Globalization, medical tourism and health equity

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Abstract

Medical tourism has never been new in history. What is new is the recognition of its emergence i) as a global medical business potentially challenging the dominance of health care markets in the developed world, and ii) as a threat, pushing health disparities even further in developing countries. Based on a review of available literature, this paper discusses the origin and growth of medical tourism as a new global business, identifies the key enabling factors of growth, and assesses its impact on health care, generally, and equity in health care, specifically.

This paper begins by looking at the recent trend of the flow of patients seeking medical care abroad and the amount of money invested in host countries. An outline of a conceptual framework is constructed to show how globalization, market economy and technological innovations have changed global health markets to create a space for the expansion of medical tourism. This paper illustrates how increasing health care costs and long waiting periods in the developed world, low wage and competitive health markets in the developing world, availability of low cost transportation, and access to advanced information technologies have created opportunity to expand medical tourism in many developing countries. Medical tourism is argued to have contributed to expanding health sectors, generating additional revenues and improving quality of and access to health services in provider countries. On the other hand, it may have become a threat to these same health systems by accelerating an internal brain-drain from public to private hospitals and promoting health disparities in destination countries.

This paper concludes that medical tourism as an alternative approach to health care is neither positive nor negative in itself, but a historical process in continuous evolution in health care systems. Finally, the paper proposes to develop an agenda for medical tourism governance to routinely monitor its growth and establish a regulatory framework for in order to translate its benefits for all.
I. Introduction

a. Background

Medical tourism has a long history, but what is new is its unprecedented growth at the global level. The first known and documented medical tourists were ancient pilgrims who used to travel from all over the Mediterranean to Epidauria in the Saronic Gulf, a sanctuary of the healing God Asklepios, for treatment (Wikipedia 2009). Traditionally, the rich and the aristocrats traveled abroad, to the spa towns and sanitariums of their favorite medical destinations, for mineral baths, innovative therapies and fairer climates to improve their health (Gray and Poland 2008; Christine 2007). The recent trend in medical travel, however, is significantly different from these earlier ones and can best be described as travel from developed countries, by the middle class, to a foreign country to avoid treatment delays, to receive affordable, quality medical care or simply to have elective surgery combined with sight-seeing and other local tourism opportunities (Gray and Poland 2008).

It is not clearly known when and how the modern version of medical tourism saw its first real boom. It has been reported that the Asian financial crisis in 1997 led many Southeast Asian nations, particularly Thailand, to seek alternative strategies to cope with their emerging economies (Turner 2007). As many private hospitals and health facilities lost their local affluent customer base due to the economic crisis, physicians and other health providers in Thailand began leaving their country to work elsewhere, while private hospitals were forced to change their marketing strategies and target patients from overseas for their survival (Turner 2007). Modern medical tourism as we have come to understand it thus began.

The customers of modern medical tourism are primarily from rich countries such as the United States, Canada, Britain, Australia, the Middle East and Japan. Although Thailand, India, Singapore, Malaysia, Jordan and some countries in South America are currently the most popular choices among medical travelers, the industry has been growing rapidly in other parts of the world as well.

b. Growth of medical tourism

The number of medical travelers has been difficult to estimate as no systematic data are recorded and the reported number of medical travelers may have included business travelers and regular tourists who needed medical care while they were abroad.
According to the most widely accepted estimate, nearly 350,000 patients from all industrialized nations traveled to a variety of less developed countries for health care in 2003 (Horowitz and Rosensweig 2007). Since then the number of medical tourists has been increasing exponentially, particularly from the USA. In 2007, nearly 750,000 US patients traveled overseas for medical treatment, while the figure increased to nearly 1.5 million in 2008 (Deloitte 2008). It has been projected that the number of American medical travelers (see figure 1) could reach 6 million by 2010 and more than 15 million by 2017 (Deloitte 2008; Horowitz and Rosensweig 2007).

The medical tourism industry used to provide cosmetic surgeries and dental procedures in earlier decades. Current medical travelers receive virtually all types of health care from cosmetic or dental care to knee or hip replacements, from cardiac and eye surgeries to organ transplants and surrogacy at medical facilities in developing countries (Horowitz and Rosensweig 2007).
Spending for the medical tourism business has been growing quickly as well. While no coordinated system is in place to gather and compile financial information for this sector, studies indicate that medical tourism worldwide could generate as much as $40 billion by 2010 (Horowitz and Rosensweig 2007; Nguyen 2009; Crawford 2006; McCallum and Jacoby 2007; Hancock 2006). One projection (see figure 2) estimates that US patients alone will spend more than $40 billion for health care services abroad by 2017 (Deloitte 2008). Other estimates indicate that the worldwide revenue for medical tourism was about $60 billion in 2006, which could increase to $100 billion by 2012 (Herrick 2007).

c. **Discourse on medical tourism**

Although medical tourism has become a major sector in the global health care system, research has remained scarce. Not only is reliable and internationally comparable information on the number of travelers or the amount of money spent on travel unavailable, but the concepts and definitions that encompass medical tourism are not standardized (Cortez 2008).

The dominant theme remains: medical tourism growth is exclusively an outcome of recent crises in the provision of Western medical care including the relentless, decades-long rise in the cost of health care and non-responsiveness to the public’s demand for timely care. The growth of medical tourism is viewed as a transient effect of such crises, with the added allure of adventure and vacation in countries far from home.

The impact of medical tourism on the health systems in provider countries has received a lot of attention in the literature. It has been viewed simultaneously as a blessing to the economy and as a threat to national health systems. Potential negative consequences include widening disparities due to unequal distribution of health care, financial deprivation of medical professionals who are delivering world class health services for third world prices, subsidizing costs of care for patients of rich countries, and diverting resources from the poor and disadvantaged to patients from abroad. Although logical in themselves, such claims are rarely
articulated within theoretical premises that might offer explanations for how and to what extent the growth of medical tourism creates major risks for the health sector, or benefits to the economy, of provider countries.

