Exploring the influences on the Caribbean’s emerging medical tourism industry

by

Rory Johnston

M.A. (Geography), Simon Fraser University, 2012
B.A. (Health Sciences), Simon Fraser University, 2010

Thesis Submitted in Partial Fulfillment of the Requirements for the Degree of Doctor of Philosophy

in the

Department of Geography
Faculty of Environment

© Rory Johnston 2016
SIMON FRASER UNIVERSITY
Summer 2016

All rights reserved.
However, in accordance with the Copyright Act of Canada, this work may be reproduced, without authorization, under the conditions for Fair Dealing. Therefore, limited reproduction of this work for the purposes of private study, research, education, satire, parody, criticism, review and news reporting is likely to be in accordance with the law, particularly if cited appropriately.
Approval

Name: Rory Johnston
Degree: Doctor of Philosophy
Title: *Exploring the influences on the Caribbean’s emerging medical tourism industry*

Examining Committee:

**Chair:** Jeremy Snyder
Associate Professor

Valorie Crooks
Senior Supervisor
Associate Professor

Eugene McCann
Supervisor
Professor

Nadine Schuurman
Supervisor
Professor

Diego S. Silva
Internal Examiner
Assistant Professor
Faculty of Health Sciences

John Connell
External Examiner
Professor
School of Geosciences
The University of Sydney

Date Defended/Approved: April 25, 2016
Ethics Statement

The author, whose name appears on the title page of this work, has obtained, for the research described in this work, either:

a. human research ethics approval from the Simon Fraser University Office of Research Ethics

or

b. advance approval of the animal care protocol from the University Animal Care Committee of Simon Fraser University

or has conducted the research

c. as a co-investigator, collaborator, or research assistant in a research project approved in advance.

A copy of the approval letter has been filed with the Theses Office of the University Library at the time of submission of this thesis or project.

The original application for approval and letter of approval are filed with the relevant offices. Inquiries may be directed to those authorities.

Simon Fraser University Library
Burnaby, British Columbia, Canada

Update Spring 2016
Abstract

Governments and hospitals worldwide have increasingly expressed interest in ‘medical tourism’, where medical treatments are privately purchased by foreign visitors seeking non-emergency care. There is steady discussion worldwide about the development of medical tourism, including countries with volumes of health service exports that are currently very small. Caribbean countries are no exception. In a region not well known for its medical tourism destinations (excepting Cuba and Costa Rica), there are regular announcements of numerous new private hospital proposals and public initiatives to create policies and incentives to support the development of the sector.

While a relatively new area of research, medical tourism has received a great deal of attention in low and middle income countries that are known to attract patients from high income countries. This has resulted in a considerable body of literature that retrospectively examines its economic and health system impacts of medical tourism in ‘successful’ destinations, often using secondary data. This has resulted in a great deal of work examining medical tourism that has focused on limited number of countries and hospitals with established volumes of health services exports, particularly Thailand, Malaysia, and India. Little is known about the perspectives and factors that are prospectively driving interest in medical tourism worldwide, nor their attendant implications for the health systems of countries attempting to market their medical services internationally.

This dissertation examines the development of the medical tourism industry in the Caribbean to prospectively explore how and why the sector is being promoted there at this time. Primarily focused on analyses of qualitative data collected from fieldwork conducted in the small island Caribbean states of Barbados and Jamaica in 2011-2013, the dissertation also incorporates semi-structured interview data from a larger study of medical tourism in Mexico, Guatemala, and Barbados from 2013-2014 to identify parallel processes and factors driving the contemporary development of medical tourism throughout the Greater Caribbean in order to better understand and articulate their health equity implications for the health systems of the region.
Keywords: medical tourism; Latin America and the Caribbean; health services research; health equity; qualitative methods; international medical travel


Acknowledgements

This research was financially supported by the Canadian Institutes of Health Research, but made possible by the generosity of so many people. Thank you to all of the interview and focus group participants for their invaluable knowledge, thoughtful perspectives, and time. Your contributions made this entire research project possible. Thank you Maddy Murphy and Lisa Bishop for your collaboration, support, and insights throughout my time in Barbados and following my return home. Thank you Alejandro Cerón, Henry Fraser, Emmanuel Núñez, Walter Flores, and Ronald Labonté for your excellence in research, patience, and generous contributions to our writing collaborations. Thank you Eugene McCann and Nadine Schuurman for being such excellent supervisors throughout the entire PhD program and Leigh Weatherhead, Nigel Gayle, Sherwin Belgrave, and Paul Facey for your friendship and assistance during my fieldwork.

Krystyna Adams, Rebecca Whitmore, and Leon Hoffman, all of you are the best labmates a person could ever ask for. You made coming to the mountain every day both thought provoking and a pleasure and helped me to keep looking at medical tourism, health, grad school, and life in new ways all of these years. Likewise, Cristina Temenos and Meghann Ormond, from the extremes of working with you by distance to being trapped in close quarters during a hurricane and all the other times in between, I have been enormously lucky to travel, share ideas, and work with both of you. Jeremy Snyder, thank you for being an amazing teacher, collaborator, and friend.

Lastly, there is no way to adequately thank my supervisor Valorie Crooks for her boundless energy and support. This dissertation marks the end of a seven year (!!) mentorship where I have been offered every opportunity a student could possibly wish for and steadily supported through all of them. Her tremendous leadership, thoughtfulness, creativity, and ceaselessly collaborative supervision since my first day of work has been a constant source of intellectual stimulation and an inspiration to observe so closely. Thank you for all of the fascinating and fun years, Dr. Crooks.
# Table of Contents

Approval .......................................................................................................................... ii  
Ethics Statement ............................................................................................................. iii  
Abstract ........................................................................................................................... iv  
Acknowledgements ........................................................................................................ vi  
Table of Contents ............................................................................................................ vii  
List of Tables ................................................................................................................... xi

## Chapter 1. Introduction .................................................................................................. 1  
1.1. Health Geography .................................................................................................... 1  
1.2. Medical Tourism: Commodified Care for Export .................................................. 4  
1.2.1. What is Medical Tourism? ................................................................................ 5  
1.2.2. Medical Tourism Matters ............................................................................... 9  
1.2.3. Medical Tourism in the Caribbean ..................................................................... 15  
1.3. Dissertation Rationale and Structure ..................................................................... 17  
1.3.1. Chapter 2: "The major forces that need to back medical tourism were...in alignment": Driving Development of the Medical Tourism Sector in Barbados ......................................................... 19  
1.3.2. Chapter 4: “Best care on home ground” versus “elitist healthcare”: concerns and competing expectations for medical tourism development in Barbados ................................................................................. 21  
1.3.3. Chapter 6: Policy Implications of Medical Tourism Development in Destination Countries: Revisiting and Revising an Existing Framework by Examining the Case of Jamaica .................................................... 22  
1.3.4. Chapter 8: Inbound Medical Tourism in Latin America and the Caribbean: Factors Driving and Inhibiting Sector Development in Mexico, Guatemala, and Barbados ............................................................... 23  
1.3.5. Chapter 9: Conclusion ....................................................................................... 24

## Chapter 2. “The major forces that need to back medical tourism were...in alignment”: Championing Development of Barbados’ Medical Tourism Sector .............................................................................................................................. 26  
2.1. Abstract: .................................................................................................................... 26  
2.2. Introduction .............................................................................................................. 27  
2.3. Methods .................................................................................................................... 30  
2.3.1. Recruitment ...................................................................................................... 30  
2.3.2. Data Collection ................................................................................................ 31  
2.3.3. Data Analysis ................................................................................................... 31  
2.4. Findings .................................................................................................................... 32  
Internal Champions ........................................................................................................ 33  
External Champions ....................................................................................................... 34  
Internal Actors ............................................................................................................... 37  
External Actors ............................................................................................................. 38  
2.5. Discussion ............................................................................................................... 39  
Connected Champions .................................................................................................. 40
Chapter 3. Bringing Additional Voices to the Table ................................................. 47

Chapter 4. “Best care on home ground” versus “elitist healthcare”: Concerns and Competing Expectations for Medical Tourism Development in Barbados................................................................. 50

4.1. Abstract .............................................................................................................. 50
4.2. Introduction ....................................................................................................... 51
4.3. Methods ........................................................................................................... 56
  4.3.1. Participant Recruitment ............................................................................. 56
  4.3.2. Data Collection ........................................................................................... 57
  4.3.3. Analysis ....................................................................................................... 58
4.4. Results ............................................................................................................... 59
  Local Setting .......................................................................................................... 59
  Health Services Export as Niche Form of Tourism .............................................. 60
  Existing International Healthcare Connections ................................................. 61
  Clarifying Expectations ....................................................................................... 62
  Scope and Structure of a Medical Tourism Sector ............................................. 63
  System Disruption versus System Improvement .............................................. 65
4.5. Discussion .......................................................................................................... 67
  Dynamic and Networked Destinations ............................................................... 67
  Grounding Health Equity Concerns .................................................................... 69
  Scale and Form of Internationalizing Healthcare .............................................. 71
  Limitations ............................................................................................................ 72
4.6. Conclusions ....................................................................................................... 73
  Acknowledgements .............................................................................................. 75

Chapter 5. From Bajan Clinics to Jamaican Hospitals.............................................. 76

Chapter 6. Policy Implications of Medical Tourism Development in Destination Countries: Revisiting and Revising an Existing Framework by Examining the Case of Jamaica ........................................... 78

6.1. Abstract ............................................................................................................. 78
6.2. Background ....................................................................................................... 79
6.3. Methods ........................................................................................................... 84
  6.3.1. Data Collection – Semi-Structured Interviews .......................................... 85
  6.3.2. Data Collection – Site Visits ..................................................................... 86
  6.3.3. Data Analysis ............................................................................................ 87
6.4. Results ............................................................................................................... 88
  Governance .......................................................................................................... 88
  Financing ............................................................................................................... 90
  Delivery ............................................................................................................... 90
<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conclusion</td>
<td>104</td>
</tr>
<tr>
<td>Acknowledgements</td>
<td>104</td>
</tr>
<tr>
<td>Chapter 7.</td>
<td>105</td>
</tr>
<tr>
<td>Expanding the Regional Scope</td>
<td>105</td>
</tr>
<tr>
<td>Chapter 8.</td>
<td>108</td>
</tr>
<tr>
<td>Inbound Medical Tourism in Central America and the Caribbean: Factors Driving and Inhibiting Sector Development and Their Health Equity Implications</td>
<td>108</td>
</tr>
<tr>
<td>8.1. Abstract</td>
<td>108</td>
</tr>
<tr>
<td>8.2. Introduction</td>
<td>109</td>
</tr>
<tr>
<td>8.3. Methods</td>
<td>110</td>
</tr>
<tr>
<td>8.4. Findings</td>
<td>113</td>
</tr>
<tr>
<td>Factors Driving Sector Development</td>
<td>113</td>
</tr>
<tr>
<td>Excess Private Sector Capacity</td>
<td>114</td>
</tr>
<tr>
<td>Foreign Trained Health Workers</td>
<td>115</td>
</tr>
<tr>
<td>International Hospital Accreditation</td>
<td>116</td>
</tr>
<tr>
<td>Public Promotion of Private Medical Tourism Projects</td>
<td>117</td>
</tr>
<tr>
<td>Inhibitors of Health Services Export</td>
<td>119</td>
</tr>
<tr>
<td>High Expense of Market Entry</td>
<td>119</td>
</tr>
<tr>
<td>Incoherent Sector-Wide Planning</td>
<td>121</td>
</tr>
<tr>
<td>Local Insecurity and High Cost of Care</td>
<td>123</td>
</tr>
<tr>
<td>8.5. Discussion</td>
<td>124</td>
</tr>
<tr>
<td>Acknowledgements</td>
<td>127</td>
</tr>
<tr>
<td>Chapter 9.</td>
<td>128</td>
</tr>
<tr>
<td>Conclusion</td>
<td>128</td>
</tr>
<tr>
<td>9.1. Chapter Overview</td>
<td>128</td>
</tr>
<tr>
<td>9.2. Review of Dissertation Objectives</td>
<td>129</td>
</tr>
<tr>
<td>Objective 1:</td>
<td>129</td>
</tr>
<tr>
<td>Objective 2:</td>
<td>132</td>
</tr>
<tr>
<td>Objective 3:</td>
<td>135</td>
</tr>
<tr>
<td>Tourism Expertise and Expectations in Medical Tourism Planning</td>
<td>135</td>
</tr>
<tr>
<td>Caribbean Care Providers Seeking Larger Markets</td>
<td>138</td>
</tr>
<tr>
<td>Caribbean Medical Tourism as Offshore Medicine</td>
<td>141</td>
</tr>
<tr>
<td>Incohesive Development Goals Heightening Threats to Health Equity</td>
<td>142</td>
</tr>
<tr>
<td>9.3. Limitations</td>
<td>144</td>
</tr>
<tr>
<td>9.4. Future Research Directions</td>
<td>147</td>
</tr>
<tr>
<td>9.5. Conclusion</td>
<td>150</td>
</tr>
</tbody>
</table>
List of Tables

Table 1-1 - Examples of Social Determinants of Health.........................................................2
Table 1-2 – Article Titles Characteristic of Competing Medical Tourism ‘Narratives’.................................................................10
Table 4-1 - Pocock and Phua’s (2011) Conceptual Framework for Medical Tourism’s Policy Implications ........................................83
Table 4-2 - Participant Overview ..................................................................................................86
Table 4-3 - Additional Policy Implications from Medical Tourism Development................96
Table 5-1 - Interview Participants’ Professional Domains ..........................................................111
Table 5-2 - Illustrative Quotes of Excess Private Sector Capacity .........................................114
Table 5-3 - Illustrative Quotes of Foreign Trained Health Workers ........................................115
Table 5-4 - Illustrative Quotes of International Hospital Accreditation ...............................116
Table 5-5 - Illustrative Quotes of Public Promotion of Private Medical Tourism Projects ........................................................................118
Table 5-6 - Illustrative Quotes of the High Expense of Market Entry ....................................120
Table 5-7 - Illustrative Quotes of Incoherent Sector-Wide Planning ........................................122
Table 5-8 - Illustrative Quotes of Local Insecurity and High Cost of Care .............................123
Chapter 1. Introduction

1.1. Health Geography

The disciplines of geography and health have a well-established academic relationship with one another. Paralleling the modern discipline’s early positivist empiricism, geographers’ studies of health were long addressed almost entirely within a medical-epidemiologic framework (e.g., studies of disease spread) (Kearns, 1993). This outlook produced research questions that predominantly sought to identify spatial patterns of disease in relation to underlying environmental and demographic factors and develop spatial rationales for medical service allocation (Andrews, 2002; Kearns, 1993). This stream of ‘medical geography,’ reflecting the established dominance of biomedical authority over health issues throughout the bulk of the twentieth century, defined geographic inquiries of health until relatively recently. However, medical geography has expanded in the past two decades and been subsumed into the broader field of ‘health geography’ (Andrews, 2002; Kearns & Moon, 2002). Health geography seeks to examine health and wellbeing as socially constructed variables that emerge from rich social contexts (Andrews, 2002; Kearns, 1993; Parr, 2002). Rather than serving as containers to organize and provide spatial boundaries for health issues, these contexts are implicated in producing and interpreting the phenomena associated with them. Characterized by Gesler and Kearns as a “braided river” (2002, p. 8), the early epidemiological tradition of medical geography is now just one strand of inquiry that coexists with the other branches of health geography that have expanded the field of inquiry well beyond issues of disease and medical treatments.

An agenda setting 1993 paper by Kearns (1993) articulated the potential benefits of using a wider, socio-cultural scope to examine issues of health and disease in geographic research. Drawing on the larger ‘cultural turn’ occurring in geography and social sciences as a whole, Kearns (1993) argued that the longstanding reliance on a
medical framework to explore health questions using a geographic frame produced an inescapable positivist focus on diseases and their clinical solutions. While this focus is useful for quantitative inquiries into population health where spatial boundaries can organize objective variables of interest, it is poorly equipped to qualitatively examine health as a subjective experience (Andrews, 2002; Kearns, 1993; Parr, 2002). The strengths and limitations of these approaches echo wider conceptual divides in health research, whereas medical geography’s understanding of disease mirrors medicine’s atomized focus on ill-health occurring in individuals’ bodies, health geography echoes one focus of contemporary public health in its emphasis on the equally powerful role of social factors that shape the health outcomes of individuals and populations. These factors, the social determinants of health (see Table 1-1), shift thinking about health away from a myopic focus on disease processes and their treatments towards a more expansive and systemic approach that examines the structural social processes and conditions that pattern the health of populations and individuals (Marmot, 2005).

**Table 1-1 - Examples of Social Determinants of Health**

<table>
<thead>
<tr>
<th>Income</th>
<th>Culture</th>
</tr>
</thead>
<tbody>
<tr>
<td>Education</td>
<td>Health Services</td>
</tr>
<tr>
<td>Employment</td>
<td>Social Status and Supports</td>
</tr>
<tr>
<td>Gender</td>
<td>Literacy</td>
</tr>
</tbody>
</table>

(Government of Canada, 2011)

Current day health geography encompasses a wide variety of research topics, theoretical approaches, and methods exploring the relationships between health and place. Shifting population health burdens ensure that medical geography’s epidemiologic and environmental determinants foci remain core research concerns. Studies of chronic diseases and some of their key behavioural and structural influences such as smoking, neighbourhood walkability, and nutrition environments are well represented in health geography today (Leslie et al., 2007; Pearce, Barnett, & Moon, 2012; Walker, Keane, & Burke, 2010). Similarly, analyses of spatial access to health services using GIS methods persist as a major stream among health geographers, with added layers of complexity incorporated into models of access that work to account for issues such as temporal patterns, traffic networks, subjective or qualitative indicators, and differing capacities of care providers (e.g. Keddem et al., 2015; Lawson, Schuurman, Oliver, & Nathens, 2013;
Wang, 2012). In contrast to these recognizably ‘medical’ approaches to geographic analyses of health are now well-established qualitative traditions examining individuals’ lived experiences of health, illness, and treatment in relation to particular places and landscapes. Research examining the role of landscapes as therapeutic outlet or understanding confluences of place and meaning in care provision or the experience of ill health are recognizable research staples in health geography (Baker & Beagan, 2015; Gatrell, 2013; Herron & Skinner, 2012; M. Snyder & Wilson, 2015). Health geographers also examine social determinants of health as they are expressed in real-world contexts to better understand how they unfold and operate (T. Brown & Moon, 2012).

Having good access to quality health care is one of the most immediately recognizable social determinants of health. While other determinants such as income, housing, and education have greater influence on health status, they are not popularly identified as factors that shape health status in the same way that access to formalized medical care is (Bambra, Fox, & Scott-Samuel, 2005; Di Cesare et al., 2013; Marmot, 2005). An extension of this is that health services research and medical interventions (e.g., pharmaceutical development) remain the focus of health research funding (Baum, Bégin, Houweling, & Taylor, 2009; Organization, 2008, p. 186). It is thus not surprising that health service provision and planning is a major area of study within contemporary health geography, particularly as the composition and scope of health services regularly change in response to the ever-evolving intersection of patient demands, provider capacities, health worker training, and political-economic decisions about how to organize and deliver health care.

The health services research undertaken by health geographers is quite varied. Health geographers have, for example, examined the impacts on patients and their families as health care systems have shifted an increasing share of care delivery from formally trained care providers in clinical environments to informal volunteers providing care in the home and the community (e.g. Milligan, 2007; Skinner, 2008). Health geographers have also sought to better understand the experiences of health care providers and users in particular care settings, programs, or care practices (e.g. Andrews, 2002; Dyck, Kontos, Angus, & McKeever, 2005; Power, 2008) More widely, health geographers perform policy and program assessments of health care initiatives to
understand their impact on care delivery and program uptake (Giesbrecht, Crooks, Williams, & Hankivsky, 2012; Procter-Scherdtel & Collins, 2013; A. M. Williams, 2006). My dissertation directly contributes to this stream of health geography by examining the planning and perceptions surrounding medical tourism, the marketing and sale of medical care to foreign patients, in the Greater Caribbean region. I believe this provides a deeper understanding of why a wide array of countries are currently promoting medical tourism while contributing to the ongoing conversation about the health system and equity implications of medical tourism for countries becoming destinations for medical care.

