complex. Moreover, although patients can theoretically change health care plans if they are told about anti-referral fees they do not like, alternatives are practicably limited in most cases to other health care plans, if any, that are offered by patients’ employers. If there are alternative plans, it is possible that they all involve some sort of physician incentives akin to anti-referral fees. In the medical tourism context, disclosures regarding the fact and amount of broker’s fees are easy to understand. Moreover, medical tourists can use disclosures regarding the fact and amount of broker’s fees to shop among a plethora of medical tourism companies and to bargain with the

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190 Id. at 230 (discussing study of incentive disclosures in which participants showed no decline in trust of health plans and only modest increase in trust of physicians). Cf. Mark A. Hall et al., How Disclosing HMO Physician Incentives Affects Trust, 21 HEALTH AFF. 197, 203 (2002) (cautioning against generalization of study findings as patient reactions were limited to positive disclosures about anti-referral fees). It is unknown whether disclosures that present more negative descriptions of anti-referral fees will result in a negative effect because the study did not address this. Id.

191 See Hall, Theory, supra note 67, at 209-210 (suggesting timely disclosure of physician incentives allows patients to better evaluate physicians’ recommendations); Hall, Law, Medicine, supra note 182, at 508-09 (patients often have deep trust for their physicians, but the deeper the trust, the stronger the sense of betrayal when trust is violated).

192 See supra notes 181-87 and accompanying text (discussing impact of disclosure of anti-referral fees on patient behavior).

193 See Hall, Theory, supra note 67, at 209-11, 231 (discussing benefits of disclosure of anti-referral fees).


196 See Hall, Theory, supra note 67, at 207 (most HMOs reward physicians for staying within budget).
companies or foreign providers for a share of the broker’s fees.  

III. CONCLUSION  

Medical tourism is a viable option for tens of thousands of uninsured or underinsured patients who need or desire treatment that they are not able to obtain in the U.S. at a price they are able or willing to pay. Domestic and foreign medical tourism companies provide valuable advertising, screening, and matching services when bringing together such patients and foreign providers and ancillary companies in a multiplicity of venues offering various packages of services. These services are often paid for, in whole or in part, by undisclosed broker’s fees disbursed by the foreign medical providers, primarily hospitals. Such broker’s fees would be considered illegal and unethical referral fees were they to involve physicians and care taking place within the U.S. There is no firm theoretical or empirical foundation for the widespread ban on domestic physician referral fees and existing mechanisms in both the domestic and medical tourism settings serve as checks on abuses argued to be associated with referral or broker’s fees.

A legislative ban—or any formal legislative controls—on medical tourism broker’s fees could only practicably be enforced against U.S.-based companies and could put them out of business or force them to relocate outside the U.S. to remain competitive. Nevertheless, patients have a right to know about broker’s fees, and market failure probably explains why there is currently little knowledge about the existence and magnitude of broker’s fees. Disclosure of the fact and amount of broker’s fees should therefore be encouraged by guidelines of professional bodies to encourage competition and enable patients to bargain with medical tourism companies and foreign medical providers. This would likely enhance, rather than undercut, patient trust in medical tourism companies and foreign medical providers, both of whom provide important services to patients who cannot afford care in the U.S.

\[197\text{ See supra note 5 and accompanying text (noting examples of medical tourism companies among which patients can choose).}\]