The literature also focuses on concerns about the safety of patients traveling abroad to receive care and the accompanying risks of carrying infectious diseases back home from provider countries. Considerable emphasis has been given to potential violations of human rights through the practice of illicit activities that the medical tourism trade allegedly promotes, notably in medical transplantation, surrogacy and such aesthetic surgeries as abdominoplasty, rhinoplasty or bariatric surgery. These may be illegal or regarded as immoral in countries from which medical tourists originate but are allowed in provider countries. However, available literature has rarely focused on the failure of global initiatives to control illicit medical practices or the role of governments of the provider countries to prohibit transplant tourism.

II. Political economy of medical tourism

The growth of medical tourism, as a new business model, cannot be explained without looking at its interactions with economic, social and political forces (Horowitz and Rosensweig 2007). Studies have attempted to link the determinants of its expansion with the demand and supply of health services in the context of changing and variant market prices across the globe (Bookman and Bookman 2007). Globalization-led economic restructuring has created a space for investment in private sector health programs in many developing countries: to expand its health services to cater to patients from abroad and compete among themselves for the market. For the patients in developed countries where the cost of health care is very high or they have to wait for a long time to get treatment, this emerging market has provided wider choices to buy health services with variant prices from many different countries (Chantarapitak 2006). The changed context has created an enabling environment for the emergence of medical tourism as an international business opportunity in many developing countries (Christine 2007; Gupta 2004).
Medical tourism is likely to be affected by a host of factors including globalization-led institutional, technological and socio-economic changes. It operates within the institutional framework of the national health system and maintains a relationship with the public health facilities and hospitals. In theory, global competition among the provider hospitals should promote efficiency and quality of care, build new hospitals, attract foreign investments along with patients, and encourage expansion of both private and public health care sectors.

The effects of medical tourism are discussed elsewhere in this paper. While this framework allows that the medical tourism approach may have potential negative effects on equity and access to care for the poor and disadvantaged in provider countries, and the safety and quality of care of foreign patients, it also implies significant positive impacts in terms of encouraging economic and social development, diversifying economies, creating infrastructure, promoting
job creation and building the health services industry (Turner 2007; Samandari et al. 2001). Like normal tourism, no frill, low cost medical care in destination countries is also likely to become popular among international customers once the quality of care is ensured. This is likely to create relatively low cost options for the local people to receive medical care as well.

III. Medical tourism: Emergence of a global business

Modern medical tourism began as a survival strategy of some Southeast Asian hospitals after the Asian recession in 1997. Today, it has become a billion dollar global business spanning virtually all continents. In the era of globalization, health care has joined other commodities in having some of its ‘production’ outsourced to countries with a competitive cost advantage. Medical tourism exemplifies this business approach. Poorer nations export health care expertise and services to patients of wealthier countries when similar services are generally more expensive. In 2007, approximately 750,000 American patients outsourced their medical treatment as part of reducing their cost of care, primarily to health facilities in less developed countries. The number of patients outsourcing their medical care is expected to continue to increase in coming years (Madden 2008). Patients in rich countries will increasingly have choices and options in selecting countries and medical facilities for their treatment. This has promoted competitions among service providers in host countries to build technologically advanced facilities, using both foreign and domestic capital, and to provide internationally accepted quality of service at affordable prices (Herrick 2007). In many instances, hospitals in host countries had to hire technicians and nurses meeting international qualification standards to remain competitive when such personnel were not available locally (Herrick 2007).

The medical tourism industry is now attempting to target small businesses and health insurance companies in developed countries, in addition to individual clients, to increase customer volume. This strategy seems to be working, it has generated interest among large corporate sectors and legislatures of developed countries as a means of reducing the cost of health care (Turner 2007; Foster and Mason 2006; Yi 2006).

a. Global increase in medical tourism

For a long time medical tourism was generally considered to be the travel of wealthy patients from a less developed country to the health facilities in more developed and medically advanced countries to get better treatment. But the global market place for health care has changed. Today, medical tourism goes in both directions, from rich and poor countries alike; and has seen developing countries become the primary destinations where high quality affordable healthcare is available (Smith 2008; Arellano 2007; Whittaker 2008; Health Worldnet 2009). According to a 2008 estimate, the medical tourism business is in operation in 28 countries globally (Discover Medical Tourism 2008). Currently, the most popular destinations for medical tourism are countries once characterized as “third world” such as Thailand, India, Malaysia, Singapore, the Philippines, Jordan, Turkey, Hungary, Mexico, Cuba, Chile and South Africa, while a few other medical tourist hubs are emerging in Dubai and Eastern Europe (McCallum and Jacoby 2007). Table 1 shows the size of the medical tourism trade in terms of patients treated, earnings generated and the type of services provided by hospitals in major host countries.
Table 1: Estimated patients treated and money spent in selected countries

<table>
<thead>
<tr>
<th>Country</th>
<th>Patients treated</th>
<th>Estimated earnings (US$)</th>
<th>Major services provided</th>
</tr>
</thead>
<tbody>
<tr>
<td>India</td>
<td>450,000 (in 2007)</td>
<td>480 million (2005)</td>
<td>Cardiac surgery, joint replacements, eye surgery</td>
</tr>
</tbody>
</table>

Source: ESCAP 2007; DiscoverMedicalTourism.com; Health-Tourism.com

Thailand has pioneered medical tourism in its modern form and is still leading in terms of number of patients treated and foreign exchange earnings. The country has the advantage of having a large tourist industry and infrastructure already in place to attract tourists from across the globe. One feature of Thai medical tourism is its flexibility in pricing for services to accommodate the means of its customers (Herrick 2007). Also, Thai international hospitals have adopted a corporate philosophy to promote customer satisfaction (Talbot 2001). The costs of medical services are often packaged with stays at ocean-front resorts, guided tours and nightclub cabarets in Bangkok to attract international patients.

India entered the medical tourism market late but is quickly catching up with other leading countries to become a leading global health care provider (ESCAP 2009). According to one report, Indian hospitals treated approximately 450,000 international patients in 2007 and earned about USD 480 million in 2005. The main strength of the Indian approach is its capacity to provide medical services at the lowest cost among all international health care providers. India has other advantages including a large pool of physicians, many of whom were trained in the UK or USA, English is widely spoken in the country and several hospitals are accredited by the Joint Commission International (JCI) (Herrick 2007). The most popular services of the Indian medical tourism industry are heart surgeries, joint replacements, hip resurfacing, cataract operations, cosmetic surgery, dentistry and gallstone removal. Like Thailand, India has always been a tourist destination that also offered alternative medical treatments like Ayurveda, Yoga and Kairali.