1.2. Medical Tourism: Commodified Care for Export

Most broadly, medical tourism is the term used to refer to the phenomenon of patients traveling internationally to access medical care. Although it is a relatively new term that has grown in use over the past decade, individuals traveling long distances for treatment is a long established practice. Many authors parallel the contemporary travel of patients across national borders with historical accounts of ill people traveling great distances to seek relief from renowned healers, curative hot springs, and remote sanitaria (e.g. Carrera & Bridges, 2006; Connell, 2006). While there are underlying similarities between these practices and medical tourism, the most fundamental being the enormous demand to seek relief from sickness combined with ever-scarce local options for treatment, medical tourism has very different implications than these historically analogous examples.

Whereas historical examples of therapeutic travel occurred in the relative absence of a widely shared, systemized approach to medical knowledge and practice, let alone systemized means of financing, organizing, regulating, and delivering biomedical care, medical tourism has received the greatest amount of contemporary academic and media interest where health care systems are well developed (Hopkins, Labonté, Runnels, & Packer, 2010; Johnston, Crooks, Snyder, & Kingsbury, 2010). This is likely because medical tourism raises questions about the quality, relevance, and accessibility of health care systems as traveling patients draw once seemingly isolated systems in relation to one another. My dissertation examines a specific aspect of
medical tourism, and this introductory chapter provides an overview of the existing research trends and debates on medical tourism, paying particular attention to accounts of its contemporary development and health system impacts. Following this, I provide an overview of what is known about medical tourism development in the Caribbean, the region of focus in my dissertation. An outline of the structure of my dissertation and an orientation to each of its constituent analyses and their rationale concludes the chapter.

1.2.1. What is Medical Tourism?

There is ongoing terminological confusion and debate in the literature on international trade in health services that complicates discussion of medical tourism specifically (Connell, 2013a). For the purposes of this dissertation, medical tourism refers to the private purchase of non-emergency medical care by individuals outside of their domestic health care system. This narrow definition provides clarity by excluding other forms of health services export or medical travel, described below, that have been routinely conflated with what is here parsed out as medical tourism. The definition provided above highlights four key aspects that contrast with other instances of health services export, where medical tourism involves 1) accessing biomedical treatments, 2) is intentional and planned for by the patient, 3) involves patients traveling from their home country to the point of service to receive care, and 4) the care not being organized or supported by the patient’s domestic health care system or insurer. These aspects work to exclude four kinds of health services export that are have regularly been collapsed into the term medical tourism: the export of non-medical complementary and alternative treatments, emergency care sought by ill or injured travelers, routine care accessed by expatriates living abroad, and formalized cross-border referrals between health care systems (Connell, 2013a; Johnston et al., 2010).

While the examples of care outlined above are all forms of health services exports, each is defined from one another by a unique kind of patient profile in terms of the motivation driving the care-seeking behaviour and the institutional and regulatory supports they are connected to. Because medical tourists are not recipients of emergency care, though they are not excluded from requiring incidental emergency care while abroad, they typically plan their care prior to leaving their home country and seek
elective treatments (Crooks, Kingsbury, Snyder, & Johnston, 2010; Johnston, Crooks, & Snyder, 2012). As they navigate their own course of care abroad, medical tourists can be exposed to medical hazards they may not be aware of when they opt to receive care in health systems governed by weak or non-existent malpractice legislation, safety protocols, or professional regulation (Cohen, 2010; Turner, 2012). At a systemic level, there are concerns that patients traveling from countries that guarantee universal access to health care, such as Canada, are undermining their home health care systems by returning with follow up care needs that have not been planned for, or more abstractly, degrading a system’s solidarity by ‘jumping the queue’ and purchasing care privately in a manner prohibited domestically (Chen & Flood, 2013; Turner, 2007). These concerns have been highlighted by the growing visibility of patients traveling from high income countries with well-developed medical regulations and systems (and correspondingly higher costs of care) to less wealthy countries with weaker regulatory capacity in order to access more affordable, unapproved, or faster medical care (Connell, 2006; Snyder, Crooks, Johnston, & Kingsbury, 2011).

While I believe the concerns that have been raised about medical tourism are well-founded, the Northern/high-income global location where the majority of academics and commentators articulating them should be noted. The most visible and discussed concerns about medical tourism reflect the high-income contexts that have produced them and ignore the implications of much more established, and likely greater, movement of patients between low and middle income countries as they seek good quality, affordable medical care that is not locally available (Crush & Chikanda, 2015; Lautier, 2008; Ormond & Sulianti, 2014). For example, the earliest academic work on medical tourism using primary data came from the experiences of Yemeni medical tourists (Kangas, 2007), and more recently the Nigerian media regularly discuss the negative impacts of outbound medical tourists, and their money, on the domestic health care (Adaoyiche, 2016; Jimoh, 2015). These ‘South-South’ flows and their health equity and system implications are not nearly as well understood as the ‘North-South’ flows that have been publicized and discussed at greater length in the past decade (Crush & Chikanda, 2015; Kangas, 2011; Ormond & Sulianti, 2014). This lack of engagement with the full range of issues raised by medical tourism in the Global South is in part a reflection of the kinds of research that characterizes early work examining medical
tourism. With some exceptions (Kangas, 2007; Lautier, 2008; Sen Gupta, 2008), this early body of research and analysis almost exclusively consists of retrospective reviews of secondary data and theoretical discussions of the economic and health system impacts conducted by academics situated in the Global North (Hopkins et al., 2010; Johnston et al., 2010).

The flows of patients travelling between lower and middle income countries for health care have, in part, informed the ongoing terminological debate about appropriate language to use when discussing medical tourism. Kangas (2010) argues that the lack of local options that drives the international journeys of patients leaving weak and inadequate health care systems merits respectful consideration that the levity of medical tourism actively undermines, and as such has experimented with terms such as ‘medical pilgrims’ and ‘medical exiles’. Similarly, Milstein and Smith (2006) uses the term ‘medical refugee’ to capture the desperate, systemically liminal state of the under- and uninsured in the United States who, under financial duress, choose to travel to foreign hospitals with less expensive services in order to afford medically necessary care. Researchers who have directly consulted with medical tourists report that rest, relaxation, or adventure associated with recreational tourism play little to no role in the course of their journeys, suggesting that the ‘sun, sand, and stitches’ imagery that is regularly invoked in the popular media is a misnomer (Crush & Chikanda, 2015; Johnston et al., 2012; Kangas, 2010; Solomon, 2011). In contrast, others have demonstrated and argued that elements of recreational tourism such as relaxation, guest / host roles, and an openness to new activities while vacationing do play a role in structuring the motivations, expectations, and experiences of some medical tourists (Ackerman, 2010; Bell, Holliday, Jones, Probyn, & Taylor, 2011; Dangor, Hoogendoorn, & Moolla, 2015; Mazzaschi, 2011). Turner (2013) and Ormond (2015) have respectively adopted ‘transnational medical travel’ and ‘international medical travel’ to cast a wide, neutral net to describe the basic experience of all international patients, whereas the international trade literature strips out the human experience and distills patients’ travels and medical encounters to the language of service imports and exports (Johnson & Garman, 2010; Lautier, 2008; R. Smith, Martínez Álvarez, & Chanda, 2011).
Acknowledging the valid critiques and variants of the term ‘medical tourism’ above, while imperfect, I believe that medical tourism remains a useful term in exploring the phenomenon of individuals travelling to privately purchase medical care abroad. The utility of the term hinges on its 1) balanced specificity, 2) established use, and 3) emphasis on the patient-as-consumer frame that defines the practice from other kinds of health services trade. With regard to the specificity of medical tourism, terms such as ‘medical migrant’ and ‘medical refugee’ are very restrictive. Where medical tourism’s recreational connotations may inappropriately lighten the experiences of patients who travel internationally because they are desperately in need of care, ‘medical refugee’ is overwrought when describing cases of elective cosmetic, hip, and dental surgeries purchased abroad by middle class consumers who are not shut out of their domestic health systems (Connell, 2013a). In contrast, ‘international medical traveler’ is so general and relatively unused that it can describe the international movements of medical doctors and nurses as workers or voluntourists (e.g. overseas medical missions) as easily as patients seeking care. The utility of medical tourism as a term is also in part due to its now established use by English language media and policy circles. While the intentions behind adopting more austere or affective language to describe medical tourism are laudable, doing so arguably moves the constructive and critical discussion that has begun to emerge in response to its impacts away from the venues and audiences that most need to hear it in order to prevent or mitigate its potential harms.

The consumerist frame inherent in the notion of tourism is an asset in distinguishing medical tourism from the other forms of international trade in health services outlined earlier in this section. Whereas ‘cross-border care’ usefully distinguishes a mode of international care delivery that is mediated by health insurers or other institutional actors (Glonti et al., 2015; Groene et al., 2009), ‘medical tourism’ emphasizes the consumer demand that drives the pursuit of less expensive, experimental, or faster care by individuals. The inherent acknowledgement that ‘medical tourism’ refers to a consumer driven mode of care delivery and out-of-pocket financing can serve as a marker of the kinds of anticipated health system impacts associated with laissez-faire health systems. These impacts are widely understood to be diminishing health returns for each consumer-dollar spent on health services and inequitable differences in care quality depending on individuals’ abilities to pay (Hsiao, 2007; Yu,
These system impacts are mitigated and mediated in equitable and efficient health systems through regulation and legislation that produce collective risk-pooling, resource-sharing, and limit over-treatment by physicians and excessive care-seeking by patients in order to effectively improve a population’s health outcomes (Hsiao, 2007; Yu et al., 2008). At the same time, the queues, higher costs, and restrictions on experimental care that can result from close regulation of health services financing and provision are the very systemic elements that medical tourism seeks to circumvent.

For the reasons outlined above, of specificity, established use, and conceptual clarity regarding commodified, consumer driven care, I will use ‘medical tourism’ throughout this dissertation instead of the other variants that have been discussed, acknowledging the ongoing academic discussion of its limitations and alternative nomenclature.

1.2.2. Medical Tourism Matters

While people traveling to seek healing is not new, the idea of medical tourism as a specifically novel form of care delivery is. It has been noted in accounts of Cuba’s and Thailand’s relatively early experiences developing their medical tourism sectors that their respective turns towards the international market were initially spurred by economic crises. In Cuba’s case, the sudden loss of economic support from the collapse of the Soviet Union compelled the country to leverage its well-established medical expertise internationally for much needed income (Ramírez de Arellano, 2011). For Thailand and the wider Southeast Asian region, the 1997 Financial Crisis sharply reduced local demand for private medical care that had grown rapidly in the preceding economic boom and motivated some private Thai hospitals to market their services outside of the region (MacReady, 2007; Ormond, 2011). The resulting flows of patients traveling from wealthy countries to hospitals located in middle-income countries was unprecedented, spawning both worldwide media attention and similar marketing initiatives by hospitals and governments in countries such as India, Costa Rica, and Malaysia (Leng, 2010; Ormond, 2011; Ramírez de Arellano, 2011). What attracted much of the initial interest in medical tourism from media outlets, closely followed by scholarly consideration of their
accounts, was the novelty of hospitals in low and middle income countries receiving international patients who were purposely choosing to travel from their high income homes for a technologically demanding service like medical care (Crooks et al., 2010). This initial bout of attention produced two dominant and competing narratives about the phenomenon that persist today (see Table 1-2).

Table 1-2 – Article Titles Characteristic of Competing Medical Tourism ‘Narratives’

<table>
<thead>
<tr>
<th>Medical Tourism as Economic Development</th>
<th>Medical Tourism as Source of Health Inequity</th>
</tr>
</thead>
<tbody>
<tr>
<td>'Radiation vacation’ and other medical tourism contribute estimated $23M to Jacksonville economy (1)</td>
<td>A new inequality? Privatisation, urban bias, migration and medical tourism (6)</td>
</tr>
<tr>
<td>Turkey sees golden egg in medical tourism, stability remains key (2)</td>
<td>Medical tourism: reverse subsidy for the elite (7)</td>
</tr>
<tr>
<td>Medical Tourism: the ultimate outsourcing (3)</td>
<td>Medicare advocates decry medical tourism (8)</td>
</tr>
<tr>
<td>A Nip and Tuck with a Safari on the Side (4)</td>
<td>Medical Tourism: Revenue Generation or International Transfer of Healthcare Problems? (9)</td>
</tr>
<tr>
<td>Apollo-hospitals—first-world health care at emerging-market prices (5)</td>
<td>Medical travel and the sale of human biological materials: Suggestions for ethical policy development (10)</td>
</tr>
</tbody>
</table>


The first narrative is defined by its focus on ‘sun, sand, and stitches’ and is regularly found in the business and tourism literature, reports by consulting firms, and the media. This narrative emphasizes medical tourism as a new route for economic diversification and development for low and middle income countries, typically citing reports that characterize the existing demand for medical tourism in the Global North as large, enormously valuable, and poised for steady long-term growth (Ehrbeck, Guevera, & Mango, 2008; Hume & Demicco, 2007; Mudur, 2004). Medical tourism is discussed as a source of infrastructure investment, foreign exchange, and high-skill employment and a means to prevent health worker emigration (Herrick, 2007; Hopkins et al., 2010; Lautier, 2008). The validity of this narrative is undermined by poor quality evidence to
support the notion of a large number of medical tourists worldwide capable of supporting the scale of medical tourism that it envisions (Connell, 2013a; Lunt, Jin, Horsfall, & Hanefeld, 2014). This lack of evidence results from a combination of widespread inconsistencies in definitions of what constitutes medical tourism and poor to non-existent surveillance of traveling patients by governments and hospitals (Connell, 2013a; Lunt et al., 2014). However, the core point of the ‘sun, sand, and stitches’ narrative, that medical care can be successfully exported from low and middle income countries, has been demonstrated by numerous well-publicized clinics and hospitals such as Bumrungrad Hospital in Thailand and the Apollo hospital chain in India (Connell, 2006; Oberholzer-Gee et al., 2007). This has resulted in the notion that medical tourism is a potential economic goldmine being picked up by many hospitals, consultants, and policy-makers worldwide over the past decade, producing a wave of marketing and economic development initiatives by numerous countries working to export their hospital services (Connell, 2013a; Hopkins et al., 2010; Leng, 2010).

The second narrative that has developed around medical tourism has predominately focused on the health equity implications raised by the issue of international patients from high income countries using the limited health resources of low and middle income countries (Hopkins et al., 2010; Johnston et al., 2010; Ormond & Sulianti, 2014). Health equity is a bioethical concept used to critically assess inequalities within populations or between individuals, particularly regarding access to health resources and burdens of harms and risks. Whereas ‘health inequalities’ describe objectively observable differences between subjects, ‘health inequities’ refer to subjective assessments of the (un)fairness and (in)justice of differing distributions of health resources and burdens among populations and the legal, cultural, and economic social structures that produce them (Braveman et al., 2011). Marmot (2007, pg. 1154) succinctly describes the essence of health equity in stating “Where inequalities in health are avoidable, yet are not avoided, they are inequitable.” There has been a great deal of

1 A key element of health equity is its focus on (sub)-populations that are most disadvantaged by existing social and economic structures and thereby facing the greatest burden of ill-health and disease (Braveman, 2011). This provides a core rationale for the emphasis of contemporary global health research on health issues that are relevant to low and middle income countries as their populations are most exposed to the compounding negative impacts of global economic and social inequalities.
critical discussion about medical tourism’s negative health equity implications; its commodification of health care, role in supporting ethically fraught and/or illegal medical markets such as the surrogacy and organ trades, impacts on the public-private distribution of human resources, incentivizing medically inefficient but commercially profitable investments, and the legal and safety implications of traveling internationally for medical care (Chen & Flood, 2013; Cohen, 2010; Turner, 2007). As noted in the previous section, while these critiques have highlighted the many potential pitfalls of medical tourism, they have arguably been addressing only one narrow range of health equity issues raised by the most visible but what are now generally agreed among scholars to be some of the least common flows of patients, those from the Global North to the Global South (Crush & Chikanda, 2015; Lunt et al., 2014; Ormond & Sulianti, 2014). This has been at the expense of ignoring the implications raised by patients traveling between low and middle income countries for care.

Fundamentally, the narrative of medical tourism as a source of health inequity has consistently failed to appropriately situate and scale medical tourism’s likely and realized impacts within the existing health systems and patient migrations that actually constitute the practice. This has arguably resulted in part from the reliance of early work on secondary data sources from industry consultants and the media that focused on the most sensational and successful examples of medical tourism (Johnston et al., 2010). Because of this, scholars have insufficiently articulated what is uniquely inequitable about medical tourism when it is primarily occurring in established private hospitals, facilities that already do not serve the majority of the local population, as a small international extension of domestic private medicine while most often treating patients from other countries with weak health systems (The Economist, 2008). That is, early critical work on medical tourism commonly failed to distinguish if and/or how the phenomenon is a symptom of or a contributor to inequitable health systems and conceptualize what kind of role, if any, trade in health services can serve to reduce health inequities within and between countries. This is a knowledge gap that my dissertation research explicitly addresses by consulting with local stakeholders in countries with governments and hospitals that are trying to position themselves as up-and-coming destinations for medical care about their beliefs and perceptions regarding health equity in relation to medical tourism.
As has already been briefly noted, the early scholarly research that produced the two narratives summarized above was almost exclusively composed of retrospective accounts of established medical tourism destinations and drawn from secondary sources of data (Crooks et al., 2010; Hopkins et al., 2010). Recent qualitative studies have begun to address the limitations of this approach by examining primary data from real world examples of medical tourism (Crush & Chikanda, 2015; Johnston et al., 2012; Lee, Kearns, & Friesen, 2010; Noree, Hanefeld, & Smith, 2016; Ormond, 2011; Whitmore, Crooks, & Snyder, 2015). This work provides a more nuanced characterization of the patients that choose to travel internationally for care and the implications of their journeys for participating health systems.

Crush and Chikanda (2015) provide a rich account of health service exports in South Africa. Their work takes care to distinguish three modes of medical travel in examining the scale of patient flows to the country, separating both 1) North-South from South-South medical tourists and 2) between medical tourists paying out of pocket, cross-border patients referred and financially supported by the health system of their home country, and the “medically disenfranchised” from neighbouring countries utilizing services in public clinics in South Africa’s border regions (Crush & Chikanda, 2015). By doing so, they demonstrate that North-South medical tourists represent a small share of the total number of medical travelers to South Africa where the majority of health service exports are derived from treating African patients lacking access to the same care locally (Crush & Chikanda, 2015). Their work demonstrates that South Africa is playing a critical role in providing health services to regionally proximate populations both via cross-border care arrangements and un-mediated medical tourism and that exports to the Global North are likely of less importance to the functioning of the health system and public health measures than South-South medical tourism.

Ormond’s (2013b) research in Malaysia highlights the relevance of approaching medical tourism as a kind of ‘complementarity of care’ within regions or among cultural communities. Her work suggests that medical tourism in middle-income settings is not primarily an issue of scarce medical resources being appropriated by wealthy outsiders, instead demonstrating how health services in Malaysia are largely exported to neighbouring Singapore and Sumatra (but also extending to wider Indonesia and the
Middle East) to patients from a range of economic backgrounds seeking treatments that incorporate Islamic traditions, care that is not available or is too expensive at home (Ormond, 2013b). Her case study of medical tourism in Malaysia documents an existing transnational health care system of trade and referral among proximate care providers and populations balancing their needs for affordable and good quality care as they move between them.

In a related vein to Ormond (2013b) and Crush and Chikanda’s (work discussed above, Lunt et al.’s (2014) analysis of South Korean health service exports shows that medical tourists accessing the hospitals they studied are predominantly South Korean emigrants and those with existing ties to the country. This is also explored by Lee et al. (2010) in their study of Korean New Zealanders’ usage of health services in Korea and the affective elements that motivate them to do so. This work further indicates that medical tourists are not dispassionate, atomized consumers assessing their global options for care online, but instead often possess strong social or cultural connections to the countries they seek care from. Echoing this are accounts from some Canadian physicians that the most significant outflows of patients they see are among newcomer populations accessing care in visits to their countries of origin (Johnston, Crooks, Snyder, & Dharamsi, 2013). These studies muddy the stark image of the medical tourist as a disconnected foreigner unjustly appropriating scarce domestic health resources, instead highlighting the personal connections and contingency that drive many individuals’ decisions to travel internationally for medical care. These additional considerations emerging from recent studies that examine medical tourism empirically, often using specific countries as case studies, with primary data confirm the value of the approach in more richly conceptualizing medical tourism and accurately understanding its implications for health systems and their users.
1.2.3. Medical Tourism in the Caribbean

The subject of medical tourism has generated a great deal of interest among governments and hospitals in the Greater Caribbean region\(^2\), including both countries in the Caribbean Archipelago and continental countries bordering the Caribbean Sea, over the past decade. With the exception of Cuba, Costa Rica, and the Dominican Republic, the current inflow of medical tourists in the Caribbean is believed to be negligible (Connell, 2013b; Ramírez de Arellano, 2011). However, the governments of the three largest Anglophone Caribbean island nations, Barbados, Jamaica, and Trinidad and Tobago, have all announced their intentions to become medical tourism destinations, as have many of their smaller island counterparts (Adams, Whitmore, Johnston, & Crooks, 2015; Connell, 2013b). Demonstrating the swell of contemporary interest in the sector, a new private hospital built to primarily serve medical tourists opened in the Cayman Islands in 2014 and the Bahamas signed a deal with foreign investors in 2013 to develop a new clinic oriented to exporting experimental stem-cell treatments to foreign patients (Caribbean Journal, 2014; Maycock, 2015). Similarly, private hospitals and national governments throughout the Greater Caribbean, such as Guatemala and Belize, have both formed national medical tourism associations to coordinate public and private sector planning and promotion for medical exports (AGEXPORT, 2013; S. Williams, 2013).

The enthusiasm among Caribbean governments in developing medical tourism appears to be driven by a shared intention to diversify their common economic dependence on recreational tourism. At a regional level, tourism contributed 15% of the total regional gross domestic product in 2014 (World Travel & Tourism Council, 2015c). This measure captures both the direct and indirect economic impacts of the sector. At the level of individual countries, the total contribution of tourism can be enormous. For example, the total economic contribution of the 2014 tourism sector to the gross

---

\(^2\) This dissertation predominately focuses on the cases of Barbados and Jamaica, two Anglophone small island states in the Caribbean. However, the fifth chapter also draws on primary data collected in Mexico and Guatemala, two Latin American countries that border the Caribbean Sea. Acknowledging the indeterminacy and limitations of regional categories (Agniew, 2013; Harrison, 2013), the 'Caribbean' is used here to capture the shared organizational and economic ties among the proximate countries studied both in relation to one another and their shared primary target market for medical exports, the United States.
domestic products (GDPs) of Jamaica, Barbados, and Belize has been estimated at 27%, 36%, and 39% respectively (World Travel & Tourism Council, 2015a, 2015b, 2015d). This reliance on tourism has the effect of amplifying the impacts of global economic perturbations within the Caribbean, as the number of tourist visits closely reflects economic health elsewhere (McElroy & de Alburyquerque, 2002). Responding to this, Caribbean countries and regional bodies such as the Caribbean Community (CARICOM) have identified diversification of their tourism sectors and an expansion of service exports as viable routes for economic growth and development (Boxill, 2004; Connell, 2013b; Girvan, 2006).

Despite the widespread interest among Caribbean governments in exporting their health services, there has been little empirical research into the issue to date. The extent of research into the topic thus far consists of two review articles of medical tourism in the Caribbean (Connell, 2013b; Ramírez de Arellano, 2011) and two articles on medical tourism in Costa Rica, one a cursory review and the other an ethnographic case study of the cosmetic tourism industry (Ackerman, 2010; Warf, 2010). My dissertation examines the activities and perspectives that are informing the development of medical tourism in four Caribbean countries. Three of the four core chapters focus mainly on data collected in Barbados and Jamaica, with the fourth including analysis of primary data from Guatemala and Mexico as well as Barbados. This array of primary data sources provides insight into a range of existing experiences with health services export and different existing health system capacities and offers a comprehensive prospective account of medical tourism development that is relevant to the Greater Caribbean region. For example, I provide evidence that the development of medical tourism is being greatly informed by Caribbean countries’ existing experiences with recreational tourism, particularly among development stakeholders without ties to the medical community. This shared experience is informing and framing the terms of regional interest in developing exporting health services, with medical tourism commonly conceptualized as a niche extension of the region’s huge recreational tourism sector.

My dissertation shows how the notion of ‘medical tourism’ is being used to describe and develop a range of different services and export formats not seen elsewhere. For example, there is differing emphasis among Caribbean stakeholders on
the services described by medical tourism, some envisioning non-intensive complementary and wellness therapies, others surgeries and biomedical treatments, and some even to describe long-term supported living complexes. This demonstrates that the definitional inconsistency plaguing ‘medical tourism’ is being deployed by differently situated stakeholders in order to liberalize and export a full range of services related to health. This variability demonstrates the value of qualitative research in understanding the full scope of potential impacts that current planning for medical tourism poses for Caribbean countries and their transferability to other contexts worldwide.

1.3. Dissertation Rationale and Structure

My dissertation contributes to the existing scholarly work on medical tourism by addressing three research objectives drawn from both of the medical tourism ‘narratives’ outlined above. Firstly, this dissertation seeks to better understand the contextual factors and processes that are prospectively driving interest in medical tourism among Caribbean governments and care providers using primary qualitative data. This will help address both the retrospective selection bias present in the earlier literature on medical tourism that has only studied the developmental experiences of successful (i.e. viable and established) destinations and the relative dearth of work using primary data to examine the issue. This approach can articulate some of the wider implications of medical tourism, particularly in regard to the precursors and impacts of development efforts that may prove to be unsuccessful in increasing health service exports. Secondly, this dissertation seeks to better understand how medical tourism and the challenges and benefits it poses are understood by both ‘expert’ and ‘non-expert’ stakeholders of countries seeking to become destinations for health care. Meeting both of the objectives above will allow me to address my third research objective, to explore the relevance of and broaden the existing discussion of the health equity issues surrounding medical tourism by examining the issue in a context where it is under-researched, directly consulting a wide range of local stakeholders, both ‘expert’ and non-‘expert’, and using a prospective research vantage.

The research objectives posed above will support my dissertation project in addressing three key knowledge gaps. First, the interest in developing medical tourism
in the Caribbean departs from earlier accounts of the phenomenon. Whereas medical tourism has previously been a niche sector spun off of existing medical facilities seeking to increase their numbers of privately paying patients by tapping into the international market, numerous medical tourism projects in the Caribbean have been conceived and planned for development from the ground up primarily with the international market in mind. There are no existing accounts that capture the dynamics driving this approach to medical tourism development and the unique implications of this strategy for economies and health systems that pursue it. Related to this, there is a wide disregard in the existing literature for the numerous variations in the structure of health services export in terms of financing, delivery, and regulation, all of which are concealed by the umbrella term of ‘medical tourism’. Thus, my project seeks to provide an account of the specific format of medical tourism envisioned in the Caribbean context in order to contribute to ongoing debates of how medical tourism can impact the operations of the specific elements that comprise health systems.

Secondly, in contrast to other existing academic accounts of medical tourism development and operation, all of which are retrospective examinations of established industries, the Caribbean cases examined in this dissertation provide an opportunity to explore the development of nascent medical tourism sectors and the factors driving their development. Thirdly, this research both develops and responds to more recent empirical research into medical tourism by providing a detailed case study of the factors and professional networks driving the interest in medical tourism in the Caribbean, including how this development is understood by local stakeholders not directly involved in sector planning. This work will provide another point of comparison and contrast for the other existing qualitative empirical accounts of medical tourism development and practice that have been produced in other contexts. While the findings of my research project are not generalizable (i.e. universally applicable to other contexts at early stages of promoting or developing their health services for export), they are widely relevant in their transferability (i.e. analogous conditions, factors, and processes and the
subsequent issues arising from them may be identified elsewhere) to other locations at all stages of medical tourism sector development.

This dissertation uses a ‘sandwich style’ structure. It is composed of three published and one publication-ready standalone papers that share an introduction and conclusion. The ‘sandwich’ approach has been used to provide concise analyses, to improve their uptake among relevant stakeholders, and because it is most in-line with current disciplinary expectations in health services research. Three brief transitional chapters are between each of the analytic chapters. These transitional chapters situate the analyses in relation to other concurrent research projects that informed them and within larger theoretical questions and contextual issues. They provide additional information to interpret each analysis. Brief overviews of the four core analytic papers and the conclusion (Chapters 2, 4, 6, 8, and 10) are provided below.

1.3.1. Chapter 2: "The major forces that need to back medical tourism were...in alignment": Driving Development of the Medical Tourism Sector in Barbados

This chapter draws from primary interview data collected in Barbados on the topic of medical tourism. This trip was the earliest round of fieldwork on the topic and was led by Dr. Jeremy Snyder from the Faculty of Health Sciences at Simon Fraser University and involved myself and my supervisor, Dr. Valorie Crooks. The data collection was prompted by interviews with Canadian medical tourism facilitators (i.e. specialized travel agents) that revealed existing flows of Canadians to Barbados for medical care. While the interviews and site visits conducted in this trip revealed very modest existing inflows of patients, the timing of the research trip serendipitously coincided with that of an American hospital group signing a lease with the Barbadian

---

3 Generalizability and transferability are concepts that describe the relevance of research findings outside of the original settings where they are generated and speak to the methodologies used to produce them. Typically, generalizable findings are produced using positivist experimental methods with a range of measurable variables taken into account and their wider applicability vouched by the researchers (i.e. the producers) of the knowledge (Golafshani, 2003). In contrast, the transferability of findings is gauged by the users of knowledge, typically produced using qualitative methodologies, who assess and articulate the particular relevance of findings outside of the contexts where they were originally identified (Toma, 2011).
government for a piece of publicly owned land that would serve as the foundation of mid-size, 100 bed hospital primarily oriented towards exporting its services to American medical tourists. In addition to this, the interviews with Barbadian health and tourism sector stakeholders indicated a serious and active interest across both the public and private sector to further develop policies and projects that would create a much larger medical tourism sector in the country.

The analysis in this chapter draws on the transcripts of 19 semi-structured interviews with stakeholders from Barbados’ health, tourism, and international trade sectors conducted in May, 2011. It situates the positions and relationships of the key ‘champions’ of medical tourism in Barbados, both in terms of professional networks and location of practice, in order to better understand why medical tourism projects and policies are being implemented and how they are being advanced. Complementing this is an account of the various health system ‘actors’ who, while critically relevant in informing the perceptions of champions that are driving the development of the sector or in their being impacted by its growth, have not been directly consulted or incorporated into planning activities.

This analysis builds upon current accounts of why medical tourism is pursued as an avenue for economic and health system development from broad and simplistic structural and economic rationales by identifying the sector’s participants and their particular motivations, outlooks, and relationships. I believe that doing so assists in understanding the professional and epistemic dynamics that are driving the development of medical tourism in Barbados. This better understanding can help articulate the factors that are unique to Barbados as well as identify relevant international networks or actors that may be active in stoking interest in the sector or informing its development elsewhere. This paper was published in the peer-reviewed *International Journal of Health Services* in 2015.
1.3.2. Chapter 4: “Best care on home ground” versus “elitist healthcare”: concerns and competing expectations for medical tourism development in Barbados

As noted in this introductory chapter, the conversation surrounding medical tourism has raised a consistent set of benefits and concerns that the practice poses to health systems and their users. One particular subset of issues regard the impacts medical tourism may have on local patients and workers in destination countries in terms of the affordability of health care and the availability of medical labour within the health system. The existing conceptual reasoning for both the positive and negative impacts for local patients and their health system are sound and not incompatible. These conceptualizations have not, however, directly engaged actual workers or users of health systems where medical tourism is being promoted to situate or further develop these conceptualized impacts. My analysis begins to address this existing knowledge gap by engaging with Barbadian citizens and health workers to better understand their perceptions of medical tourism, the impacts associated with it, and how, if at all, they wish to see medical tourism developed in their country.

This chapter examines data from two focus groups held in Barbados in May, 2013, one with users of the local public health system and the second with nurses working in the public health system. I led the design and execution of these focus groups, with key support for the project provided by Krystyna Adams, my lab-mate who is a PhD student in Simon Fraser University’s Faculty of Health Sciences and Lisa Bishop, a recent Master’s in Public Health graduate from the University of the West Indies’ Cave Hill campus in Barbados. These focus groups recruited a total of 16 participants, with seven attending the nurses’ focus group and nine the system-user focus group. Working from verbatim transcripts of the focus groups, all of the conversations were qualitatively coded using NVivo 10 (QSR International, 2012) by both Ms. Adams and myself using a triangulated approach.

This analysis seeks to complicate the simple and reductive narratives of economic progress versus declining health system accessibility that dominate discussions of the benefits and harms of medical tourism. The discussions in the focus groups, while by no means representative, both challenge and verify the elements of
conceptualizing medical tourism as the appropriation of scarce health resources by relatively wealthy foreigners in the countries they visit for care. Participants in both focus groups articulated a number of common conditions, norms, expectations, and concerns about medical tourism that emerge from the intersection of Barbados’ existing geographical, economic, and health system arrangements. This analysis works to provide an account of the issues raised by participants and analyse the common themes that emerged from the focus groups. Doing so constructively contributes to the ongoing conversation about the relationship between medical tourism and health equity in a manner that is relevant to health systems users and planners. This paper was published in the peer-reviewed *International Journal for Equity in Health* in 2015.

1.3.3. **Chapter 6: Policy Implications of Medical Tourism Development in Destination Countries: Revisiting and Revising an Existing Framework by Examining the Case of Jamaica**

   Media and academic discussions of medical tourism include examples from medical facilities in countries all over the world, but a primary focus has been on hospitals in Asian countries where medical tourism has become established and very visible. Hospital brands such as Bumrungrad, Raffles, Apollo, and Parkway, located in Thailand, Malaysia, India, and Singapore are the most regularly cited cases of established medical tourism destinations in both the popular and academic literature (e.g. Connell, 2006; Oberholzer-Gee et al., 2007; Turner, 2007). This well-established regional concentration of medical tourism has understandably invited examination and a number of empirical studies have emerged in recent years from this context.

   Pocock and Phua’s (2011) paper in *Globalization & Health* is one example from the body of literature examining medical tourism in Southeast Asia. Drawing its analysis from issues relating to medical tourism in Malaysia, Thailand, and Singapore, it is distinct as an effort to produce a generalized framework that organizes the effects of medical tourism on national health systems. My chapter explores the applicability and usefulness of Pocock and Phua’s (2011) framework outside of the context from which it was derived by applying it to the planning efforts in a Caribbean country. This analysis uses qualitative interview and observational data collected during two separate research trips.
to Jamaica, the first in October 2012 and then another in June 2013. This data comprises daily journal entries, site visits to established and proposed medical facilities, and 18 interviews with health system, tourism, and trade development stakeholders. This analysis prioritizes including a breadth of sources and identifying framework-relevant instances over identifying emergent themes and thus does not employ qualitative coding schemes for comprehensive categorization. Instead, the data have been examined by the three authors of the paper (myself, Dr. Valorie Crooks, and Dr. Meghann Ormond from Wageningen University, Netherlands), using Pocock & Phua’s (2011) framework as a guide for each reviewer to highlight issues that converge or diverge from the core impacts highlighted in their model.

This analysis explores the strengths and limitations and potential transferability of Pocock & Phua’s framework by employing it in a different geographic context than where it was derived. Doing so assists in further articulating elements of the framework that are most and least useful in explaining specific health system reforms and redirections that are spurred by medical tourism. This paper was published in the peer-reviewed journal *Globalization & Health* in 2015.

### 1.3.4. Chapter 8: Inbound Medical Tourism in Latin America and the Caribbean: Factors Driving and Inhibiting Sector Development in Mexico, Guatemala, and Barbados

This chapter uses data from a multi-country study led by my supervisor, Dr. Valorie Crooks, examining the health equity impacts of medical tourism development in Mexico, Guatemala, and Barbados. The dataset compiled in the course of the study is extremely large and, by employing a shared set of methodological protocols in all three study sites and numerous researchers examining the data and triangulating their perspectives, rigorously compiled by qualitative methodological standards. The dataset comprises 150 thirty to sixty minute interviews with health, trade, and civil society stakeholders from both the public and private sectors that were conducted by local researchers affiliated with the study in Mexico and Guatemala between 2012 and 2013, and myself, Dr. Crooks, and Dr. Jeremy Snyder in Barbados in the summer of 2012. These interviews examined the potential and realized health equity impacts across the
domains of health human resources, public health care, private health care, civil society, and investment.

This analysis used NVivo 10 (QSR International, 2012) to manage the dataset in order to facilitate coding and thematic analysis. It identifies the shared 'drivers' of and 'inhibitors' to developing medical tourism in Latin America and the Caribbean in order to conceptualize why and how medical tourism is being so widely pursued at this time in the region. By comparing and contrasting this regional conceptualization with the predominant developmental narratives about medical tourism created elsewhere, this analysis assists in articulating the specific, cross-cutting health equity implications of sector development in Latin America and the Caribbean and identifies additional considerations that are likely more widely transferable. This chapter was submitted to the Bulletin of the World Health Organization in November, 2015 and is currently under review.

1.3.5. Chapter 9: Conclusion

The concluding chapter revisits my dissertation’s three broad research objectives and uses them to structure a review of the key findings from the four analyses, particularly those that thematically cut across all of them. This approach unpacks and examines each of these issues both in relation to existing literature on medical tourism development and its impacts and existing health-systems frameworks that have been developed from (sub-)national contexts. I distinguish how medical tourism as a development strategy simultaneously serves a range of distinct and somewhat disconnected roles among its various stakeholders; as an antidote to chronic resource limitations among health workers and administrators, a means to attract foreign investment and exchange for public investment promotion corporations, and a tourism diversification strategy among traditional recreational tourism stakeholders. The health equity implications of these various interpretations of the broad concept of 'medical tourism' are explored and situated within situated within the existing literatures on medical tourism and health systems policy.
By approaching medical tourism and the issues it raises from a health-systems framework and utilizing primary data describing the early efforts by Caribbean governments, hospitals, and investors to develop medical tourism, my concluding chapter helps move critical discussions of medical tourism away from generalized and poorly defined accounts of the impacts of international patient flows towards identifying the specific health system elements that distinguish medical tourism and its health equity implications from other, more equitable, efficient, and effective arrangements for international trade in health services, arrangements that could benefit small and/or chronically under-resourced health systems such as those found throughout the Greater Caribbean and elsewhere.
Chapter 2. “The major forces that need to back medical tourism were...in alignment”: Championing Development of Barbados’ Medical Tourism Sector*

2.1. Abstract:

Governments around the world have expressed interest in developing local medical tourism sectors, framing the industry as an opportunity for economic growth and health system improvement. This article addresses questions about how the desire to develop a medical tourism sector in a country emerges and which stakeholders are involved in both creating momentum and informing its progress. Presenting a thematic analysis of 19 key informant interviews conducted with domestic and international stakeholders in Barbados’ medical tourism sector in 2011, we examine the roles that ‘actors’ and ‘champions’ at home and abroad have played in the sector’s development. Physicians and the Barbadian government, along with international investors, the Medical Tourism Association and development agencies have promoted the industry, while actors such as medical tourists and international hospital accreditation companies are passively framing the terms of how medical tourism is unfolding in Barbados. Within this context we seek to better understand the roles and relationships of various actors

*This chapter has been published as: Johnston, R., Crooks, V.A., Snyder, J., Whitmore, R. (2015). "The major forces that need to back medical tourism were...in alignment": Championing Development of Barbados’ Medical Tourism Sector. International Journal of Health Services, 45(2): 334-352.
and champions implicated in the development of medical tourism in order to provide a more nuanced understanding of how the sector is emerging in Barbados and elsewhere and how its development might impact equitable health system development.