Malaysia also began its active role in the medical tourism industry after the financial crisis of 1997 caused a drop in the number of domestic patients visiting private hospitals. These hospitals were forced to search for alternative patients overseas, through government trade missions and other promotional activities. While starting late compared to its regional competitors, Malaysia quickly moved to expand its business and generated about USD 43 million in 2005. It is expected to generate at least USD 55 million in 2010 (ESCAP). Popular treatments that the country offers include cardiac and cardio-thoracic surgeries, radiotherapy and radiology. Most of the international patients it received in 2006 were from Indonesia (72%), Singapore (10%), Japan (5%) and West Asia (2%) (ESCAP 2009). The Ministry of Health has actively coordinated with about 34 private international hospitals, tour agencies and other relevant bodies to promote medical travel in Malaysia.
Although costs of medical care are higher than in Thailand or India, Singapore has a reputation for high-quality medical facilities and is well known for delivering cutting-edge medical treatment, including surgeries such as liver and heart transplants and complex neurosurgical procedures. It attracted more than 410,000 international patients from 60 countries to generate more than USD 560 million in 2006 (ESCAP 2009). Singapore is home to three high quality hospitals accredited by the JCI (Herrick 2007).

Several other developing countries such as the Philippines, Jordan, South Africa and Mexico have been either quick to recognize the opportunities of medical travel or are expanding its already developed infrastructure to get their share of the fast expanding global health care market (ESCAP 2009). Given their high-quality medical professionals and competitive cost of service, they are working toward becoming the next medical care destinations in their regions. Since the early 1990s, Jordan has been trying to become the medical hub for the Arab world, to treat patients primarily from the Middle East. The government provides incentives for private investment in the health sector. Its hospitals have specialized in cardiac surgery, spinal injuries, cornea transplants and alternative medicine. Several health facilities in Jordan are formally linked with prestigious hospitals in Europe and North America as a strategy to become more attractive to international patients.

Among the Latin American countries, Cuba attempted to become a world medical power in the 1980s. The Cuban government created a company to arrange medical treatments and travel for foreign patients and hosted thousands of patients each year from Latin America, the Caribbean, Russia, and the United Kingdom. The Cuban hospitals have gained a reputation in ophthalmology, joint surgeries, neurology, and treating skin diseases. However, the country could not attract a large number of US patients for geopolitical reasons. Cuba is also somewhat unique amongst countries engaged in medical tourism, as there are no private facilities involved. The Cuban health system from training, to export of health workers, to import of health patients is under public management.

Medical tourism is also being introduced as a business model in countries not very well known for tourism such as South Korea, the UAE, Turkey, Hungary and Costa Rica. A number of Eastern European countries have started providing dental care and plastic surgery for international patients. Chile, as a regional medical hub in Latin America, has attracted patients from Bolivia, Peru, and Ecuador. Several Chilean clinics have established agreements with health care centers and private insurers in other countries in the region as a strategy to promote medical tourism. Mexico has long been popular among US patients seeking dental care and cosmetic surgeries. Turkey has also become a medical tourist destination by providing low cost services and accrediting some of its hospitals with JCI. Several other countries are also trying to attract foreign patients including Argentina, China, Colombia, the Dominican Republic and South Africa. The medical tourism business has adopted multiple export strategies, and comprises a diverse set of countries across the globe. It is gradually expanding to provide services in all medical procedures (Horowitz and Rosensweig 2007; Bookman and Bookman 2007).
b. Enabling factors for growth

Medical tourism providers adopted an approach that most multinational and corporate business enterprises follow in terms of designing marketing strategies, pricing, branding, management and maintaining the quality of services (Bookman and Bookman 2007; Turner 2007c). This approach, along with increasing global integration of businesses, and the cost and wait-time crises in western health care systems, created opportunities for many health facilities in developing countries. Key enabling factors for growth of medical tourism are discussed below.

Cost and affordability

The major driving force of medical tourism industry is the provision of cost effective private medical care combined with the attraction of visiting exotic sites in the destination countries (Gupta 2004; Deloitte 2008). The health care package includes traditional therapies as well as surgical and specialized treatments (Gupta 2004). The industry is now facilitated by the corporate sector specialized in both medical care and tourism. The industry has a network of professional medical brokerages who reach out to clients with inadequate or no health insurance coverage, seeking inexpensive healthcare from abroad.

Table 2: Comparative costs of selected medical services (US$)

<table>
<thead>
<tr>
<th>Procedure</th>
<th>United States</th>
<th>India</th>
<th>Thailand</th>
<th>Singapore</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart valve replacement</td>
<td>159,000</td>
<td>9,500</td>
<td>10,500</td>
<td>13,000</td>
</tr>
<tr>
<td>Heart bypass</td>
<td>122,000</td>
<td>10,000</td>
<td>12,000</td>
<td>20,000</td>
</tr>
<tr>
<td>Knee replacement</td>
<td>41,000</td>
<td>8,500</td>
<td>10,000</td>
<td>12,000</td>
</tr>
<tr>
<td>Spinal fusion</td>
<td>63,000</td>
<td>5,500</td>
<td>7,000</td>
<td>9,000</td>
</tr>
<tr>
<td>Hysterectomy</td>
<td>20,000</td>
<td>3,000</td>
<td>4,500</td>
<td>6,000</td>
</tr>
</tbody>
</table>


The differences in the cost of care for various treatment options between rich and developing countries are substantial. Table 2 indicates that the cost of care in host countries is, on average, only 10% of the cost in rich countries (ESCAP 2009). For example, the cost of open-heart surgery is $70,000 in Britain and up to $150,000 in the US while it’s between $3,000 and $10,000 in India’s best hospitals (Gupta 2004). Surgery on both knees costs $7,700 in India while it costs more than twice as much in Britain ($16,950). Similarly, dental, eye and cosmetic surgeries in rich countries cost three to four times as much as in India or Thailand. The primary reason for such cost differences between the two types of countries has been low wage rates in host countries compared to most of the developed nations (Herrick 2007). In the face of continuing health care cost increases in developed countries, it is likely that patients, insurers and employers, particularly in countries where employers share the costs of private health insurance, will continue seeking low cost treatment abroad (Forgione and Smith 2007; Health Worldnet 2009).