### 2.2. Introduction

In the past decade, national governments around the world have expressed interest in cultivating medical tourism sectors (Connell, 2013a; Lunt & Carrera, 2010). Here we refer to medical tourism as involving the intentional pursuit of privately financed medical care outside a patient’s country of residence. Framed as an opportunity for both economic growth and health system improvement, marketing treatment to privately-paying international patients is done in an increasing number of hospitals and health systems worldwide (Connell, 2013a; Pocock & Phua, 2011). Industry newsletters such as the International Medical Travel Journal (www.imtj.com) and Medical Tourism Magazine (www.medicaltourismmag.com) regularly publish profiles of new regions, countries, or cities looking to enter this multi-billion-dollar global industry, demonstrating a desire among governments and trade groups to get into an industry that is perceived to be rapidly growing.

In this article we aim to explore how initiatives to develop medical tourism emerge in new locations by examining the sector in Barbados. By identifying stakeholders who have been actively creating and sustaining interest in the sector, we articulate how medical tourism has been championed as a viable economic and health system improvement strategy. We additionally seek to identify numerous ‘actors’ who are passively implicated in the planning and considerations informing medical tourism’s growth.

This analysis contributes to the small but growing body of literature that explores how medical tourism and the policies supporting the sector emerges in different contexts (e.g., (Heung, Kucukusta, & Song, 2011; Leng, 2010; Ormond, 2013b; Pocock & Phua, 2011; Ramírez de Arellano, 2011). Health care experts have raised many concerns about the potential for medical tourism to undermine health equity of health systems, all of which have been discussed at length elsewhere (e.g. (Connell, 2011; NaRanong &
NaRanong, 2011; Turner, 2007). Though in this article we are not focused on the health equity impacts of Barbados’ developing medical tourism sector per se, we believe that the insights gleaned from examining the stakeholders, both active and passive, involved in driving and informing its development can help identify parties that have a role to play in mitigating negative health equity outcomes and enhancing positive ones. We contend that the structure of these connections has implications for equitable and accountable policy development in internationalizing health systems.

On Barbados: Brief background context

Barbados is an English-speaking, high-income small island nation located in the Eastern Caribbean, with a population of approximately 280,000 (World Bank, 2014). The country is reliant on trade in services, with tourism and offshore financial services being the economy’s largest export sectors (Ministry of Finance and Economic Affairs, 2012). As a small island state dependent on income from recreational tourism, one of Barbados’ greatest economic challenges is its heightened sensitivity to global economic cycles (Ministry of Finance and Economic Affairs, 2012). In light of this, the Barbadian government has identified a larger medical tourism sector as one avenue through which the country can diversify its economy and strengthen its health system (Barbados Advocate, 2009, 2012).

Barbados has a well-established public health care system that provides citizens universal access to medical services, including complex tertiary care. A range of private primary and secondary health care is also available, but tertiary care is only provided at the public Queen Elizabeth Hospital (Pan American Health Organization, 2008). Physicians practicing at this hospital have private admitting privileges, which has contributed to its established history of participating in regional transnational care by admitting privately-paying patients from elsewhere in the Eastern Caribbean (Walters, Fraser, & Alleyne, 1993). While private health care spending has increased over the past decade, reaching 35% of the total spending on health services in the country as of 2008, public spending by the Barbadian government remains dominant in the country (Pan American Health Organization, 2008).
Barbados’ medical tourism sector is currently very small. Beginning in 2000, medical tourists have been identified as a target market by three small, private specialty clinics, two of whom are still operating. These operational clinics are the Sparman Clinic, a cardiac care provider, and the Barbados Fertility Centre, a fertility specialty centre. This latter facility is the figurehead of the current sector, having been the most successful in recruiting medical tourists into its patient base (Snyder, Crooks, Turner, & Johnston, 2013). There have also been numerous attempts by individual physicians and investors in the past decade to develop larger medical facilities incorporating medical tourism, all of which were ultimately not realized (Johnston, Crooks, Snyder, Fraser, et al., 2013). A common element to all of these ventures, regardless of their success or scope, is that medical tourism has been viewed by care providers as a mechanism for supporting their facilities beyond the small Barbadian population rather than the sole focus of their operations (Johnston, Crooks, Snyder, Fraser, et al., 2013).

In contrast to the early development efforts described above, the national government has recently begun a concerted push to attract more medical tourists and develop new health service exporters (e.g., Atwell, 2009; Barbados Advocate, 2009; Geralyn, 2008). Barbados’ national foreign investment promotion corporation, Invest Barbados, has attended numerous international industry conferences organized by the Medical Tourism Association along with local healthcare providers. Policy makers also participated in a planning and promotion workshop for medical tourism in 2008, co-sponsored by the Canadian International Development Agency (CIDA) and the Caribbean Export Development Agency (CEDA), in which planning exercises to promote medical tourism alongside health and wellness tourism more broadly were undertaken (Caribbean Export Development Agency, 2008). These planning and networking events were followed by the national government awarding the lease of St. Joseph Hospital, a long derelict publicly owned facility, to American World Clinics in 2011. This company plans to open an 85 bed hospital in 2015 that will employ a rotating roster of visiting American physicians and primarily serve medical tourists (American World Clinics, 2013). This novel ‘offshore’ model plans to employ local health workers as well, including nurses and medical technicians. If successful, the American World Clinics Barbados facility will mark a significant change in the scale and scope of Barbados’ medical
tourism sector and raise a host of regulatory and resource management implications for its health system (Snyder, Crooks, Turner, & Johnston, 2013).

2.3. Methods

In this exploratory study we aimed to examine the anticipated health equity impacts of Barbados' growing medical tourism sector by consulting with both local and international stakeholders. Here we conceive of stakeholders as those whose professional positions have some degree of involvement in the country's health system or developing medical tourism sector. Guided by case study methodology, which requires attentiveness to the context in which a phenomenon is occurring (Meyer, 2001), we conducted one-on-one semi-structured interviews and observational site visits to medical facilities in May of 2011. All stages of the study design below were reviewed and approved by our institution’s ethics review board.

2.3.1. Recruitment

Following ethical approval for this study from our institutional board, we purposefully recruited stakeholders to participate in face-to-face interviews while we were on-site in Barbados. We focused on breadth in our recruitment strategy to achieve representation from a diverse range of agencies and individuals from target sectors (public health care, private health care, government, allied businesses), as opposed to interviewing multiple representatives of single organizations. To identify stakeholders, we reviewed media coverage and the websites of organizations pertaining to health care, tourism, business development, and medical tourism in Barbados. Upon completion of interviews, participants were also asked for additional sector stakeholders to invite to the study.

Fourteen interviews were conducted on site in Barbados, and upon return to Canada, an additional five interviews were conducted by phone. Phone interviews were conducted with individuals whose schedules could not accommodate an interview during our on-site visit or who are not located in Barbados.
2.3.2. **Data Collection**

Interviews lasted between 0.5 to 1.5 hours and were conducted at a time and location of the participant’s choosing. They were conducted after participants reviewed and signed a consent form which indicated that anonymity would be protected. In keeping with standard protocols in Canadian-led health research, participants were given a US$50 honorarium upon completion of the interviews in order to acknowledge their time and valuable contributions to this study.

To enhance consistency, all interviews were conducted by the third author. Interviews were organized using a semi-structured guide consisting of 30 questions. The guide probed for issues about: (1) participants’ professional backgrounds; (2) knowledge about medical tourism in Barbados; (3) public perceptions of medical tourism in Barbados; and (4) anticipated health equity impacts of medical tourism in Barbados. Regular team meetings were held throughout the data collection period in order to discuss recruitment strategies and emerging findings. Through this process it was agreed that interviewing would cease when no new target sectors or agencies for recruitment could be identified, which occurred after the nineteenth interview.

2.3.3. **Data Analysis**

All interviews were transcribed verbatim upon completion of data collection. Transcripts were first independently reviewed by the investigators. A coding scheme was then proposed by the third author and changes were made to the scheme based on the feedback obtained from the other investigators. Coding was managed using N7, a qualitative data management program, and all coding was done by the same research assistant in close coordination with the third author.

Following the completion of coding, a meeting was held among the investigators to discuss emerging analytic ideas that would guide inductive thematic analysis of the data (Fereday & Muir-Cochrane, 2008). During this meeting the analytic framework focused on internal/external actors/champions used here was identified. This framework was proposed by the second author and consensus was reached regarding which stakeholder groups fit into which of these categories. A full thematic analysis of the data
using the internal/external actors/champions framework was then conducted by the first author. The analytic framework facilitated the identification of relevant, illustrative data extracts pertaining to the relationships informing the sector’s development, all of which were circulated among team members in order to seek consensus on interpretation (note that quotes included here come from these extracts). In the following section we share the findings of this thematic analysis.

2.4. Findings

Analysis revealed a number of themes related to policies and initiatives surrounding the development of medical tourism in Barbados. Chief among these themes are the roles played by different stakeholder groups and their relationships to one another. Participants identified a number of key individuals or organizations ‘championing’ the sector by exporting health services, creating frameworks to guide the growth of the sector, and organizing workshops and conferences to raise interest and awareness about medical tourism. Other stakeholders who factor into the current operation or prospective development of the Barbadian medical tourism sector but are not involved in actively promoting it emerged as another distinct group. Here we refer to them as ‘actors’ who are passively implicated in sector development. A further distinction can be made between actors and champions who are ‘external’ and ‘internal’ to Barbados. This distinction captures whether a stakeholder is located in Barbados or internationally.

In the sub-sections that follow we separately examine the respective roles of internal and external actors and champions in advancing Barbados’ medical tourism sector. It is worth noting that all participants are situated in one of these for stakeholder groupings, and members of all four groupings are represented among the 19 participants – this despite the fact that this framework emerged from the data and was not our sampling strategy.
Internal Champions

Two groups were identified as internal champions: (1) physicians seeking to export their services and (2) the Barbadian government. The Barbadian physician community has a history of wariness when it comes to the expansion of medical tourism, with some only recently supporting its development while others remain opposed. Participants noted that some local physicians practicing in the private system have opposed a model of medical tourism where foreign physicians will temporarily visit the country and treat foreign patients due to a fear of increased competition for local patients, with one participant remarking: “I know [medical tourism] kind of scares local physicians” (Public Sector – Trade and Investment). However, participants also reported a strengthening of support for medical tourism among Barbadian physicians in recent years as they see an opportunity for medical tourism to enlarge the overall size of the private patient market as Barbados develops as a medical destination. One participant described this outlook in saying: “If you look at the pie as getting bigger because [medical tourism] is bringing in a bunch of people who aren’t coming [to Barbados] now which is really our target” (Private Sector – Health).

The Barbados Fertility Centre opened in 2001 and is the only medical centre offering specialized fertility services in Barbados. Despite being small and specialized, the fertility clinic’s success at attracting international patients was seen as a good model for a wider Barbadian medical tourism industry as the clinic was successful in staking its long-term growth on attracting international patients. The clinic’s owners have served as a source of information for domestic and international champions. It was noted that there had been multiple groups of prospective investors “that Invest Barbados have brought in [to Barbados] and usually they bring them in to meet with [the fertility clinic] because... [it has] walked the walk” (Private Sector – Health).

The second group of internal champions are members of the Barbadian government working to develop the sector. The Ministries of Tourism and Health, as well as the nationally owned foreign investment promotion corporation Invest Barbados, are the three agencies most regularly discussed as pushing the medical tourism sector forward. Participants reported that Invest Barbados has been a key champion, one participant summarizing their key role in saying “much of what is happening in medical
...comes through them. The initial contact is through them” (Public Sector – Health). Since 2008, representatives from Invest Barbados have attended annual trade shows held by the Medical Tourism Association in order to identify potential international investors and promote Barbados as a medical tourism destination. Invest Barbados was further identified as a champion in its role overseeing the creation of a favourable taxation environment for foreign investment in the health sector.

The Ministry of Health, as head of the country’s inter-ministerial Medical Tourism Task Force, has taken the leadership role in the creation and modification of regulatory frameworks to oversee the development of the sector. It was noted that the Ministry has been conscious of its role in mitigating the potential negative health equity impacts of medical tourism, with one participant summarizing:

Is there a level of service for one set of people, primarily medical tourists...those are questions I’ve heard voiced...to the Ministry of Health, which is the regulatory body for...health in Barbados, so if there’s a question like that coming from the Ministry of Health then you know that the Barbados government will be looking at medical tourism very closely. (Public Sector – Trade and Investment)

One participant’s comment summarizes the overall impression of the collective efforts of the internal champions of medical tourism in Barbados:

Most of the major forces that need to back medical tourism were indeed in alignment and working together. I remember [previously there were] factions...between the government, the local medical community, the Ministry of Health, you know the medical school, [now] everybody is, is kind of pulling in the same direction. (Private Sector – Health)

Cooperation between these internal champions has been key to the mobilization of state efforts to scale up the medical tourism sector over a relatively short period of time.

**External Champions**

Participants made it clear that the momentum gathering around the development of a medical tourism sector is not emerging solely from stakeholders based in Barbados.
There are numerous external champions who have taken up roles in promoting the sector. External groups that are driving Barbados’ interest in medical tourism include: (1) international investors, (2) the Medical Tourism Association, and (3) international development agencies. International investors were identified as important champions due to their attempts to develop new medical tourism facilities. One participant related numerous instances of investors looking to build new medical facilities in Barbados: “there are a number of North American investors. I think that the other day we had [...] some investors out of Latin America” (Public Sector – Health), indicating this group’s role in stoking interest in the sector. Another clarified that “we need investors to provide the facility” (Public Sector – Trade and Investment), highlighting the critical role outside investors play in sustaining the possibility of scaling up medical tourism to Barbados. The successful bid by American World Clinics to build a large new hospital dependent on medical tourists is an example of the central role external champions are playing in expanding the sector.

The Medical Tourism Association markets itself as an international organization that exists to promote medical tourism among patients, care providers, and planners and administrators of health care. The Association actively recruited representatives from Barbados to attend its annual conference each year between 2008 and 2010, with Barbados responding in kind and inviting the president of the Association to present at a government-sponsored health and wellness tourism seminar in 2010. These activities highlight the influence of the connections between the Medical Tourism Association and internal champions in Barbados. This is further evidenced in a participant stating:

what [Invest Barbados is] looking at doing is establishing a, a stronger relationship with the Medical Tourism Association... as a matter of fact... Invest Barbados invited...the CEO of the Medical Tourism Association to participate in a seminar, that was like three, four, five weeks ago and it was... beneficial. (Public Sector – Trade and Investment)

It was reported that American World Clinics’ interest in the St. Joseph Hospital refurbishment project arose from interactions at the Medical Tourism Association’s conference in 2009, where a participant reported that members from American World
Clinics “serendipitously...made contact with the Health Ministry...and one thing led to another” (Private Sector – Health)

The third external champion that emerged in the analysis was that of international development agencies, including the Caribbean Export Development Agency (CEDA), the Inter-American Development Bank, the Commonwealth Secretariat, and the Canadian International Development Agency (CIDA), all of whom were cited as supportive of a growing medical tourism industry in the Caribbean in general and Barbados more specifically. This support took the form of commissioning or issuing reports and conferences supportive of medical tourism. For example, one participant noted:

there was a study done by Caribbean Export Development Agency maybe two or three years ago about... selling medical tourism services from the Caribbean and they had identified Canada as one of the markets where they figured the Caribbean would be successful because of the fact that Canadians are looking outside of their own country for medical services.” (Public Sector - Trade and Investment)

Similarly, participants reported that CEDA and CIDA jointly funded an international conference held in Barbados in 2008. The conference aimed to raise awareness about the health and wellness tourism sector among Caribbean nations and included presentations from international consultants sharing the experiences of countries such as Malaysia and the Dominican Republic in developing their own medical tourism sectors. Barbados hosted a national conference on health tourism the following year. Developing medical tourism services was a core feature of both conferences, although it was promoted alongside less intensive health services such as massages, spas, and acupuncture. Many participants cited these meetings as key sites in the development of a medical tourism strategy for Barbados, with one participant crediting them with “…setting [the Ministry of Health] up where [they] are now looking to put a strategic plan in place” (Public Sector – Health). Another participant echoed this: “The first conference was about three years ago and then they have repeats that conference last year and then after that... these sub-committees now have... set up” (Private Sector – Health).
Internal Actors

There were three groups of ‘actors’ within Barbados that commonly arose in discussions about the planning of the medical tourism sector: (1) the Queen Elizabeth Hospital, (2) the Barbadian health and wellness tourism industry, and (3) the Barbadian public.

The Queen Elizabeth Hospital factors into the conception of the current Barbadian health system among the planners of medical tourism, but is not present at the planning table itself. According to one participant “the Queen Elizabeth Hospital... has never been engaged or asked of their opinion or discussion around whether [Barbados] can in fact embark on [medical tourism]” (Public Sector – Health). Given its critical role providing a full range of medical services to Barbadians, the hospital frequently arose in discussions of how medical tourism may impact the domestic health care market. Typically, medical tourism was viewed by champions of the industry as not being in competition with the Queen Elizabeth Hospital, but as entirely separate because medical tourism was typically envisioned as divorced from the public health system. One participant summarized this when saying “I wouldn't have seen the two of them [medical tourism and local health care] related before...because it's that sectionalized on this island that it would be just for tourists” (Private Sector – Health). Providers marketing to medical tourists were either seen to be offering services unavailable in the public system, as in the case of the fertility clinic, or if offering services available in the public system, serving a different patient market. Similarly, the hospital and the larger public health system were not considered as sharing the same human and public resources as medical tourism providers. Plans for large-scale medical tourism development are based on using foreign medical labour. One participant clearly articulated this outlook in saying “the expectation is that they will be using mainly... American physicians or international physicians” (Public Sector – Trade and Investment).

Another internal actor informing the development of medical tourism is the broader health and wellness tourism sector in Barbados. Medical tourism was perceived as a niche set of surgical intervention-focused services within this wider sector that includes spa and recuperative holidays as well as complementary and alternative medicine. Some participants conflated the two sectors, discussing the entire ‘health
tourism’ sector as a coherent whole that Barbados is working to promote and only weakly distinguishing medical procedures. It was explained by one participant that tourism officials perceive medical tourism as merely “a niche product or as an expansion to the tourism product that is currently offered” (Public Sector – Health). However, some participants were careful to differentiate the development of the medical tourism industry from the health and wellness sector, but still saw the success of each closely tied to one another. Overall, the notion of a strong, broad health and wellness tourism sector helped to fuel the desirability of a larger medical tourism sector in the country.

Collectively, the Barbadian public is an actor in the development of medical tourism in the country. Given the small size of the current sector, most participants perceived medical tourism as a non-issue for Barbadian citizens, one participant stating that “the notion of medical tourism doesn’t have a lot of traction or public profile” (Public Sector – Trade and Investment). However, one participant described a perception that “a lot of Barbadians feel very frustrated that the tourists get looked after better” (Private Sector – Health) and may be able to more readily access health services than locals. Actions to gain the approval of the public and manage the ‘optics’ of medical tourism were a common goal among sector champions. Several participants suggested this goal could be achieved if potential positive impacts were emphasized in communications with the public. One participant explained that it is:

...more proactive on the part of government to...pre-empt any...possible challenges along those lines... So in all Minister’s speeches and when they record in the newspaper ...a point was always made to reassure the public that this would be an overall benefit. (Public Sector – Trade and Investment)

**External Actors**

Just as there are groups and individuals outside of Barbados who have actively championed the development of a medical tourism sector in the country, there are also people residing outside of Barbados who have influenced this sector but have not served as champions. External actors that were described as having some stake in the development of a Barbadian medical tourism sector were: (1) medical tourists and (2) international hospital accreditation organizations.
Participants expressed a perception that prospective medical tourists from North America and the United Kingdom will prefer Barbados as a destination over other countries for a variety of reasons, including its English-speaking population, cultural familiarity, proximity to North America, and beaches and natural setting. One participant described the appeal of Barbados for medical tourists as: “You go to the beach with your significant other, you enjoy the restaurants, the hotels, you have your procedure...you have an enjoyable environment where they speak English” (Private Sector – Health).