Health insurance coverage

Lack of partial coverage of health insurance in most developed countries is another important driving force in deciding to choose a foreign country for medical care. The number of people without health insurance coverage in the US was estimated as 45 million (or 15.6 per cent of
the total population) in 2003 (Turner 2007c; Milstein and Smith 2006; Starr, Sered and Fernandopulle 2005). In addition, lack of insurance for dental care and delay for some medical interventions such as orthopaedic operations, spinal surgery ophthalmologic, knee and hip replacements are a serious problem in Canada and many countries in Western Europe. The growing uninsured or underinsured patients in rich industrialized countries along with the rapid increase of healthcare costs has stimulated patients to travel overseas for affordable healthcare (Pafford 2009). The recent economic recession has led to an increase in the number of uninsured persons in the US and left a large population needing affordable healthcare with little choice but to go abroad for major treatments.

**Choice**

The medical tourism model promotes patient choice by providing access to a set of service packages with variant costs and quality not found in developed countries. It also expedites access to care, when needed, by substantially reducing waiting periods in some countries for services from public facilities (Turner 2007b). The model provides opportunities for such surgical procedures as facelifts, hair transplants, dental treatment and liposuction, as well as non-surgical procedures such as hair removal – most of which are not covered by health insurance and are either expensive or severely restricted for legal reasons in most developed countries (Turner 2007a). Other choices include opportunities to select destinations (countries), providers (hospitals and physicians) and the types of services based on their expertise and costs of care (Turner 2007a; Cortez 2008).

**Waiting time**

A large number of international medical travelers have been from such developed countries as Canada and the United Kingdom where health care is under the public domain. The primary reason for those patients to travel abroad is to avoid long waiting times for non-elective surgery and other critical procedures in their own countries. According to an estimate, nearly 900,000 Britons are waiting at any given time for admission to National Health Service hospitals where shortages of capacities force the cancellation of more than 50,000 operations each year (Medical Tourism.com 2009).

Despite the small improvement in 2007, the total wait time remains high in Canada, both historically and internationally. On average, Canadians are still waiting 121 days or more on average for necessary medical treatment and the wait time is still increasing (Esmail, Hazel and Walker 2008). Figure 4 shows the increase of wait times between 1993 and in 2008. Canadians wait longer than Americans, Germans, and Swedes for cardiac care, which may sometimes lead to adverse consequences for cardiac patients. Statistics Canada data from 2003 show that a total of 1.1 million Canadians had difficulties getting to see a physician of any kind when in need (Sanmartin et al. 2004).
One study reports that the cumulative economic cost of waiting in excess of recommended wait times for joint replacement surgery, cataract surgery, coronary artery bypass graft and MRI scans to be $14.8 billion in Canada even if additional $4.4 billion loss of revenues as a result of reduced economic activity is not counted (The Centre for Spatial Economics 2008). In addition, the long wait contributes to unrecognized costs such as physical impairment and anxiety, and physical and psychological pain and suffering that cannot be measured (Esmail, Hazel and Walker 2008). Wealthy Canadian patients found medical travel as an alternative for surgical procedures in such countries as India, Thailand, Malaysia or the Philippines where they can get the services almost immediately.

**Access to information technology**

Increased access to information flow regarding medical travel and the pleasure of travel overseas has also significantly contributed to the growth of medical tourism (ESCAP 2009). Most of the international health providers as well as their brokerages have their own websites that facilitate a variety of services. Patients can learn about options, compare costs, select hospitals, make travel arrangements and can contact providers and medical specialists for informed choices. Websites also provide such information as hospital accreditation, doctor’s credentials, patient testimonials in addition to cost of treatment and logistics. International hospitals in developing countries use electronic medical records to store and access patient files before discussing the procedures with potential patients via conference call (Herrick 2007). Medical tourism providers use a business model that combines the personalized services of the hotel industry where tasks and procedures have been streamlined for the highest efficiency (Herrick 2007).
Reputation of innovative services

Provision of quality assured, often atypical, specialized medical care in international hospitals is another important determinant of the growing popularity of medical travel abroad. Medical care providers in Thailand, for example, have a reputation for cosmetic surgery and dental procedures. Indian hospitals are well known for hip resurfacing technology – a procedure that requires a shorter rehabilitation period compared to total hip replacement as suggested in most Western hospitals. Some Indian hospitals offer advanced treatments that are not yet approved in the West such as robot assisted joint replacement. For renal care and kidney transplants with affordable prices, the choice for many patients is the Philippines. Providers in Singapore, where the cost of medical services is relatively higher than neighboring medical tourist hubs, emphasize complex cases (such as separation of conjoined twins) or the highest quality care to attract medical tourists from developed nations, and wealthy patients from less developed Asian countries who used to travel to reputable medical institutions in Europe or North America (ESCAP 2009). The medical tourism industry offers a relaxing vacation period following the medical procedure in their package. For many western medical tourists, a trip to Thailand or India with some travel and adventure carries extra benefits of getting pleasure.

Cost of production of services

The medical tourism industry is modelled to provide cost effective services using relatively low cost health professionals from the provider countries (Gupta 2004). There are other ways in which service costs are kept low. In most provider countries, malpractice litigation costs are much lower than in most highly developed countries, which has helped to reduce the cost of care. For example, a physician in Thailand pays about $5,000 per year for a liability insurance policy while an American physician needs to pay more than $100,000 annually for the same (Herrick 2007). The professional liability insurance premium for a surgeon in India is only 4% of what it is in the US (Horowitz and Rosensweig 2007).

Hospitals in developed countries have to follow detailed health care regulations while health care regulations in most provider countries are quite flexible and business-friendly. In the provider countries, hospitals can employ physicians directly to provide a certain number of hours per month in return for a guaranteed fixed fee — a practice prohibited in many Western countries (Herrick 2007). The provider hospitals can also hire reputed and popular physicians as part-time consultants to attract more customers from abroad.

The proliferation of advanced medical technologies and increasing public demands for long-term health care has increased the cost of care in most developed countries, regardless of the market-based (the U.S.), social insurance (Canada, France, Germany, Japan), national health service (Finland, New Zealand, Norway, Sweden, U.K.), or hybrid (Italy, Spain) models of health care financing and provision (Keaney 2002). Unlike the developing world, patients in the developed world spend only a fraction in out of pocket payments on health care, with the remaining paid by insurers, employers and government. As a result, providers face less competition to keep prices low.
Restrictions on travel

One positive and significant aspect of the medical tourism model is the opportunity of provider countries to expand their health infrastructure and health human resource base (Bookman and Bookman 2007; Turner 2007a). Wider political issues have also redirected medical travelers to other destinations to seek out health care. The US was a preferred destination for many affluent patients from the Middle East prior to the attack on the World Trade Centre on 11 September 2001 (ESCAP 2009). The subsequent tightening of entry requirements in the US (and in many other Western countries) has diverted a large share of the medical tourism business to other destinations. This has created an opportunity for health facilities in Jordan to position themselves to receive much of the diverted patient load and assume a role as regional referral center for patients from neighboring countries (ESCAP 2009). On the other hand, Cuba, although entering the market in the 1980s, with the potential to lead the business, did not flourish as expected because of its political isolation in the region and travel restrictions imposed by some countries.

Quality of care

Given that accreditation is a vital issue in choosing a hospital for health care by many patients in the West, most of the provider hospitals in the developing countries are now accredited either by the Joint Commission International (JCI) or the International Standards Organization (ISO) (Herrick 2007). Some provider countries have adopted their own accreditation standards to reassure potential patients about their high quality health care. A few of them were affiliated with prestigious Western universities or health care systems to become more attractive to international patients. In many cases, the physicians are trained and certified in the West, to ensure the safety of the potential patients as well as to attract more international patients to their facilities (Herrick 2007). Intense competition among the international health providers to demonstrate the quality and expertise of their professional staff can have a lasting positive effect on the growth in medical tourism.

c. Ethical and legal issues

The main driving force behind the promotion of medical tourism is to maximize profits by providing health services that can be bought off the shelf from the lowest priced provider anywhere in the globe. The approach, therefore, is not likely to encourage the health care market forces to follow internationally accepted standards, governmental regulations, patients’ rights, or legal and ethical issues. It would be difficult, if not impossible, to develop and implement internationally recognized agreements regarding oversight, care provision, ethics and legal recourse. One important feature of the medical tourism market is the provision of services that are either illegal in many developed countries, not paid for by insurance companies (such as facelifts, hair transplants, dental treatment and liposuction) or which have to go through long legal procedures to get those services (such as surrogacy and organ transplant) (Turner 2007b).
Reproductive tourism

Reproductive (surrogacy) tourism provides a woman with a chance to experience motherhood if she is unable to become pregnant and give birth by natural means. The process is not only costly but is also ridden with many legal hurdles in most developed countries (Inhorn and Pasquale 2009). These factors push many couples to explore alternative countries and facilities providing surrogate mothers. Although this service can be bought in many countries, India has become most successful in providing reproductive outsourcing because surrogacy is legal in India, where a surrogate mother can easily sign away rights to the child without facing any legal problems. Also, it takes much less time to take delivery of the child, compared to 2-4 years in UK. The cost of surrogacy process ranges between $20,000 to $35,000 in India, which includes doctor fees, medicines, pre-natal care, delivery, legal charges as well as surrogate compensation; the process may cost between $30,000 to $100,000 in those developed countries where it is allowed (Inhorn and Pasquale 2009; Asia’s Medical Tourism 2009).

Cosmetic tourism

Improvements in medical technology have resulted in an unprecedented interest in body contouring as a form of aesthetic surgery, such as abdominoplasty, rhinoplasty or bariatric surgery. The pregnancy-stretched abdomen can now be brought back to an almost pre-pregnancy state, nose shape can be improved and obesity (where diet plans and workouts fail) can be reduced through surgical procedures. Most of these cosmetic surgeries are not covered by medical insurance in the West and are very expensive. Thailand, India and Mexico have become the cosmetic tourism hubs. Customers have come primarily from the US, Canada, Britain and other European nations. One source estimates that about 29,000 British went overseas for cosmetic surgery and spent USD 156 million in 2007 (Intuition Communication 2009).

Medical transplant tourism

These severe shortage of human organs for transplant has led to an international organ trade. Although some countries, such as India, have made the sale of human organs a criminal offense (the 1994 Indian Human Organs Transplantation Act), nearly 10 per cent of all transplantations in the world (about 93,000 kidney, liver and heart transplants each year) are estimated to have been carried out illegally (Shimazono 2007). The Istanbul Declaration in 2008 called a halt to these unethical activities and urged safe and accountable practices to protect poor people from the exploitation inherent in organ sales (WHO 2008), however, critics suggest that expansion of medical tourism will further promote an organ-selling spree among desperately poor countries (ESCAP 2009). India, Pakistan, China, the Philippines, Iraq, Egypt, Turkey, Brazil, Bolivia, Peru and East European countries are commonly cited organ-exporting countries, where organs from local donors are regularly transplanted in foreigners through sale and purchase (Shimazono 2007). On the other hand, Australia, Canada, Israel, Japan, Oman, Saudi Arabia and the USA are reported as major organ-importing countries (Shimazono 2007).

Organ suppliers are generally very poor, mostly women and vulnerable people living in the poverty-stricken regions of the world who can either be easily motivated or coerced. A study
reports that 71 per cent of such providers lived below the poverty line, 71 per cent were female and 96 per cent had to sell their organs to pay off their household debt (Goyal et al. 2002; Shimazono 2007). Most of the organ suppliers experienced deterioration of health after donation and became unable to do labour intensive jobs (Health Worldnet 2009). Medical transplant is thus considered by some as a “globalized apartheid medicine” since it benefits the rich patients generally from the developed countries over the poor and vulnerable who have no choice (Smith 2008; Scheper-Hughes 2005).