Several participants emphasized patients on wait-lists in Britain and Canada as one of the key target markets that will support medical tourism in Barbados. Most shared a perception that the market for medical tourism is large and growing. Thus champions’ perceptions of this anticipated market’s size, composition, and demands, rather than efforts to directly consult medical tourists or incorporate more conservative assessments of the number of patients traveling internationally for care and their motivations for doing so, are shaping the evolution of Barbados’ medical tourism sector.

International hospital accreditation bodies such as Joint Commission International (JCI) were discussed as actors key to the success of the industry, mainly by improving the confidence of prospective patients in their claims to high quality standards. For example, one participant stated that: “if you don’t have [JCI] certainly the American patients are not coming” (Private Sector – Health). The fertility clinic already holds this certification and other facilities are thought to be seeking it. However, one participant further explained that “one of the...issues in relation to medical tourism is the ability for you to have a facility that meets the [JCI standards]...we really don’t have that [financial] capacity” (Public Sector – Health) due to the cost for both the price of accreditation and associated renovation costs. Some champions shared a concern that such barriers to accreditation of new and existing private health care facilities would limit the pace at which the sector could develop.

2.5. Discussion

The findings illustrate how the idea of a ‘medical tourism sector’ is being conceptualized and mobilized by key stakeholders involved in the development of health services export from Barbados. These findings contribute to a wider literature that
provides accounts of the factors driving (or obstructing) the emergence of medical tourism in particular locations (e.g. Mamun & Andaleeb, 2013; Pocock & Phua, 2011; Ramírez de Arellano, 2011; Turner, 2010a), but particularly those that focus on fine-resolution accounts of how the industry operates in particular places (e.g. Kangas, 2011; Leng, 2010; Ormond, 2011). Employing a conceptual framework that parses out the internal and external actors and champions and their relationships to the developing medical tourism sector brings forth two key points for further discussion, those of: (1) the composition of the networks championing the development of medical tourism in Barbados; and (2) the position and role of non-involved actors whose presence frames the terms of how medical tourism is unfolding in Barbados.

**Connected Champions**

Our analysis demonstrates how the expansion of the medical tourism sector in Barbados is primarily driven by a cluster of connected champions within the country. These internal champions are represented by two groups: government organizations and private health care providers. Narratives around the early history of medical tourism in Barbados were peppered with accounts of individual physicians’ and investors’ plans that were ultimately abandoned or redirected towards primarily serving locals, with the notable exception of the Barbados Fertility Clinic. This early uncoordinated entrepreneurial activity is in sharp contrast with the interest and support provided by the government around 2008 and thereafter.

Barbados’ internal champions share connections to external champions who, while not connected to one another, have collectively facilitated planning for the sector. Two of these, the Medical Tourism Association and international development agencies, have provided forums both outside and within Barbados for internal champions to connect with one another, meet with international investors and medical tourism consultants, and articulate their development strategies. These forums have disseminated particular models, including the ‘health and wellness tourism continuum’ and the development experiences in well-known medical tourism destinations. These have subsequently been locally mobilized to structure and promote the development of the Barbadian medical tourism industry. The models were regularly referred to by numerous participants we spoke with, indicating that they were successful in focusing
stakeholders on a common goal and vision. This mirrors elements of the experience of Malaysia as documented by Ormond (6), where the emergent, piecemeal medical tourism sector received sudden government attention that sought to coordinate the sector’s growth.

A number of key issues arise from the involvement of disparate external champions in driving the development of Barbados’ medical tourism sector. The diverse mixture of non-governmental champions supporting the development of medical tourism in Barbados (international development agencies, regional export development agencies, and the Medical Tourism Association), suggests potential for incoherence in the kind of sector each partner envisions and thus are cultivating collectively. This is especially the case given the ongoing incoherence in the definition of ‘medical tourism’ itself, both in Barbados and more widely. For example, exporting surgical services might be an afterthought in light of a perceived greater viability of the health and wellness tourism for one group while surgical care is the primary focus of another. Similarly, the models mentioned as influencing medical tourism’s development in Barbados represent very different health systems and socio-economic contexts (i.e., Malaysia, India, the Dominican Republic). This is especially pertinent as one of the major approaches to medical tourism development being pursued in Barbados and other Caribbean nations aims to provide foreign physicians a location from which to export their services, rather than exporting excess, established capacity in the private health sector. Both approaches, with their strikingly different implications for health worker supply, local employment, reliance on local health infrastructure, and economic outcomes, are captured by the broad push for medical tourism. As such, the policy measures and/or lessons derived from elsewhere may not translate effectively to the Barbadian context, an issue is compounded by the dearth of impartial information in much of the medical tourism sector (Lunt & Carrera, 2010). Definitional incoherence and hype-driven policy development of medical tourism has been noted elsewhere (Connell, 2013a) and should be acknowledged by policy-makers in the use of consistent, clear definitions and critical scrutiny of the available data on the scale and nature of the global industry.

International investors differed from the other external champions, international consultancies and economic development agencies, as they are more directly involved
in the day-to-day operations of medical tourism in Barbados. Foreign investment groups most broadly and American World Clinics specifically are significant in the combination of their powerful influence and status as foreigners. The high costs of constructing new hospitals make it very likely that small island nations will be dependent on foreign capital for large scale medical projects to be realized. That such a powerful champion and beneficiary of the sector is positioned outside of the country raises important questions regarding how their respectively limited knowledge and responsibility in the success and operation of the existing health system may impact the way it operates into the future and the degree to which economic benefits from the sector will remain locally.

Disparate Actors

None of the internal actors passively influencing Barbados’ medical tourism sector are involved in its planning, but they are ubiquitously present in discussions by those championing the sector’s development. The perception of medical tourism as just one form of health and wellness tourism, a sector so wide as to include interventions as mild as massages to those as intensive as cancer care (Goodrich, 1993; Lunt & Carrera, 2010), presents a troubling equivocation between treatments that demand entirely different kinds of health resources and have distinct health system impacts. This equivocation raises two risks. First, it presents the risk that the policies used to cultivate the medical tourism sector are derived from or related to the health and wellness sector more widely. This may subsequently encourage the development of medical tourism as a mere subsector of the wider health and wellness tourism industry and thereby in a manner that does not account for the unique regulatory and management challenges it poses to existing domestic medical services. Second, the lack of clarity around which health and wellness services in particular are being planned for or incentivized may result in indistinct public perceptions of what is being expanded, thereby avoiding constructive local scrutiny.

The relevance of these above concerns is demonstrated by the conspicuous omission of the Queen Elizabeth Hospital and the Barbadian public from the planning of the medical tourism sector. Champions perceived the Queen Elizabeth Hospital to be insulated from the growth of the medical tourism sector and if anything, a beneficiary from the staff training and retention opportunities a larger and internationalized private
health services sector would offer. This differed from the perceptions of participants involved in the administration of public health care, who held serious concerns about the negative health equity impacts a large medical tourism sector could pose for local patients. Similarly, champions believed that there exists widespread public support for the development of medical tourism in Barbados and that dissent can be managed if the perceived economic benefits are emphasized in local promotion. Mirroring the lack of engagement with the Queen Elizabeth Hospital, participants did not identify any formal consultation with community members by internal or external champions to verify their perceptions. The emphasis by champions on managing public opinion, combined with the lack of clarity surrounding what specific services are being promoted by the government’s interest in ‘health and wellness’ tourism, is troubling given the sector’s potential impacts on health equity locally.

The perception that there exists a large population of frustrated North American and European patients who are willing to travel abroad for culturally familiar and/or proximate care is fundamental in driving the current development of medical tourism in Barbados. It was a belief in the existence of this group and the nature of their desires, rather than a firm sense of their numbers or evidence of their actual demands, informing champions’ perceptions. This is indicative of the impact that the popular imaginary of (North American and European) patients traveling great distances for medical trips is playing in driving sector planning and development. This target patient population is eclipsing the proximate, regional flows that experts believe constitute the bulk of global health services export in places such as Thailand and Malaysia (Connell, 2013a; Ormond, 2013b), for which a regional Eastern Caribbean market of comparable scale does not exist due to its small population.

In their accounts of sector development strategy, participants articulated a close, if not mutually-reinforcing, connection between international accreditation agencies and the expectations of foreign patients. Accreditation was discussed as a critical component to gaining a foothold into the international health services market, especially in meeting the demands of American patients. The existence of JCI was thus seen as a (perhaps the) key facilitative actor in determining the successful development of the medical tourism sector because it was widely believed that care providers would be
uncompetitive without accreditation. Some participants further tied this popular perception to the developmental strategies disseminated by external champions in their conferences and reports. This pressure to adopt JCI accreditation over other routes of certification mirrors the Malaysian experience, where hospitals seeking to market themselves as medical tourism destinations were originally required to first receive JCI accreditation to do so (Ormond, 2013b). This perception among medical tourism stakeholders of the importance of international accreditation in gaining access to the American market helps to explain the self-reinforcing popularization of the JCI brand in particular. Future research must seek to provide impartial assessments of the clinical relevance and rigour of international accreditation and its process given the critical role it is performing in shaping development and planning of the medical tourism sector (Turner, 2010b).

**International Parallels in Medical Tourism Development**

The findings demonstrate some parallels with Ormond’s (2011) work on medical tourism policy in the Malaysian context. The Barbadian experience parallels Malaysia’s, where internal champions such as the Ministry of Health frame public hospitals and the public health care system as first and foremost a public good, to be maintained and insulated from erosion by the private market (Ormond, 2011). Public sector champions in both contexts maintain a similar confidence in the ability of medical tourism to operate within existing domestic private health systems without leeching resources from the public health system. However, unlike Malaysia and other established medical tourism destinations, Barbados’ example provides a sharp departure from the idea of medical tourism as a ‘feather in the cap’ of the existing health system and an indicator of the high quality of care available locally (Edmonds, 2011; Ormond, 2011). Instead, medical tourism in the Barbadian context is moving towards an offshore model where foreign providers care for foreign patients and the operations are financed by foreign investment. In choosing to locate itself in Barbados for the regulatory, cost, and aesthetic benefits, and intending to insulate itself from the existing Barbadian health system, the American World Clinics project specifically and the growing medical tourism sector in the Caribbean more broadly raises pressing questions about the different modalities of medical tourism and how they might impact the health systems they are inevitably connected to.
Implications for Future Research

Future research examining the emergence of medical tourism in other locations can benefit from developing similar profiles of industry ‘actors and champions’ in order to identify the particular contextual dynamics driving and shaping the expanding interest in medical tourism. This wider understanding can help delineate both the relationships and dynamics responsible for the expanding global interest in medical tourism and the particular concerns informing its composition and developmental trajectory across different jurisdictions. More concretely, such research can identify the significance of external groups such as the Medical Tourism Association, international investors, and (inter)national aid/economic development organizations in popularizing medical tourism and their interactions with domestic champions in negotiating and advancing one another’s interests.

The conceptual framework of internal/external actors/champions is a useful structure for thinking through how interest in medical tourism is prompted and maintained in locations previously unassociated with the phenomenon. However, the time since data collection has resulted in some of the prospective sector development plans discussed by participants not being realized. In particular, the American World Clinics hospital project is yet to break ground, despite recent reports that the project is still proceeding (Angelchik, 2014). As such, this type of analysis can thus be read as a time capsule that captures the dynamics driving medical tourism in a particular place at a particular time. This must be kept in mind for others endeavouring to use this type of framework in research examining the medical tourism sectors in other countries.

2.6. Conclusion

This study of the medical tourism sector in Barbados demonstrates that distinct groups of stakeholders are shaping this sector. Internal and external champions are taking active steps to promote the development of medical tourism in Barbados, most centrally in the cooperation between the government and international investors, agencies, and trade groups. The perceived expectations and demands of internal actors such as the public health sector and Barbadian public are intersecting with external
actors such as medical tourists and accreditation groups and consequently shaping the kind of planning being advanced by sector champions. The particular interactions between these actors and champions demonstrate that the development of medical tourism is highly context specific and is greatly influenced by local history, culture, government, and health system development, among others. Nonetheless, certain external champions, such as international trade groups, development agencies, and accrediting agencies, will have an influence on medical tourism development across most contexts.

This study and the existing academic research on medical tourism raise concerns that medical tourism development may take place against a background of assumptions that may not be borne out in practice. Primary among these assumptions are that the market exists for a much larger medical tourism sector and that this sector will not negatively impact the existing public health sector. As we have demonstrated, an array of parties are informing and sustaining these perceptions in the development of medical tourism in Barbados and, without doubt, other nations as well. Improving our understanding of the interactions between these actors is imperative to accurately understanding, and thereby better informing and critiquing, this development globally.

**Acknowledgements**

Thank you to all of the participants who generously provided their time and knowledge to this study. Funding for this study was provided by the Canadian Institutes of Health Research (Planning Grant #235953) and Mr. Johnston has been provided academic support through the Frederick Banting and Charles Best Doctoral Award program. This research was funded by a Canadian Institutes of Health Research Planning Grant – International Research Collaborations Priority (application #235953)
Chapter 3. Bringing Additional Voices to the Table

As the earliest analysis, the fieldwork conducted in May 2011 for Chapter 2 set the stage for my understanding of medical tourism development in the Caribbean. Two perspectives in particular stuck with me from that trip: the widely shared view of interview participants’ that medical tourism was unlikely to produce the health equity concerns that had been clearly conceptualized in the existing literature; and participants’ belief that Barbadians also did not share concerns about the negative impacts of developing this sector and were widely supportive of medical tourism due to its economic potential. This echoed the outlooks of the Canadian medical tourists I had interviewed in the previous year who were largely unable or unwilling to describe any health equity implications raised by their trips in relation to the countries they visited (Johnston et al., 2012). Both of these experiences demonstrated the challenges of empirically exploring the health equity concerns surrounding medical tourism by consulting stakeholders directly involved in its development and practice. A powerful point of contrast between the two groups of participants was the difficulty of examining health equity in different cultural contexts than my own. In my first trip to Barbados, a conversation about ‘two-tiered healthcare’ revealed the non-universality of the term. In Canada it refers to co-existing private/public payment schemes while in Barbados it describes qualitatively different tiers of care within in the same system. These challenges stoked my curiosity about the perceptions of medical tourism among health system users and workers at the margins of the practice. I was concerned about the harms associated with medical tourism, but wondered how they were perceived by and were they relevant to those within health systems exporting medical care.

In the same summer as the Barbados fieldwork in 2011, I led a series of focus groups for the second half of my Master’s research project. These focus groups were with Canadian family physicians about their experiences with patients traveling as medical tourists (Johnston, Crooks, Snyder, & Dharamsi, 2013). This was my first
extensive experience with focus groups and taught me the usefulness of the method for articulating collective knowledge held among groups with shared experiences. This experience also demonstrated the particular effectiveness of focus groups at excavating relevant ideas and perspectives from participants who initially present themselves as having very little to share. These lessons were at the front of my mind going into my PhD research project given the challenge I anticipated of exploring the health equity implications of medical tourism, particularly in a location where it was not yet a large sector. I was aware in August 2012 that I would be returning to Barbados the next year for a considerable period as a research assistant for my supervisor’s larger study on medical tourism and that I would have the time to organize focus groups among Barbadians not involved in developing the sector. My interest in conducting these focus groups was only reinforced during my first trip to Jamaica and Grand Cayman Island in October 2012, where the most commonly cited health equity concerns surrounding medical tourism were again shown to have a relative lack of traction among stakeholders leading development there (Johnston & Crooks, 2013).

Collectively, these experiences directly led me to hold focus groups with Barbadian nurses and health system users in 2013, the results of which are analysed in Chapter 4. The analysis supports the perspectives of those promoting medical tourism in the Caribbean whose views are captured elsewhere in this dissertation as it does demonstrate there is public support for the sector. However, the Barbadian focus group participants demonstrated that this support is chiefly a by-product of the tourism frame implicit in local promotion of ‘medical tourism’. This frame does not readily engage with the conceptions of ‘international medical travel’ that underlie many academic critiques, particularly those that actively try to disengage with tourism terminology (e.g. Kangas, 2010; Turner, 2013). Similarly, the form of medical tourism being promoted in Barbados (and the wider Caribbean) of offshore hospitals encourage conceiving the sector as siloed from the existing health system and thereby unrelated to its strengths, limitations, and future operation. Together, Chapters 2 and 4 begin to articulate a country-specific understanding of medical tourism within Barbados and its relationship to the already ongoing health equity conversation occurring there (Crooks & Sobers-Grannum, 2016). The interpretations, boundaries, and expectations for the sector expressed by participants in both analyses, particularly the importance of protecting the strong public
healthcare system, the relevance of the tourism economy, and the kinds of international patients readily framed as ‘medical tourists’, are useful points of reference that are built upon in later chapters and contribute to the global conversation about the health equity impacts of medical tourism.
Chapter 4. “Best care on home ground” versus “elitist healthcare”: Concerns and Competing Expectations for Medical Tourism Development in Barbados

4.1. Abstract

Introduction: Many countries have demonstrated interest in expanding their medical tourism sectors because of its potential economic and health system benefits. However, medical tourism poses challenges to the equitable distribution of health resources between international and local patients and private and public medical facilities. Currently, very little is known about how medical tourism is perceived among front line workers and users of health systems in medical tourism ‘destinations’. Barbados is one such country currently seeking to expand its medical tourism sector. Barbadian nurses and health care users were consulted about the challenges and benefits posed by ongoing medical tourism development there.

Methods: Focus groups were held with two stakeholder groups in May, 2013. Nine (n=9) citizens who use the public health system participated in the first focus group and seven (n=7) nurses participated in the second. Each focus group ran for 1.5 hours and was digitally recorded. Following transcription, thematic analysis of the digitally coded focus group data was conducted to identify cross-cutting themes and issues.

Results: Three core concerns regarding medical tourism’s health equity impacts were raised; its potential to 1) incentivize migration of health workers from public to private

5 This chapter has been published as: Johnston, R., Adams, K., Bishop, L., Crooks, V.A., Snyder, J. (2015). “Best care on home ground” versus “elitist healthcare”: Concerns and Competing Expectations for Medical Tourism Development in Barbados. International Journal for Equity in Health, 14:15.
facilities, 2) burden Barbados’ lone tertiary health care centre, and 3) produce different tiers of quality of care within the same health system. These concerns were informed and tempered by the existing a) health system structure that incorporates both universal public healthcare and a significant private medical sector, b) international mobility among patients and health workers, and c) Barbados’ large recreational tourism sector, which served as the main reference in discussions about medical tourism’s impacts. Incorporating these concerns and contextual influences, participants’ shared their expectations of how medical tourism should locally develop and operate.

Conclusions: By engaging with local health workers and users, we begin to unpack how potential health equity impacts of medical tourism in an emerging destination are understood by local stakeholders who are not directing sector development. This further outlines how these groups employ knowledge from their home context to ground and reconcile their hopes and concerns for the impacts posed by medical tourism.

4.2. Introduction

The term ‘medical tourism’ is used to describe the practice of individuals traveling internationally with the intention to access medical care. This practice is reported to be growing in popularity, indicated by the increasing interest among medical facilities and healthcare providers to market and cater to foreign patients looking to access more affordable, locally unavailable, or more timely access to medical care (Lunt & Carrera, 2010; R. Smith et al., 2011). In contrast to patients referred out-of-country by their domestic health system, medical tourists direct their own course of care and purchase it out-of-pocket.

The increasing visibility and popularization of medical tourism has raised numerous concerns regarding the impacts of the practice on equitable health service delivery and system development. The influx of additional, private-paying international patients is thought to reduce access to and quality of care for local patients by increasing the demand (and thereby costs) for treatments and by further incentivizing migration of health workers from the public sector to better paying private facilities that are primarily located in urban centres (Connell, 2011; Turner, 2007). At a systemic level, the capital
and labour used to develop new private secondary and tertiary care facilities, often in part publicly subsidized, are arguably inefficient uses of scarce health resources that could be more effectively used in primary care settings more in line with the needs of local populations (Turner, 2007).

In light of these concerns above, this article examines the perspectives and issues raised by local citizens and health workers in Barbados, a country seeking to become a medical tourism destination. We do so in order to better understand the local concerns and expectations surrounding medical tourism among stakeholder groups who are not directly overseeing or influencing the development of the sector and who are commonly identified in existing analyses of medical tourism as those directly impacted by its development. Their perspectives serve to inform and complicate the largely speculative, health system-level conceptualizations of the impacts of medical tourism on health equity summarized above (for additional discussion, see (Connell, 2011; Turner, 2007) by grounding these debates within the localized context of the experiences and expectations of existing users and workers of the Barbadian health system. This approach allows us to explore the strengths and limitations of existing health equity concerns while identifying additional impacts for further consideration.

This consultation builds upon a previous study examining the early planning for medical tourism in Barbados, as well as our wider work consulting patients, physicians, caregivers, and regulators in the Canadian context about medical tourism (Casey, Crooks, Snyder, & Turner, 2013; Johnston et al., 2012; Johnston, Crooks, Snyder, & Dharamsi, 2013; Snyder, Crooks, Turner, Adams, et al., 2013). Together, these stakeholders play critical roles in medical tourism as it is actually practiced and are able to provide important insights into the potential challenges and opportunities it poses to the development and operation of health systems.

**Medical Tourism in the Caribbean**

Many Caribbean countries have recently demonstrated an interest in pursuing medical tourism as a development strategy (Connell, 2013b; Ramírez de Arellano, 2011; Snyder, Crooks, Turner, Adams, et al., 2013). As tourism dependent states, Caribbean countries are especially vulnerable to fluctuations in the global economy due to their
powerful impact on the number of tourists traveling for leisure (Zappino, 2005). While policies directly supporting medical tourism have historically been limited in the Caribbean (with the exception of Cuba), the sector has recently been promoted by many Caribbean governments as an appealing means of expanding tourism-oriented economies in a way that builds on existing tourism infrastructure (Connell, 2013b; Ramírez de Arellano, 2011). Demonstrating a regional expansion of interest in exporting health services internationally, many Anglophone Caribbean countries have been involved in the creation of policies, hosting of conferences, and/or development of facilities for medical tourism (Chambers & McIntosh, 2008; Connell, 2013b).

Projects currently being discussed or pursued in the Anglophone Caribbean include the Health City, Cayman Islands development, a 104 bed hospital staffed by international health workers and focused on the American patient market that began operating in early 2014 (Smith, 2014). Plans by American doctors to build a new facility in Montego Bay, Jamaica that will primarily treat medical tourists have been well received by the national government, while Turks and Caicos has discussed plans to attract foreign patients by marketing surgical services to international patients at two existing hospitals (Collinder, 2013; International Medical Travel Journal, 2013b). Additionally, governments in Bahamas, St. Kitts and Nevis, and Grenada are all reportedly exploring their options for developing medical tourism industries (Connell, 2013b). All of these island economies heavily rely on recreational tourism for foreign exchange to fund their public services, including healthcare (Zappino, 2005). As such, medical tourism has been presented as one particularly appealing avenue for economic development given its reputation for generating large revenues and creating high quality employment (Connell, 2013b; Horowitz, Rosensweig, & Jones, 2007). This dominant discourse, informed by typically inflated projections of the industry’s growth potential and a narrow liberal-economic rationale, regularly neglects to incorporate concerns regarding potential negative impacts of medical tourism on healthcare systems and health equity more generally (Hopkins et al., 2010; Johnston et al., 2010). This may be particularly true in the Caribbean region where research has demonstrated the prioritization of tourism policies and limited involvement of local stakeholders in the development of existing tourism infrastructure (Scheyvens & Momsen, 2008; Zappino, 2005).
Barbados, the most easterly island in the Caribbean with a population of approximately 280,000 (Pan American Health Organization, 2008), is an Anglophone Caribbean country actively working to expand its medical tourism sector. Tourism is among the largest economic sectors, with tourism contributing 11% of the country's total gross domestic product and directly employing approximately 14,500 Barbadians in 2013 (World Travel & Tourism Council, 2014a). In contrast, the medical tourism sector in Barbados is currently very small. One facility, the Barbados Fertility Centre, has had great success with recruiting the majority of its patients internationally, primarily from the United Kingdom, Canada, the United States, and other Caribbean countries (Ramírez de Arellano, 2011). The clinic has served as a proof of concept for medical tourism's fit with the country and has contributed to the Barbadian government’s plans to develop additional medical tourism facilities (Connell, 2013b). The largest and most developed of these plans has been the government’s lease of public land home to a long-defunct private hospital (St. Joseph’s Hospital) to the American World Clinics (AWC) company in 2011. AWC plans to build a 105-bed hospital that will be staffed by locally recruited nurses and a rotating roster of visiting American physicians. The facility will be available to local patients with the means to privately pay for their services, but will mostly focus on serving the international market (Johnston, Crooks, Snyder, Fraser, et al., 2013). This novel approach to healthcare delivery is only the latest of many ‘offshore’ services found in the Caribbean, including the medical education, banking, and gambling sectors (Eckhert, 2010; Mullings, 2004). While construction has yet to begin, the project is reportedly still proceeding and remains the biggest medical tourism proposal to be actively pursued in Barbados and among the largest in the Caribbean to date (Angelchik, 2014; Cumberbatch, 2013; Johnston, Crooks, Snyder, Fraser, et al., 2013).

Here we draw on discussions with local citizens and healthcare providers in Barbados in order to better understand the context in which medical tourism is being pursued in the country and local perspectives on its potential impacts, with a focus on their implications for health equity. Barbadian citizens currently have universal access to healthcare, provided through publicly funded and managed facilities that include primary care polyclinics and the Queen Elizabeth Hospital (Pan American Health Organization, 2008). This latter facility is the only hospital capable of providing comprehensive tertiary care on the island (Barbados Ministry of Health, 2003). While the universal public system
provides a common safety net for all Barbadian citizens, many access care in the private sector (Pan American Health Organization, 2008). Private primary care is greatly preferred by citizens with financial means necessary to pay for it, with 50% of all primary care provided delivered through the private healthcare system (Barbados Ministry of Health, 2010). Additionally, there is a small private hospital used by local medical consultants for privately-purchased, non-intensive services (Pan American Health Organization, 2008). Despite a strong presence of private medical care for primary care and elective treatments, there are no private providers that offer comprehensive tertiary care, with all emergencies necessitating referral utilizing the public hospital (Pan American Health Organization, 2008).

While the Barbados Fertility Clinic is the only facility in Barbados currently marketing to international patients outside of the Caribbean, regional patients (typically from smaller, proximate islands) regularly purchase health services at private and public medical facilities in Barbados (Snyder, Crooks, Turner, Adams, et al., 2013). Barbadians also travel throughout the region to access healthcare, both through public cross-border care arrangements and medical trips that are privately financed through insurance or out-of-pocket payments. However, the majority of citizens accessing healthcare off the island do so at extra-regional facilities, often in the United Kingdom or Miami (Barbados Ministry of Health, 2003). Due to the relatively small size of Barbados and resulting limitations to the provision of specialized care, international patient mobility has become a norm in this context. There is also a parallel outflow of health workers, with high levels of nurses in particular emigrating from the country to earn higher incomes elsewhere, resulting in nursing shortages and corresponding challenges in providing effective and efficient health services (Pan American Health Organization, 2006).

As a tourism-dependent small island state, Barbados provides an example of a country with a vulnerable, service-dependent economy working to diversify its tourism market. As such, the findings of this analysis are likely to be relevant to other countries in similar economic circumstances that are looking to grow their medical tourism sectors, especially other Anglophone Caribbean nations. By seeking Barbadian citizens’ first-hand perspectives on the development of a local medical tourism industry, this paper
offers grounded insights into the complicated economic and health equity considerations posed by the growth of medical tourism.

4.3. Methods

The core research question informing this study is: how do Barbadian citizens and health workers understand medical tourism and what concerns and expectations do they have for the sector? Focus groups were chosen as the qualitative data collection method best suited to explore this question as they encourage the inclusion of a wide range of nuanced perspectives on a topic, especially among participants who may not have expert knowledge with the topic at hand but can bring broadly relevant knowledge to bear on the question (Parker & Tritter, 2006; Sim, 1998).

4.3.1. Participant Recruitment

Two focus groups were planned for May, 2013. Each focus group was structured to involve a distinct group of stakeholders; the first comprised Barbadian citizens with no professional ties to the health services sector and the other made up of Barbadian nurses. We originally intended for the health worker focus group to include a mix of health workers in different professional roles, but with the exception of one physician who expressed interest, only nurses responded to our calls for participants. We then decided to conduct the focus group with only nurse participants to concentrate the focus of the group on issues raised and perspective offered by a single, front-line care profession. Participants were recruited through a mixture of channels, including newspaper advertisements, community email lists, posters in public spaces, and snowball recruitment among participants. All recruitment materials stated the researchers’ institutional affiliations, the goal of the study, and provided contact information for the investigator who directed and managed on-site recruitment. The study protocol was reviewed and approved by the research ethics boards of Simon Fraser University and the University of the West Indies (Cave Hill) prior to participant recruitment.
Upon expressing interest in the study, potential participants were provided a document that further outlined the study goals, logistics of data collection and analysis, the risks and benefits of participation, and a copy of the consent form to review prior to the focus group. Eligible participants for the citizens’ focus group were required to 1) be over the age of 18, 2) be a Barbadian citizen, 3) have utilized the public health system in the past five years or have a household family member who has done so, and 4) not be involved in the provision of health services in the country. The nursing focus group used the same eligibility criteria as points 1 and 2 above, but also required participants to have been employed as a nurse in the public health system within the last five years.

4.3.2. Data Collection

The focus groups each ran in the early evening for 1.5 hours and were held in a hotel meeting room. In recognition of the evening schedule, participants were provided with a meal. Nine participants, five women and four men, attended the citizen focus group and seven participants, five women and two men, attended the nursing focus group, meeting the prospective target of 6-10 participants per group. All participants in both focus groups had completed post-secondary education and, with the exception of one member of the ‘citizen’ focus group, were also all employed in professional positions. The mean age of the citizen focus group was 50 years (median of 51 years), with the mean age of nursing participants being 48 years (median of 48 years). No participants withdrew from the focus groups once enrolled.

Both focus groups were structured using the same format with four core probes (general and overarching questions) punctuating what was otherwise an open conversation. Additional sub-questions were only used in cases where participants required additional prompting or re-framing to begin discussing the current probe. Participants were given a brief introduction by the co-moderators at the beginning of the evening that served to introduce the investigators, the research topic, and outline ground rules for focus group interactions. Moderators provided additional questions when a line of conversation concluded or in cases where clarification was required and only intervened in the conversation in cases where a participant indicated a desire to speak but was unable to break into an exchange. Additionally, at the end of a lengthy exchange
covering many topics, the lead moderator would provide a verbal summary of what they understood the consensus to be as well as any unresolved disagreements that remained in order to invite clarification and correction from the group. Focus group (co-)moderation was shared between the first two authors, with each taking the lead role for one focus group. All of the participants were provided with a small gift valued at USD $10 at the conclusion of the focus group to thank them for their time and contribution to the study.

4.3.3. Analysis

Both focus groups were digitally recorded and transcribed verbatim, during which participants’ identities were anonymized. Following transcription, both transcripts were separately reviewed by the first three authors who each created their own interpretation of a comprehensive and robust coding scheme. Subsequently, a meeting among the investigators integrated these schemes by comparing suggestions and resolving redundant and outlier coding categories in order to generate a single scheme. The transcripts were then uploaded to NVivo (QSR International, 2012), a qualitative data management program, and coded by the first and second authors using this scheme. After the transcripts were independently coded, inter-rater reliability was assessed in order to highlight any outlier interpretations between the coders by reviewing the coding agreement report generated by NVivo. There was a median value of 87% agreement (mean=86%) across 26 discrete codes, ranging from 62% for the two lowest codes to 98% for the two highest. The first and second authors thoroughly discussed their difference in interpretation by reviewing and recoding each piece of text within codes with low-agreement in order to harmonize interpretation. As a final step, the coded text was reviewed by the first three authors in order to identify cross-cutting themes and issues present across both focus groups and understand their relationships with one another. These themes along with their associated coding extracts were shared with the full team of investigators in order to confirm interpretation of the findings. In the section that follows we present the findings of the thematic analysis, integrating findings from both the citizens and nurses.
4.4. Results

Overall, both focus groups touched on many of the same issues and shared a similar tone and perspective on the opportunities and challenges posed by medical tourism. The nurses spoke in both their capacity as Barbadian citizens and users of the health system, bringing their experiences as health care professionals to some, but not all, issues. As such, there was a great deal of thematic convergence across the focus groups, both being broadly supportive of the idea of a larger medical tourism sector in Barbados. Both groups approached medical tourism as an economic benefit and a means to increase local access to medical specialties not available on the island. However, the conversations also raised numerous concerns about how the sector could negatively impact the country and its health system. The nursing focus group additionally identified potential positive and negative outcomes stemming from medical tourism in relation to employment of nurses, Barbados’ medical culture, and nursing training. Thematic analysis identified four cross-cutting focus group themes that clarify the sources, bounds, and intersections of the expectations and concerns that were raised. Here we organize these themes into the two broad domains of ‘Local Setting’ and ‘Competing Expectations’. Themes pertaining to ‘Local Setting’ were largely descriptive and worked to situate medical tourism in a localized understanding of the Barbadian context. In contrast to this are the themes associated with ‘Competing Expectations’ that highlighted tensions in ideas around how the developing medical tourism industry and its impacts might unfold in Barbados. These domains and their themes are explored in detail below. Unless specifically noted, the themes and issues raised were common to both focus groups and where quotes are provided, the focus group source is noted in brackets.

Local Setting

The first of the two major thematic domains that arose across the focus groups were ideas and issues pertaining to Barbados as a dynamic tourism-dependent setting that a larger medical tourism sector would be developing from and interacting with. As a setting, Barbados’ long experience with and reliance upon tourism was critical in participants’ understandings of the potential economic and social impacts medical tourism creates for the country. Likewise, the longstanding international networks that
connect Barbados’ patients and health workers to hospitals abroad in terms of training, employment, and care seeking, served to normalize medical tourism for the participants and offer a lens with which to interpret their understanding of and expectations for the sector.

**Health Services Export as Niche Form of Tourism**

The significant role of recreational tourism in Barbados’ economy and society served as the most common point of reference for participants across both focus groups and situated their understanding and expectations of medical tourism. Participants noted that medical tourism was one among a host of diversification strategies for the country’s tourism sector being discussed in public forums alongside sports, heritage, and eco-tourism. Both focus groups noted that public conversation about medical tourism has been ongoing but sporadic, with government press releases and investor plans for facilities triggering ‘buzz’ in the media for developments that had yet to be realized. Altogether, medical tourism was not a pressing concern for participants and was situated unremarkably as just one form of tourism within the ongoing public conversation about tourism diversification and development. Because the existing tourism industry served to prime participants’ initial understandings of medical tourism and their expectations for its development, medical tourism was initially framed as an economic development issue and only secondarily understood as one concerning healthcare.

Participants of both focus groups perceived that Barbados has an international reputation for safety and privacy and that this reputation is a critical support for its tourism sector. However, medical tourism was seen as a disruption to maintaining the country’s reputation for safety due to the regulatory and monitoring challenges the sector poses. One participant summarized this concern:

...if you had a serious issue like you know some virus broke out because of whatever malpractice issue ... then all of a sudden no one is going to come here anymore for any medical tourism and then they may also impact on the general tourism, the sun, sea and sand because like say in Barbados you allow person to come there for treatment and they die. (Citizens)
Mirroring participants’ emphasis on interpreting medical tourism through their understanding of the recreational tourism sector, the potential negative impacts of health services export included wider economic impacts, not just those of healthcare and health equity.

**Existing International Healthcare Connections**

The stories shared by participants demonstrated that there is a popular awareness that Barbados is deeply integrated within existing international networks of care, in terms of Barbadians traveling for treatment, Barbadian hospitals providing care for patients in the surrounding region, and the well-established international routes of health workers moving to and from the country. Existing outbound medical travel by Barbadians was raised in both focus groups and was more relevant to participants than inbound medical tourism, summarized here by one participant stating

> I really don’t think that medical tourism is much on people’s radar here as something that is very prevalent or touches people’s lives from day to day you know, I don’t think most people even know to what extent that it happens …I think the average person is more, has more on their radar leaving for a medical procedure if it’s necessary than other people coming. (Citizens)

Discussions of mobility among Caribbean patients highlighted existing regional outbound healthcare networks. One participant noted that “I can envision people, wealthy Barbadians who would go to Miami, who would go to New York and those kind of places… I can see some of them remaining here, if there is such a facility and that saves us foreign exchange (Nurses). The idea of patients traveling abroad for medical care was, thus, a familiar one.

Further discussion among participants indicated that a factor influencing utilization of non-local health services was a desire to see specialists with higher volumes of patients, and thereby expertise, than is possible locally. For example:

> I think a lot of the issue with having the best care is not necessarily somebody here being unable to give you an opinion or unable to do the procedure, but when you look for example at Miami Children’s and you think about the fact that if you have to have something done for you [sic] child here who has a relatively rare something that the doctor here may
have seen twice, whereby you’ve got 500 children going through Miami every year [...] the level of expertise is always going to be different. (Citizens)

Although there was recognition that the development of a medical tourism sector could enable Barbadians to access care locally that is not currently available, there was concern among some participants that they would not want the presence of such services to lessen their access to procedures abroad that are funded by government or private insurance. “I would be very upset to be forced [by my insurance company] to go to [a renovated] St. Joseph Hospital [in Barbados built for medical tourists] because it’s now available here but it’s not necessarily the best care” (Citizens). Participants were keen to ensure that the development of a domestic medical tourism sector would not erode their own access to health services both at home and abroad.

While discussions on existing patient mobility mainly focused on Barbadians traveling to international destinations, inbound regional care networks were also mentioned as playing an important role in providing healthcare to Caribbean patients. Discussions on regional patient mobility particularly emphasized Barbados as an existing destination for patients from smaller nearby islands such as Antigua. Some participants indicated that the development of medical tourism in Barbados should consist of a concerted effort to increase the regional patient flow to Barbados. This was seen as a measure to enhance access to the “best care on home ground” (Citizens) for Caribbean patients by using the income generated from the increased provision of healthcare regionally to support health worker specialization and technological innovation locally; “If technologically it is more advanced and more effective and that is what you need for your health, if it is accessible, then I think we should make a way to make it available [to other Caribbean citizens]” (Citizens). Participants thereby expanded their understandings of scope of medical tourism beyond the existing local narrative of inbound Americans, Europeans, and Canadians to include a regional focus.

Clarifying Expectations

The focus groups explored different dimensions of an expanded Barbadian medical tourism sector, which were informed by participants’ knowledge of and exposure to medical tourism in Barbados thus far, specifically the Barbados Fertility Clinic and the
planning for the St. Joseph Hospital renovation by American World Clinics. Discussion of these two very different projects, in terms of scale, ownership, range of specialization, and system integration clarified participants’ expectations for what shape medical tourism in Barbados might take, the potential for local economic benefits, and the facilities’ degree of integration with the existing healthcare system. Discussions also highlighted some tensions between their expectations around the potential benefits to and negative impacts on the Barbadian healthcare system. For example, participants debated the system changes emerging as a result of interactions between medical tourism and the existing health system in relation to local regulations, professional associations, healthcare professionals, and local patients. In this section, we examine two distinct groupings of expectations, those pertaining to the scope and structure of the sector and those pertaining to its impacts on the health system.