IV. Medical tourism, health development and equity

In an increasingly globalized world where financially capable patients have wider choices and opportunities to go abroad for health services, the growth of medical tourism appears to be inevitable (Leahy 2008).Privatization of health care, diffusion in information technology, fewer restrictions on movement and low cost air travel have expanded the scope of traveling abroad for health care (Health Worldnet 2009). While previously only the rich and the famous could afford to be medical tourists, medical tourism is now accessible to a larger section of the population particularly in the developed countries. Not much is known about the implications of medical tourism as very few rigorous studies have examined this issue. While medical tourism has been a boon for some people in destination countries and for those medical tourists able to afford such services, from a public health perspective it is mixed blessing. In examining the implications of medical tourism, we focus on the potential threats of increasing health disparities as well as opportunities.

a. Health infrastructure development

Medical tourism has the potential to create opportunities to boost gross domestic product and to create a more favourable balance of trade by lowering the fiscal deficit of the national economy (Arellano 2007; Bookman and Bookman 2007). As a major source of foreign exchange, it can stimulate overall economic growth including tourism, transport, pharmaceuticals, hotels, food suppliers to hospitals and restaurants, and create more jobs in the tourism industry (Nguyen 2009; ESCAP 2009). It improves the image and reputation of the country, helps create international bonds with citizens of other nations, and acts as a role model of an efficient provider for the public health sector (Smith 2008; Nguyen 2009; Arellano 2007).

Such arguments, however, are contested or challenged in several points. Evidence suggests that economic development programs rarely create opportunities for the poor and disadvantaged (Smith 2008). Introduction of high tech medical facilities may, in fact, simply reduce the employment opportunities for the labour-intensive job market. The creation and expansion of large and high-tech health facilities may wrongly be perceived as ‘development of the health sector’ in the public’s eyes to draw their attention away from faltering public health systems (Smith 2008; Bookman and Bookman, 2007).

Expansion of medical tourism emphasizes building only large specialized hospitals to enhance their capacity and income beyond the limited domestic ‘market’ or what is needed for most of the populations (Vijay 2009). It has been argued that increasing emphasis on technology driven tertiary care for foreigners may potentially have distorted the healthcare landscape in these
countries and, thereby, have deprived their own native-born poor populations (Leahy 2008; Herrick 2007).

The medical tourism sector has been reported to be subsidized by the government while public health expenditure has consistently been reduced in some provider countries (Smith 2008; Chacko 2005; Lautier, 2008; Vijay 2009). In several countries, the private hospitals built for the medical tourists receive special tax benefits in return for their commitment to provide a certain amount of free medical services for the poor patients of the localities (Vijay 2009). Such agreements have never materialized. However, others argue that the private sector cannot and should not be blamed for the lack of access to health care for the poor and disadvantaged populations as the poor were neglected by their public health systems long before the medical tourism model developed (Economist 2008).

b. Equitable distribution of health care

Medical tourism has been criticized for i) the creation of a two-tier system of health-care delivery by broadening the gap between haves and have-nots, and ii) building impressive high-tech hospitals that serve only the needs of affluent outsiders (Arellano 2007; ESCAP 2009; Smith 2008; Bookman and Bookman 2007; Chanda 2001; Whittaker 2007; Health Worldnet 2009). It has also been argued that medical tourism could potentially divide health care systems by diverting larger public sector funds to implement policies that are biased in favor of their business, thereby aggravating inequalities in health care access (Bookman and Bookman 2007). As Woodward et al. (2002) points out “it (medical tourism) may also divert human resources from public services to more profitable services for the elite or foreign markets, thus reducing staffing levels, lowering staff quality, and/or raising salary costs for the public sector.” The poor may have less access to healthcare because it is either too expensive for them or not available where they live (Connell 2006; Ramesh 2005). It should be noted, however, that although cheaper by most Western standards, the costs of private hospitals that treat medical tourists have always been out of reach for the majority of the poor within destination countries. This raises the question to the argument that medical tourism may lead to increasing health disparities.

It can be argued that access to care by the poor will be affected by medical tourism for the short-term only if appropriate measures are taken to create a space for the poor to access the high quality health care that medical tourism could provide close to their home. There are many ways to create opportunities for the poor. One widely known option has been the provision of cross-subsidies for poor patients by the rich (Bookman and Bookman 2007). However, generating revenues through the cross-subsidization process has been difficult to implement. Evidence suggests that Indian private hospitals, who provide services to international patients, have failed to fulfill their expected role to treat local poor for free in return for government subsidies (Gayathri 2009). On the other hand, Cuba’s Servimed is an example where it is claimed that many of the profits from foreign patients get reinvested in local health care provision (Bookman and Bookman 2007). Another promising option is the creation of a social business oriented health care industry where a substantial amount of the profits goes to benefit the poor and underserved (Yunus 2007).
The argument that private hospitals serving medical tourists will continue to treat only foreign patients is improbable, since the revenue generated from foreign patients will remain well below the running cost of most of these hospitals (Herrick 2007). Such hospitals have focused on the affluent and financially well-off population of their own countries as a strategy to expand their customer base. Availability of the advanced medical care in those hospitals with relatively lower cost has, in fact, expanded access to high quality medical care for the population able to afford such care.

Medical tourism has the potential to accelerate health technology transfer to less developed countries. With the expansion of medical tourism, some of the large hospitals in the host countries have transformed themselves to become centers of excellence and regional hubs for advanced medical care. The newly gained status and strength of these hospitals have the potential not only to reduce the dominance of major Western medical facilities but also to contribute to a reduction in global inequality by providing high quality care for clients in the regions. In the developed world with a large proportion of the population without health insurance, the growth in medical tourism might contribute to a reduction in health disparities in those countries by creating opportunities for such persons to receive essential medical care abroad.

c. Mobility of health professionals

The effects of the expansion of medical tourism on the mobility of medical professionals are unclear. It may be argued that the classic model of brain-drain, where medical professionals from poorer developing countries move to wealthier developed nations for more opportunities to work, higher pay and professional development, will be affected by the growth of the modern form of medical tourism. Fewer health professionals will have reason to seek greater practice opportunities abroad, although other dynamics are also at play.