**Scope and Structure of a Medical Tourism Sector**

The ongoing planning to develop foreign-owned hospitals in Barbados that will primarily staff non-local specialists and export their services to international patients (i.e. offshore medical services) was generally accepted by participants, but they did raise concerns about the degree of meaningful integration with the local economy. Some participants drew unfavourable parallels with all-inclusive recreational resorts in the Caribbean. Participants critiqued this tourism model for generating (mostly low-skill) employment for locals but few additional economic benefits for the host communities. There was shared agreement that medical tourism facilities had no obligation to reinvest profits locally but should in turn not be granted public subsidies such as tax concessions. It was also generally agreed among participants that any new medical facilities in Barbados should be affordable to local users such that they might directly benefit from their presence. Overall, a skeptical current ran through both focus groups as to the scale of benefits for Barbados in hosting foreign-owned hospitals:

I don't think that Barbados will benefit to the extent that we may think, that you may have a lot of spin offs, you can have thousands of jobs being generated and that sort of thing. I don't want to sound too pessimistic, but I like to err on the side of caution... the bulk of money will be staying over there [with international investors], it won't be here. Yes we will get something, but it will be the crumbs. (Nurses)
Participants wondered if and how any new medical tourism facilities might rely on, or operate in complete distinction from Barbados’ public healthcare facilities. Participants across both focus groups almost unanimously agreed that any new facilities should be self-sufficient in delivering the full spectrum of care they require, including critical care for emergent complications, and that they should not require any support or services from public hospitals and clinics. Because Barbados currently has only one (public) hospital capable of delivering tertiary care, participants did not want any private facilities introducing additional burden to the public system, one stating:

[W]e don’t want a situation where the new facilities impact on the QEH. They should be able to contain themselves. I think they should have an ICU [intensive care unit] and if there are any complications they should be able to maintain or at least...so that it doesn’t impact on general healthcare. (Citizens)

In the citizen focus group, some participants considered the potential for private facilities arranging to pay for any public care services they might need in the event of an emergency, but this was rebutted by other participants who thought any private imposition on the already burdened public system was unacceptable as it would directly translate into reduced access for local patients.

Finally, participants in both focus groups articulated a vision for what they thought would be the most successful and well-received form of medical tourism among Barbadians. At first consideration, participants closely associated medical tourism with cosmetic surgeries, for which there was widespread acceptance for a well-developed export sector. More generally, participants encouraged a form of medical tourism to Barbados that focused on elective, low-risk specialties and developing an internationally renowned niche.

[S]o what I’m say is instead of doing all these things if you were to build a facility and you were to advertise to the world, right that we have this facility we do knee replacements, we do hip replacement or we do something or the other and pick out half a dozen thing that you would specialize in so if you want a brain tumour work on, go somewhere else we don’t want you come here because we’re not involved in that. (Citizen)
Relatedly, some participants expressed a preference for local physicians forming the core of a Barbadian medical tourism industry through cultivating specialist niches among local providers instead of hosting large, foreign owned and staffed medical facilities. “What are we willing to invest in our people and getting our country up? Why not look at it that way... Why bring in somebody to run it for us?” (Nurses)

**System Disruption versus System Improvement**

Participants raised concerns that medical tourism could work to loosen regulatory standards for healthcare providers and weaken the nurses’ labour union. Discussion about professional oversight indicated that some participants were concerned that the potential for reliance on foreign healthcare professionals to provide the labour in new medical tourism facilities could overwhelm or elude professional regulation, one saying “are [foreign healthcare providers] just going to walk all over or circumvent the Barbados Medical Council or Nursing Council?” (Nurses). Participants in the nursing focus group emphasized their expectations that local training and licensing requirements should apply to foreign trained care workers and questioned the potential for pressures by international investors in private medical tourism facilities to change the standards set by these professional bodies. One participant raised the strong unionised labour tradition in Barbados, including nursing staff, and a concern that nurses could be impacted “if the owners of these facilities do not want persons who are unionised” (Nurses). This concern was framed by discussions of past instances of resistance to organized labour among international corporations set up in Barbados. Taken together, the focus groups demonstrated that there is concern about how offshore medical facilities would integrate with existing local professional institutions and labour norms.

Participants expressed an expectation that the development of a medical tourism industry would improve the existing healthcare system. It was hoped that medical tourism would provide local patients access to a wider range of specialties and services while also offering opportunities for knowledge-exchange between international and local care providers. This hope was partly informed by existing experiences where there have been cases of “a patient who has a special need and they bring down their specialised doctor, when the procedure is being done, both parties are present; the [doctor] from Barbados and the specialised doctor. So there is a little training goin’ on” (Nurses).
However, participants were also concerned that foreign health workers at new medical tourism facilities may serve to alter local patients’ health and healthcare expectations. This concern is summarized by the following quote:

It’s going to be a little bit of an issue for our medical professionals here. Because if you are going to get a real specialised person that is going to say ‘the doctor in the West Indies says that after 5 minutes you are dead, that is a lie, I can resuscitate you in 2 minutes or in half a second.’ So then the average person is going to say ‘oh well these doctors and medical people here [in Barbados] don’t really know what they are doing, I want outside treatment. (Nurses)

The expectation for collaborative, in-person engagement among health professionals that is suggested by the particular form of medical tourism participants advocated for in Barbados was thus seen to be in tension with the potential for conflict between clinical cultures and competition for patients.

Participant discussions highlighted concerns about the potential loss of healthcare workers in the public sector due to the emergence of medical tourism facilities as they expected the medical tourism sector would be a more attractive employer for health workers than the public sector. One participant expressed this concern in saying:

if the whole industry tends to grow, [and] if the facilities are set up in such a way that locals can’t really use the services and the doctors are attracted to go and work with these facilities and then locals don’t have access... to qualified doctors. Because obviously the most experienced ones are going to be attracted to go and work privately and they may not spend a lot of time working for the QEH. (Citizens)

Alternatively, participants also framed the medical tourism industry as a potential catalyst for improved working conditions in the public sector, expecting that increased competition from the private sector could “force our government, force our nursing governing body to review, to respect us, to encourage to continue education and give the opportunity for us to further our education without any further harassment or obstacle” (Nurses). The potential for new private facilities to increase local demand for nurses and introduce direct exposure to different clinical management styles raised hope among the nurse participants for improved working conditions, pay, and overall respect
for the nursing profession in Barbados. However, this was tempered by concerns that foreign owned facilities might plan on importing nurses to provide specialties rather than employing locals and providing employment and training opportunities.

### 4.5. Discussion

Much of the academic work examining medical tourism to date has focused on tracing the *potential* health equity implications of patients electively tapping into international networks of medical care beyond their home health systems. This early body of literature is largely focused on the potential impacts posed to abstracted health systems, including both systems that are ‘sending/losing’ and those ‘receiving/gaining’ patients (e.g. Blouin, 2007; Chambers & McIntosh, 2008; Horowitz et al., 2007). Only recently has scholarly research started to produce empirical accounts of the experiences of medical tourists, medical tourism facilitators, healthcare workers, and health system administrators in both ‘home’ and ‘destination’ countries (e.g. Hanefeld, Horsfall, Lunt, & Smith, 2013; Johnston et al., 2012; NaRanong & NaRanong, 2011; Ormond, 2011). Here we have used an empirical account to begin addressing another key existing gap in the medical tourism literature, namely how medical tourism is perceived by citizens and health system users in countries at a nascent stage of sector development. In the sub-sections that follow we examine the significance of the findings shared above and the implications they hold for further empirical investigation about medical tourism.

**Dynamic and Networked Destinations**

The focus group findings illustrate how Barbados’ medical tourism initiatives are being developed in a place that is enmeshed in existing international networks and relationships of trade, care, and migration. Participants highlighted a number of existing considerations that inform their understanding of medical tourism and their hopes and concerns surrounding the sector that reflect this dynamism. Firstly, the recreational tourism sector, with its large and existing role in the economy, emerged as an important part of national identity in the focus groups and served as a regular point of reference for framing what kind of national economic development is viable and welcome. The enormous economic value of tourism recognized by both focus groups as critical to
sustaining the country’s high standard of living, served as a dominant frame that had participants consider medical tourism as a niche form of tourism first and health services export second. This ordering seemingly prompted participants to accept the premise of the industry from the outset and begin working backwards to find the boundaries of where unacceptable interaction and infringement on existing health services begins instead of proceeding from the opposite direction and assuming the practice was unwelcome and working forward to find under what conditions it might be acceptable.

Similarly, other contextual factors familiar to Barbados and the wider Anglophone Caribbean resulted in participants’ ideas about and perceptions of migratory healthcare as rather unremarkable. The extraordinarily high rates of nursing emigration from the Caribbean and the existing regional care networks, both publicly and privately financed, that participants were all familiar with (and some had personally relied upon) contributed to broad agreement across both focus groups that an expanded medical tourism sector is an appropriate fit for Barbados’ future economic development. A key complementary factor underpinning the participants’ ease in conceptualizing the industry on the island was a resigned acceptance of the critical role international trade in services plays in the current Barbadian economy with regard to financial services and recreational tourism. The broad acceptability of exporting health services shared among the participants, however, was quickly contested once they began to explore the potential outcomes in detail. Instead, participants favoured a more tailored vision of medical tourism consistent with Connell’s critique of the Caribbean medical tourism sector (Connell, 2013b), as a sector that focuses on the development of niche areas of medical expertise. This finding suggests that new medical tourism developments being proposed in Barbados may be assisted by medical tourism’s indistinct and broad conceptualization among local residents, serving to prevent local critique and pushback until specific (potentially undesirable) projects are well underway.

Finally, participants’ general enthusiasm for incorporating regional Caribbean patients in developing Barbados’ medical tourism sector builds upon Ormond’s [36] call to consider regional ‘complementarities’ in care provision in discussions of internationalizing healthcare. Meanwhile, there is little discussion about the potential to grow regional healthcare networks through medical tourism in the policy and public
discussion about sector development (see, for example, Alleyne, 2010; Barbados Advocate, 2012; Johnston, Crooks, Snyder, Fraser, et al., 2013; Kirton, 2013). As a development strategy, Barbados would likely benefit from working with its neighbours to better document and formalize existing patient flows within the Caribbean in order to identify what specialties are locally oversupplied and in high demand regionally. While such an approach would not exclude simultaneous efforts to attract patients from outside the Caribbean region, reframing medical tourism so that it consciously includes all international patients and not exclusively those hailing from the ‘Global North’ would encourage the development of health infrastructure that is most relevant to local users. Such a narrative, however, runs counter to the ways in which medical tourism is regularly promoted in the Caribbean and elsewhere by industry groups such as the Medical Tourism Association, where the focus is on recruiting patients from the United States and other high-income nations.

**Grounding Health Equity Concerns**

Both focus groups raised three of the potential negative health equity impacts of medical tourism that are consistently discussed in the literature: 1) internal health worker migration from public to private facilities, 2) public resources being provided to private facilities to incentivize development, and 3) the emergence of two tiers of quality in medical care (Sen Gupta, 2011; Turner, 2007). Each of these concerns was perceived to be unwelcome, but each to a differing degree according to potential tradeoffs with health system benefits. Small-scale internal health worker migration, particularly in regard to nurses, was not desirable but was largely discussed by participants to be an understandable cost of trading in health services. Participants demonstrated tolerance for private sector competition for nursing labour, with many of the nurses, perhaps unsurprisingly, interested in a wider range of employment and training opportunities locally, higher pay, and a more rewarding work environment than what is currently found in the Barbadian health system. More significantly, some participants’ opposition to local specialists diminishing their participation in the public sector alongside their acceptance of additional private sector competition for nursing labour distinguished between what kind of labour competition emerging from medical tourism is understood to be unacceptable and that which is perceived as fair. Conversely, there was broad agreement among both focus groups that participants did not want any public resources
directly supporting the medical tourism industry, especially for foreign-owned facilities, with high resistance to tax concessions for workers’ income or facility profits. This differential weighting of various health equity concerns expressed by participants demonstrates the benefit of exploring the relevance of each concern for particular settings in future research and questions the suitability of framing all forms and instances of medical tourism as inherently prone to inequitable outcomes.

The (un)acceptability of medical tourism contributing to two different tiers of care within Barbados was much less clearly delineated within the focus groups than other health equity impacts that were discussed and caused the fiercest debate among participants. The existing Barbadian healthcare landscape, with a comprehensive and universally accessible public health system co-existing with a small private hospital and many private primary care clinics, informed the conversation around this concern. Because the existing universal public system attenuates any extreme situations of Barbadians being completely denied access to medically necessary care that medical tourists would be able to obtain privately, most participants saw expansion of medical tourism as an acceptable enlargement of the country’s existing private healthcare sector. However, some participants were brought to emotional exchanges at the prospect of hospitals supported by medical tourism exacerbating existing private/public healthcare inequities and inequities between citizens and foreign visitors on the island. Whereas the existing private hospital in Barbados is staffed by local specialists who also serve patients in the public hospital, the potential for a medical tourism facility to offer superior-quality care for local patients because of better amenities and/or more highly trained (foreign) specialists would produce an unacceptable alternate tier of care within the local healthcare system. One participant articulated this mode of medical tourism as “elitist healthcare” (Nurses) that would undermine health equity in the country. These concerns, when taken together, articulate a coherent vision of inequity where commercial interests in healthcare override access to equivalent quality care for local patients. This distinction of universal access to equivalent quality and range of care versus strictly equal financial and temporal access to care is critical in understanding what particular (and inevitable) trade-offs are considered fair in Barbados and what ‘two-tier’ care means across different international contexts.
Finally, the concern raised by some participants that a local, comprehensive-service private hospital made possible by medical tourism might ultimately limit their care options due to private health insurers refusing to continue to reimburse out of country alternatives has, to our knowledge, not been raised in the existing discussions of the health equity impacts of medical tourism. This finding highlights the unknown range of potential disruption to established healthcare norms and patient expectations that new hospitals supported by medical tourism pose. Along these lines, it underscores the need to undertake empirical research in order to capture on-the-ground insights about the complex ways in which medical tourism can positively or negatively impact health equity in specific places.

**Scale and Form of Internationalizing Healthcare**

Underlying all of the participants’ views about medical tourism in Barbados was an ongoing negotiation of the form and scale of medical tourism that was seen as an acceptable, if not desirable, fit for the country. Participants were largely pleased with the existing medical tourism activity, namely the Barbados Fertility Centre’s success in attracting international patients, due to the clear economic benefits of increased tourist numbers and the attendant local availability of fertility services. This broad agreement across both focus groups that Barbados should develop a medical service export strategy that relies upon a reputation for excellence in low-risk elective treatments provided by local practitioners was informed both by two of the participants’ core concerns not informed by health equity, namely protecting Barbados’ international reputation and maximizing economic gains for the local economy.

Participant concerns that the financial benefits of medical tourism might leave the island under foreign ownership were raised in relation to examples of unintended consequences from previous foreign investments in Barbados. Nursing participants’ expectations for the strong local nursing and support staff unions to be respected and integrated into the plans of foreign owned facilities raise questions of how equitable labour relations might be supported or undermined by the novel offshore model of medical tourism being pursued in the Caribbean, particularly given earlier instances of acrimonious relations between foreign-owned corporations and local organized labour. Similarly, the expectations of both focus groups for Barbados’ health professional
associations to be consulted and their certification requirements respected by offshore medical facilities highlight points of potential stress in globalizing healthcare arrangements. While the nursing focus group in particular saw great potential for training opportunities in a foreign-owned facility, participants also raised the example of a previous foreign investment in information technology that did not follow through on meaningful training of local workers that was part of its concessions package indicating some concern in promised benefits being realized. These expectations highlight investment conditions that might be leveraged by national governments considering foreign-owned medical tourism projects in order to ensure they benefit the existing domestic health system and its workers.

Relatedly, participants saw the potential for offshore hospitals to mirror the negative aspects of all-inclusive resorts in the Caribbean. When coupled with concerns around questions of long-term commitment among foreign investors, wariness of local care providers, and the hesitation to provide tax concessions as an incentive for facility establishment, there are potentially serious roadblocks for public support for offshore medical facilities in Barbados as well as the wider Caribbean. However, these same concerns might be outweighed by participants’ hopes for access to a greater range of care options, employment, and training locally, all of which were repeatedly tied to participants’ preferences for a locally integrated and small scale medical tourism industry. These preferences for the scope and scale of the industry by study participants echo and contribute to Connell’s (Connell, 2013b) exploration and critique of the current planning for medical tourism going on in the Caribbean, where he identified the region as likely to be unsuitable for large scale, comprehensive health services export.

Limitations

While this analysis provides some insight into the perceptions of some nurses and health system users in a specific medical tourism destination looking to expand its industry, it does not capture the outlooks of physicians, patients who solely rely on the private health sector, nor patients who are solely reliant on the public health sector. As such, the range of perspectives shared in the focus groups were limited in their scope to only one professional group and, with regard to education and employment, a relatively homogenous section of health system users who rely on a mixture of private and public
health services. However, we do not seek to provide a comprehensive account of the health equity concerns and benefits posed by medical tourism, but instead to both broaden the scope of existing health equity impacts that have been theorized and also explore their relevance among some of the groups that have been framed as those most directly impacted.

4.6. Conclusions

Our motivation for seeking to address the existing research gap surrounding local residents’ understandings of medical tourism in countries seeking to expand this sector is informed by two complementary concerns. Firstly, the growth of medical tourism, especially in the case of patients from high-income countries accessing care in low-income settings, has raised many significant health equity concerns regarding the fair use and distribution of domestic healthcare resources as they are incorporated into, or diverted toward, the international market. Arguments for economic development, complementarities between healthcare systems, existing systemic dysfunction, and prospects for improved care quality in destination countries have all been raised to complicate the ugly aesthetics of (relatively) wealthy foreigners unjustly appropriating scarce health-care resources in poorer nations (e.g. (Lautier, 2008; Ormond, 2011; R. Smith et al., 2011)). This health equity debate is ongoing and important, but arguably requires finer resolution and further grounding. This paper demonstrates the ability for empirical examples of medical tourism development to add nuance to this conversation. In the instance of Barbados, a relatively high-income nation possessing a universal healthcare system, the striking popular image of medical tourism characterised by full-service private hospitals amidst endemic poverty and poor local access to healthcare that has been popularized by cases such as India and Thailand does not hold. However, health equity concerns specific to the Barbadian context do factor into citizens’ considerations regarding the development of this sector and suggest directions in which medical tourism might be least disruptively pursued in small-island contexts.

Secondly, the exploration of the health equity impacts posed by medical tourism has yet to engage with a larger existing debate about what health equity actually is. This debate, in its most crude conception, pits universally normative claims about the
definition of good health and its value against culturally relativistic doubts about any truly ‘global’ conception of global health equity (e.g. Koplan et al., 2009; Rowson et al., 2012)). We argue that global health equity is least constructively conceived as a pre-determined normative goal or vision to be prescriptively satisfied and instead most valuably understood as a political process unfolding at international, national, and sub-national scales, one that meaningfully consults and incorporates the wishes and perspectives of stakeholders at each of these levels. This analysis is a small instance of the kind of consultations that can contribute to health system development that encourages genuinely equitable health outcomes understood to be acceptable and fair by its workers and users.