Hospitals catering to foreign patients will continue searching for highly skilled professionals to raise the quality of care and reputation of the facilities to attract new customers. This recruitment drive is likely to accelerate i) internal migration of medical professionals primarily from the public facilities to hospitals for foreign patients (Smith 2008), ii) reverse brain-drain of professionals from the developed countries to their home country hospitals, and iii) migration of professionals from the neighbouring countries to newly built medical tourism hub centers in the region.

As expected, internal brain-drain has been reported in Thailand, creating a shortage of doctors in the public hospitals in Bangkok because of the higher pay offered at Bumrungrad, a major hospital in the region that treats medical tourists (Madden 2008). This has prompted criticism of medical tourism on the speculation that the flooding of foreigners into developing countries would divert money and expertise from the public health facilities in the rural areas to further worsen the care for disadvantaged people. At the same time this is seen as a distraction from the need to cut costs and improve quality in rich-world health systems (Economist 2008). Nonetheless, the external brain drain has been somewhat replaced by an internal brain drain where more doctors have left public health facilities to work in private large hospitals. Although it is difficult to get a clear picture of the flows of internal brain-drain of health
workers due to a lack of monitoring and formal reporting systems, it has been observed that medical tourism has encouraged such movements (Smith 2008; WHO 2007). The argument of the negative effect of internal brain-drain, however, has been countered by the contention that the growth of medical tourism may have reduced the flow of health care professionals from provider countries to the developed world (Smith 2008).

Brain-drain of health professionals from the developing to developed countries is well documented. It is claimed that medical tourism, in being capable of providing attractive salaries to its skilled professionals, has the capacity to reverse the flow (Vijay 2009). Although debatable, anecdotal evidence suggests that a large pool of highly skilled medical professionals trained in developed countries were attracted to return to their home countries, as they found it lucrative and more satisfying to work at home (ESCAP 2009). In addition, returning professionals had gained experience of working in major medical facilities in developed countries with international goodwill (Arellano 2007). Critics, however, argue that such reverse brain-drain would not help patients of their home countries because they would use infrastructure and other resources of their own country to serve the foreigners thus depriving their own people (Vijay 2009).

A large influx of international health travellers to provider countries would likely raise the demand for more private hospitals or expansion of the existing health infrastructure. This will require more health professionals and the potential loss of more doctors not only from the public sector, but also from the least developed neighbouring countries. In other words, expansion of medical tourism may have negative effects on poor patients in public facilities in the region who are in need of care and support (Vijay 2009).

d. Quality and patient safety

Intense competition among health facilities in the global health market is likely to promote technological advances and improve medical infrastructure in their own institutions. Medical tourism encourages hospitals to invest in high-quality facilities, cutting-edge technology and human resources to attract international patients. It has been reported that the best hospitals in Asia and Latin America now rival or surpass many hospitals in the rich world for safety and quality (Economist 2008). The facilities can provide better care for the affluent local population and promote equity in access to private care for patients who otherwise would not have access to such facilities and services (Bookman and Bookman 2007; Henderson 2004; Turner 2007). Upgraded facilities can have a demonstration effect on the national health system by raising the overall standard of health care and forcing public health facilities to invest more to improve their quality of care (ESCAP 2009; Bookman and Bookman 2007; Arellano 2007).

e. Competition and cost-containment

Dramatic increases in health care costs in developed countries have become a concern not only among the consumers of health care but also among the employers and health insurance companies. Promotion of medical tourism has been considered a viable option to face this challenge and to contain health care costs as it encourages global competition and puts pressure on very expensive facilities to lower their prices (Deloitte 2008). It has been projected that
patients from the US alone will spend about USD162 billion to receive health services overseas by 2012 (Pafford 2009). It is not known, however, whether medical tourism has the leverage to lower the cost of medical care because increased competition for qualified medical personnel could raise the cost of services if physicians and nurses currently working in the developed countries choose to return home (Herrick 2007). Also, it remains to be known whether the cost of care would increase or remain stable in the provider countries. The subsidies given to private hospitals in purchasing land and reducing import duties for medical equipment may increase the cost of spending on public health in the provider countries. Also, the implementation of internationally accredited quality systems for hospitals may also lead to higher treatment costs.

f. Medical waste management

The problem of medical waste management in the provider countries, as a result of a large influx of surgical patients from overseas, has already become a serious concern, but remains largely unnoticed in the medical literature. The local people are not generally aware of the threats they are exposed to living close to medical waste dumps. One study reports that a bed in a hospital generates on average 1 kg waste per day, out of which 10-15 per cent is infectious, 5 per cent hazardous and the rest general (Vijay 2009). Given that most developing countries have no proper medical waste management system, the problem of medical waste management is likely to grow with the promotion of medical tourism.

V. An agenda for medical tourism governance

One of the greatest achievements of modern times is the increasing longevity of human life. With population aging, the demand for medical and long-term care has gradually been increasing, particularly in developed countries. Globalization of health care systems has created risks and challenges even while opening new opportunities for the provision of better and more affordable medical care for a larger population. With the rising costs of production, health services in many developed countries are now increasingly outsourced. Relatively poor or uninsured patients of the rich countries are now moving abroad, mostly to developing countries, to receive health care within reasonable costs, although often by ignoring the risk of quality of services they receive. This trend is likely to increase over time as medical tourism becomes an accepted part of the solution to high health care costs or long wait times to receive care in the West. Medical tourism will expand further once governments allow health insurers and employers to extend their coverage abroad, although this expansion may generate additional health disparities in the provider countries.

Expansion of medical tourism appears to be inevitable within the context of a new global economic order. What is needed is to create a medical tourism governance structure by the key stakeholders in this sector such as representative of the governments, medical care providers, employer groups, pharmaceutical companies, health insurers, international medical brokers, and the patients. They will carefully consider all relevant issues such as the experience and achievements of medical tourism approach so far, expectations from expanded medical tourism, and identification of the existing problems and potential obstacles to reaching targets, impact on the health systems of provider countries, and equity of health care for those worse off in developing countries. Given the lack of evidence of the outcome of expanded medical
tourism in recent decades, it would be difficult at this juncture to set out policy options for the future of medical tourism. However, based on the analysis presented in this paper, a potential and researchable agenda for medical tourism can be suggested.

a. Medical tourism audit

Managing risks that medical tourism may create while preserving benefits it can offer requires a clear understanding of how it affects the cost of health care and the quality of services. Also, it is important to monitor the long-term effects of medical tourism on access to and utilization of services, efficiency and effectiveness of care, and health equity in developing countries, and ensure that monitoring results are fed effectively into decision-making processes at the national and international levels.

Conducting a global audit to understand the current status of medical tourism and developing a routine monitoring system to keep track of its growth and effects would provide an evidence base on which informed decisions could be made. Several relevant issues remain to be understood before developing a good governance system of medical tourism. Some of these are existing mechanisms to monitor the quality of care at medical tourism facilities, current practices and responsibilities of managing legal and malpractice issues, maintaining privacy of patients, continuity of care or patient follow-up after returning to home countries, and effects of medical tourism on the access to health services in both provider and recipient countries. Also, an appraisal to look at the current structure, process and outcome of the medical tourism business would help in devising a future strategy for its growth. At present, no legitimate authority, recognized by the stakeholders, exists that could develop quality and safety standards for medical tourism, a global database to monitor trends, and a set of criteria for auditing or reviewing the medical tourism business on a regular basis.

b. Regulations and policy options

In the absence of regulatory systems and guarantees of rights or protections, patients are taking a calculated risk by seeking medical care abroad (Cortez 2008). One of the inherent weaknesses of the medical tourism trade is that no single authority has jurisdiction over the patients, health providers, referral networks, employers and insurers.

With the expansion of business at the global level, the system calls for a set of policies under a regulatory framework and establishment of a legitimate authority to develop, modify and implement those policies. The development of both structure and scope of the proposed regulatory framework requires a systematic review of the medical tourism sector and intensive discussion with the stakeholders. This paper suggests that the scope of the proposed agency or authority would be to protect public interest by creating and monitoring guidelines for international health trade, advocating standardization for the qualification of physicians and other medical professionals, granting licenses and accreditation for international hospitals, regulating the activities of international health brokers, employers and insurers, and assisting in sharing information, outcomes reporting and other aspects of the medical tourism trade among stakeholders (Cortez 2008).
Several national and international healthcare groups have understood the need of having such an authority and are working to develop an effective system to respond to the fast transforming healthcare practice, technologies and medical delivery procedures in the world (Health-Tourism.com 2009). The program of International Health Regulations (IHR) of WHO is already in place to respond to acute public health risks that have the potential to cross borders and threaten people worldwide (WHO 2008). The WHO, as a legitimate and widely accepted international agency, may take the responsibility of functioning as a provider of knowledge and evidence, and initiate the development of policy guidelines for medical tourism governance.

c. Translating benefits for all

Making medical tourism work to reduce health inequity in both rich and poor countries requires fundamental changes in the current form of medical tourism. A clear understanding of needed changes calls for systematic studies on the impact of the expansion of medical tourism on the diffusion of advanced medical technologies in the developing world and their effects on access to care for poor and disadvantaged patients living in provider countries.

Extending the benefits of improved health services geographically means that both private and public hospitals in provider countries coordinate in ways that maximize the opportunities medical tourism has created. This may mean substantial changes in institutional arrangements such as the removal of legal obstacles for the expansion of the private sector, provision of insurance coverage for international patients and formulation of policies regarding patient safety and malpractices. Promotion of such collaboration among various stakeholders is likely to enhance the financial capacity of the public health sector, help improve the standard of services of public facilities and improve availability and quality of services for the public at large. However, it remains to be clearly understood how, to what extent and under what mechanism those stakeholders with opposing interests would work together to reach a common goal.

Provider hospitals should maintain a diversified and balanced portfolio of local and international patients in order to avoid the excessive reliance on revenue from international patients and business risks. One study suggests that the provision of services to local clients would minimize, to some degree, the risks associated with dependency on international patients (ESCAP 2009). Like normal tourism business, international health providers should be encouraged to promote effective, but low cost medical facilities for average patients. This would likely provide wider choices and better opportunities not only for patients from abroad but for the local population as well.

Both private and public health insurance carriers in developed countries should be encouraged to extend their coverage of services overseas. They should be provided incentives to encourage beneficiaries to use offshore facilities for expensive surgical procedures and take advantage of low-cost treatments (Madden 2008; Health Worldnet 2009).

The health benefits of medical tourism should reach to the patients of provider countries who cannot afford to buy services from the international hospitals. It is not known how this noble goal could be achieved. This paper proposes to examine several options to reduce medical
tourism led health disparities by i) creating public-private partnership arrangements where public hospitals refer selected patients to international hospitals for specialized services, and ii) designing and implementing a fair distributional strategy of services of international hospitals at the national level. This is a difficult and challenging task for both the governments of provider countries and the proposed regulatory agency. Based on the experiences (of India and Thailand), existing modalities and institutional arrangements may need to be revised and implemented to ensure that both public and private hospitals and insurers comply with new arrangements. The purpose would be to maximize the health well-being of all populations rather than assuming that health benefits would trickle down towards the disadvantaged populations by policies oriented towards expansion of medical tourism and private hospitals alone.

This paper concludes that medical tourism as an alternative approach to health care is neither positive nor negative in itself but a historical process in continuous evolution within the health care system. While expansion of medical tourism has been inevitable in the changed global context, it is proposed that an enabling environment for its growth that limits negative consequences on health is created. This paper argues that devising an agenda for medical tourism governance to routinely monitor its growth, developing a regulatory framework for medical tourism acceptable to all stakeholders and translating the benefits of this approach for all is the next logical step in the evolution of medical tourism.
References