Finally, while our research findings highlight the importance of gaining contextualized considerations of health equity processes, particularly in relation to international healthcare markets, this research also demonstrates potentially shared experiences and concerns amongst tourism-dependent countries. Participant framing of this industry as another tourism diversification strategy indicates the high degree of interaction between the medical tourism and recreational tourism sectors in a national context that is deeply reliant on visitors. Participant discussions emphasized the importance of recreational tourism on the island and their expectation that the sector be protected and prioritized in policy-making and in any considerations of diversifying the country’s service exports. In these discussions, Barbados the country became Barbados the brand. This framing is counter to many scholars’ calls to move away from the term ‘medical tourism’ in favour of the more solemn ‘international medical travel’ (e.g. Kangas, 2010; Runnels & Turner, 2011). The strong relationship, in terms of economic and policy development, between the medical and recreational tourism sectors in tourism dependent locales demonstrates the importance of engaging with the language and literature of tourism when considering the development of the health services export sector, its potential impacts on local and global populations, and the creation of regulations and/or norms within the global industry. This engagement could be of use in better understanding and responding to the vulnerabilities characteristic of tourism-dependent contexts that are developing their health services export sector.
Acknowledgements

The authors wish to thank the focus group participants for their time and the invaluable experiences and perspectives they shared. Thanks also to Dr. Madhuvanti Murphy of the University of the West Indies, Cave Hill for her support and feedback on the project. This research was supported in part by Operating Grant funding from the Canadian Institutes of Health Research (application #257739). RJ is funded by a PhD fellowship from the Canadian Institutes of Health Research. VAC is supported by a Scholar Award from the Michael Smith Foundation for Health Research.
Chapter 5. From Bajan Clinics to Jamaican Hospitals

Chapter 6 moves from the preceding two chapters’ sole focus on medical tourism development in Barbados to examine the case of Jamaica. This shift in focus from country-to-region is continued in Chapter 8, which further expands the regional scope by including interview data from Guatemala and Mexico. This focal shift allows comparison and contrast of the developmental issues and implications surrounding medical tourism in the wider Caribbean.

In the early planning for my PhD project, I had intended on examining medical tourism development in Barbados, Jamaica, and Trinidad & Tobago, the three largest countries in the Anglophone Caribbean. However, discussions with participants in my initial fieldwork in Barbados and Jamaica in 2012 indicated that Trinidad was at a similar stage of sector development, albeit with a larger and better resourced private health sector. This suggested that there would be few unique insights from studying medical tourism development in Trinidad and thus I shifted my third fieldwork site to Belize in order to include a site with greater economic, health system, and geographic contrast while remaining within the Anglophone Caribbean. As the data collected from my Belize fieldwork is not formally incorporated into this dissertation, Chapter 6’s focus on Jamaica is the only remaining point of comparison within the Anglophone Caribbean that was originally intended as the entire focus of this dissertation.

The examination of Jamaica’s medical tourism sector in Chapter 6 provides a useful developmental foil for the analyses of Barbados in Chapters 2 and 4. At the same time, it enters into direct conversation with existing analyses of the development of medical tourism in Southeast Asia and its health system impacts there. The chapter’s dual role allows me to explore and confirm the relevance of key issues stemming from medical tourism development in Barbados, suggesting the applicability of the previous
two analyses to the wider Caribbean, while also contrasting them with what has been distilled from retrospective accounts from Malaysia, Thailand, and Singapore. Chapter 6 therefore provides a critical comparative hinge both among the analyses of the dissertation and for their relevance outside the Caribbean.
Chapter 6. Policy Implications of Medical Tourism Development in Destination Countries: Revisiting and Revising an Existing Framework by Examining the Case of Jamaica

6.1. Abstract

Background: Medical tourism is now targeted by many hospitals and governments worldwide for further growth and investment. Southeast Asia provides what is perhaps the best documented example of medical tourism development and promotion on a regional scale, but interest in the practice is growing in locations where it is not yet established. Numerous governments and private hospitals in the Caribbean have recently identified medical tourism as a priority for economic development. We explore here the projects, activities, and outlooks surrounding medical tourism and their anticipated economic and health sector policy implications in the Caribbean country of Jamaica. Specifically, we apply Pocock and Phua’s previously-published conceptual framework of policy implications raised by medical tourism to explore its relevance in this new context and to identify additional considerations raised by the Jamaican context.

Methods: Employing case study methodology, we conducted six weeks of qualitative fieldwork in Jamaica between October 2012 and July 2013. Semi-structured interviews with health, tourism, and trade sector stakeholders, on-site visits to health and tourism infrastructure, and reflexive journaling were all used to collect a comprehensive dataset of how medical tourism in Jamaica is being developed. Our analytic strategy involved

---

organizing our data within Pocock and Phua’s framework to identify overlapping and divergent issues.

**Results:** Many of the issues identified in Pocock and Phua’s policy implications framework are echoed in the planning and development of medical tourism in Jamaica. However, a number of additional implications, such as the involvement of international development agencies in facilitating interest in the sector, cyclical mobility of international health human resources, and the significance of health insurance portability in driving the growth of international hospital accreditation, arise from this new context and further enrich the original framework.

**Conclusions:** The framework developed by Pocock and Phua is a flexible common reference point with which to document issues raised by medical tourism in established and emerging destinations. However, the framework’s design does not lend itself to explaining how the underlying health system factors it identifies work to facilitate medical tourism’s development or how the specific impacts of the practice are likely to unfold.

### 6.2. Background

As international trade in services has become increasingly desirable, health services have been identified as a promising export sector by many national governments and business consultancies worldwide (Lautier, 2008; R. D. Smith, Chanda, & Tangcharoensathien, 2009). Medical tourism is one form of health services export that has recently attracted considerable attention, often reported as a sector that is quickly growing and immensely valuable (Connell, 2013b; Horowitz et al., 2007). Most generally, medical tourism describes the temporary movement of a patient outside the health system of their habitual country of residence for the purpose of purchasing medical care (Ormond, 2014). Here we consider medical tourism to be restricted to patients who intentionally travel to another country primarily for medical care and pay for their care privately. We impose this restriction in order to exclude ‘cross-border’ patients who are referred abroad by their home health systems and thereby face a different profile of health and financial risks than do medical tourists acting on their own (Glinos,
Southeast Asia provides what is perhaps the best documented regional example of medical tourism development and promotion, with numerous hospitals and national and provincial governments strategically targeting the sector for investment and further growth in the wake of the 1998 Asian Financial Crisis. Private hospitals in Singapore, Thailand, and Malaysia are all known to be attracting significant numbers of medical tourists from both within and outside the region (Heung, Kucukusta, & Song, 2010; A. Whittaker, 2008). These countries’ national governments have been very supportive of medical tourism, creating policies and organizations to increase the export of medical services. The policies and strategies adopted among these countries commonly include the creation of visas specifically for medical tourists (International Medical Travel Journal, 2013a; Leng, 2010; Meikeng, 2009), the reduction or elimination of taxation on imported medical equipment and supplies (Leng, 2010; Turner, 2007), incentives and/or requirements for international hospital accreditation (Leng, 2010), and international marketing efforts that advertise the high quality of medical care available (Leng, 2010; Ormond, 2013b). When taken together, these initiatives demonstrate a regional concentration of similar promotional and development initiatives among proximate health care markets competing for international privately-paying patients.

The Caribbean provides another example of region-wide interest in medical tourism. While Cuba has long supported its health system by treating medical tourists, its early pursuit of the sector was initiated by the collapse of economic support from the Soviet Union (Leng, 2010). St. Lucia, Barbados, the Cayman Islands, and Jamaica are among the countries in the Caribbean whose governments and hospitals have more recently identified medical tourism as a strategic priority for economic development (Adams, Snyder, Crooks, & Hoffman, 2014; Connell, 2013b; Feinsilver, 2010; Ramírez de Arellano, 2011) These latter countries and their health care sectors share similarities in their common development of facilitative frameworks for private health sector investment, their formation of national committees to guide the development of policies that support medical tourism, their participation in international trade conferences promoting medical tourism, and/or their development of new facilities whose primary
purpose is to treat medical tourists (Adams et al., 2014; Connell, 2013b; Ramírez de Arellano, 2011). These activities are an indication of the sustained and widespread interest across many Caribbean countries in developing their health services sectors for export. However, little is known about the perspectives, information, and goals driving these planning initiatives in the Caribbean or how a medical tourism sector is understood to interact with the existing health systems of these countries. This article provides a case study of the planning and development activities for the medical tourism sector in Jamaica using primary qualitative data collected in on-site fieldwork. This account provides insights into how and why the sector is emerging there and the implications its development for health policies.

**Jamaican Context**

In the past five years, Jamaica has undertaken all of the medical tourism development initiatives common to Caribbean nations described above (Benzler, 2011; Braham, 2014; Cunningham, 2013; International Medical Travel Journal, 2011; Jamaica Promotions Corporation, 2013). A small-island state with a population of 2.7 million, Jamaica is classified as an upper-middle-income country, although the country is deeply indebted and its economy is characterized by long-term stagnancy (Tennant, 2011; World Bank, 2013). Recreational tourism is one of the country’s largest economic sectors, representing roughly 8% of direct contribution to the country’s gross domestic product in 2013 (26% of the total including indirect and induced effects) and 7% of direct employment (Holzner, 2011; World Travel & Tourism Council, 2014b). The tourism industry – highly enclavic, dependent on imports, and with significant levels of foreign investment – is concentrated on the western and northern coasts, with Kingston, the capital and country’s economic centre, located on the south-central coast (D. A. Williams & Deslandes, 2008). Medical tourism has been framed by local proponents as a viable and lucrative sector that should be developed as a natural extension of the country’s existing tourism product (I. Brown, 2011; Cunningham, 2013; Jamaica Information Service, 2007).

In spite of the country’s economic difficulties, Jamaica has a relatively robust, if severely under-resourced, health system. Jamaica’s training programs for both
physicians and nurses are internationally respected, the country has a strong foundation of primary care delivery that has secured low rates of communicable disease and infant mortality, and the country possesses an established network of secondary and tertiary care centres in urban centres (Plummer, Roberts, Leake, & Mitchell, 2011). This strong provider network and Jamaica’s small size have resulted in geographically accessible health care throughout the country (Pan American Health Organization, 2012). Jamaican citizens have universal access to publicly funded primary care clinics and secondary and tertiary hospitals without user fees, although most Jamaicans with private health insurance or the means to afford out-of-pocket payments prefer to access primary and secondary care at private facilities due to negative perceptions of the public system (Bourne, 2010; Plummer et al., 2011; Scott & Theodore, 2013). This is a source of inequitable access between poorer and wealthier Jamaicans, with a greater range of care options and resources available to the portion of the population with a lower burden of poor health because of their higher socio-economic status (Scott & Theodore, 2013).

Overall, the vast majority of inpatient services are provided in public facilities while the private sector provides roughly half of the total share of outpatient services (Anderson-Jackson, McGrowder, Bourne, Crawford, & Whittaker, 2009).

While there are few financial barriers facing Jamaicans seeking public medical care, the country’s weak economy has proved a major challenge in sustaining adequate financing for the country’s medical facilities across both the public and private health sectors (Plummer et al., 2011; Scott & Theodore, 2013). Funding shortfalls have contributed to major staffing shortages among nurses and specialists nationwide, especially as they face relatively few barriers migrating to the more lucrative health systems of Canada, the United Kingdom, and the United States (Cawich et al., 2013; Salmon, Yan, Hewitt, & Guisinger, 2007). These health system factors serve as important context for Jamaica’s developing medical tourism industry, which is focused on the country’s private health care sector. Jamaica has eight private hospitals (Plummer et al., 2011), although there is little third party data available on their quality, range of services, or utilization. Reports on Jamaica’s overall health sector capacity do not provide detailed breakdowns of the public/private share of the country’s 4,800 hospital beds or its health human resources, nor are there reliable collations of
information about the private health sector in general (Tomblin Murphy, MacKenzie, Guy-Walker, & Walker, 2014).

Study Rationale and Goal

In this article we seek to contribute to the ongoing scholarly conversation about the impacts of medical tourism on health systems, their workers, and their local users (Hopkins et al., 2010; Johnston & Crooks, 2013; Lautier, 2014; A. Whittaker, 2008) by documenting and critically assessing the planning and perceptions surrounding the development of medical tourism in the Caribbean country of Jamaica. We do this by applying Pocock and Phua’s (Pocock & Phua, 2011) conceptual framework of the policy implications for destination countries posed by the development of medical tourism. Pocock and Phua previously developed this framework, published in Globalization & Health, following a retrospective review of the literature on the well-established medical tourism sectors in Malaysia, Singapore, and Thailand. Their purpose in developing this conceptual framework was not to assess the systemic elements of ‘successful’ health services exporters, but instead to highlight and organize common health policy implications raised by medical tourism for destination countries. Table 4-1 outlines the health system impacts and their associated policy implications identified by the framework, which are structured around core health system elements into the domains of governance, financing, delivery, regulation, and health human resources.

Table 6-1 - Pocock and Phua’s (2011) Conceptual Framework for Medical Tourism’s Policy Implications

<table>
<thead>
<tr>
<th>Policy Implications</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Governance</strong> (Legislation and Planning)</td>
</tr>
<tr>
<td>• number and content of health sector commitments in multi- and bilateral trade agreements</td>
</tr>
<tr>
<td>• regional trade blocs promoting trade in health services</td>
</tr>
<tr>
<td>• national medical tourism committees or agencies</td>
</tr>
<tr>
<td>• creation of medical tourism travel visas</td>
</tr>
<tr>
<td><strong>Financing</strong> (Fundraising and Payment)</td>
</tr>
<tr>
<td>• increase in out of pocket payments</td>
</tr>
<tr>
<td>• increasing interest in internationally portable health insurance</td>
</tr>
<tr>
<td><strong>Delivery</strong> (Service Provision and Infrastructure)</td>
</tr>
<tr>
<td>• growth of private health sector</td>
</tr>
<tr>
<td>• foreign direct investment in health infrastructure</td>
</tr>
</tbody>
</table>
Regulation
(Protocol Creation and Enforcement)

- public and private sector quality control
- international accreditation of health facilities
  (e.g. Joint Commission International)
- number of medical tourist visits facilitated by brokers

Human Health Resources
(Training and Supply of Care Personnel)

- distribution of specialists between public and private health sector
- future human resource capacity (re: training, availability, professional to population ratios)

The broad scope of the health system domains and the high-level considerations identified in Pocock and Phua’s framework encourage its application beyond the original context where it was developed. We use the existing framework to organize our findings from fieldwork in Jamaica that seeks to understand how medical tourism is being developed there. As Jamaica is prospectively developing a medical tourism sector located outside of the region where the conceptual framework was derived, we extend the framework and its implications outside its original geographic and temporal scope while also providing the first in-depth account of Jamaica’s plans for medical tourism. This approach explores the wider relevance of the framework and its implications in a new context and identifies numerous additional system impacts and policy implications from the Jamaican experience that refine or are not captured by the existing Pocock and Phua framework. These include new policy implications in every existing domain of the existing framework and the creation of an entirely new domain, that of ‘consumers’. Taken together, we believe our revised framework, derived from new insights gleaned from Jamaica, provides a more comprehensive range of relevant policy implications emerging from the development of medical tourism for monitoring and policy development worldwide.

6.3. Methods

Building on our existing Caribbean fieldwork (Adams et al., 2014; Johnston & Crooks, 2013; Johnston, Crooks, Snyder, & Whitmore, 2015), Jamaica was identified as a highly relevant site to prospectively explore how medical tourism is being pursued by Caribbean governments and health care providers that do not have an existing reputation for health services export. Ongoing monitoring of Caribbean media and online medical tourism promotion outlets such as the Medical Tourism Association and the
International Medical Travel Journal indicated Jamaica’s interest in developing a medical tourism sector. This was further reinforced by the presence of Jamaican representatives at the 2011 Global Healthcare Congress where the first two authors were in attendance. These initial impressions of Jamaica’s promotional activities for medical tourism made it clear that the country does not have sizeable existing inflows of international patients but that its government and care providers are working to build a medical tourism sector. This indicated that the country would serve as a suitable case to explore how medical tourism is emerging in a new location using Pocock and Phua’s framework to identify the health policy implications of its development.

After receiving ethics approval from Simon Fraser University’s research ethics board, we travelled to Jamaica in October, 2012, for a two-week period of on-site fieldwork. The first author returned to Jamaica for an additional four weeks of fieldwork in June/July, 2013. The research trips were structured within a case study methodological framework and employed a range of qualitative methods to better understand how medical tourism is currently understood and being mobilized in Jamaica. Semi-structured interviews with health system and tourism sector stakeholders; site visits to municipalities, health facilities, and recreational tourism locations; and daily researcher group journaling structured around shared reflective questions were all used to rigorously compile a comprehensive dataset.

6.3.1. Data Collection – Semi-Structured Interviews

While on-site, we sought to interview key-informants that could speak to the planning and development efforts for medical tourism in Jamaica as well as the existing health and/or tourism sectors. Potential interview participants were identified based on reviews of publicly available reports and news coverage of medical tourism in Jamaica, contacting individuals and organizations with roles relevant to medical tourism development, and ongoing referrals from interview participants. We sought to maximize the diversity of key-informants in order to capture a breadth of perspectives. Seventy-six potential participants and organizations were contacted and asked to follow up by phone or e-mail if they were interested in learning more about the study or scheduling a face-to-face interview at a time and location of their convenience. A letter of information outlining
the purpose and scope of the study as well as its risks and benefits was provided to participants prior to the interview, whereupon consent was obtained. Whenever possible, interviews were digitally recorded. However, six participants declined to be recorded and requested that only written notes be taken by the interviewer(s).

In total, 18 semi-structured interviews lasting from 30-60 minutes were conducted with representatives of public and private hospitals, extant and planned; government ministries; organizations charged with overseeing professional and regulatory roles in the medical sector; and individual medical professionals and tourism experts. Interview questions generally inquired about current strengths and challenges within the health system, medical tourism initiatives, and anticipated impacts of a medical tourism sector, though specific questions were tailored in order to speak to each participant’s expertise. Table 4-2 provides an overview of the participant numbers and their professional domains. Note that the total number is higher than 18 due to some cross-categorization of participants.

Table 6-2 - Participant Overview

<table>
<thead>
<tr>
<th>Employment Sector</th>
<th>Number of participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Governance</td>
<td>7</td>
</tr>
<tr>
<td>Academic and Training</td>
<td>4</td>
</tr>
<tr>
<td>Private Health Sector</td>
<td>5</td>
</tr>
<tr>
<td>Public Health Sector</td>
<td>3</td>
</tr>
<tr>
<td>Trade and Development</td>
<td>2</td>
</tr>
</tbody>
</table>

6.3.2. Data Collection – Site Visits

We based ourselves in Kingston, the Jamaican capital, during both fieldwork periods in order to facilitate interviews and visit Jamaica’s core medical infrastructure. A five-day trip to the country’s recreational tourism hub on the west coast was also conducted to meet with stakeholders and observe tourist and medical facilities there. Site visits were made to five existing medical facilities identified in interviews or news reports as potential locations for medical tourism, as well as two green-field locations positioned as future locations for medical tourism facilities. Site visits involved visiting surrounding communities where the (proposed) facilities are located, touring facilities to
view infrastructure and see operations first-hand, and informal conversations with workers and users when appropriate. Detailed written notes were taken by the researchers during and immediately after site visits and were transcribed and uploaded to our secure shared server for later analysis.

At the conclusion of each day during the first fieldwork period, we took one hour to write reflective notes around a set of common questions in order to capture our impressions of the site visits. Following writing, we met for an additional hour to discuss the written observations and interpretations of sites visited and debrief about the details shared in interviews during that day, recording common and divergent issues and interpretations. This daily exercise sought to ensure that a comprehensive range of observations was captured and also to improve interpretative agreement. During the second fieldwork period the first author kept an independent journal that recorded impressions and observations that was later shared among the team.

6.3.3. Data Analysis

Following each fieldwork period, all interview transcripts and field notes were compiled in a secure shared database. The database also holds all reports and news articles that were compiled in preparation for and collected during the research trips. Using a categorization scheme adapted from Pocock and Phua’s framework of policy implications emerging from medical tourism, the plans, issues, and actors referred to across the full dataset were organized into their respective domains (governance, financing, delivery, regulation, health human resources) by the first author. Plans, issues, and actors that did not conform to the existing scheme were noted and categorized separately. Following this, a synthesis of the categorized and non-conforming findings was circulated to the second and third authors to confirm their interpretation and comprehensiveness and achieve consensus. This process resulted in the most consistent of the non-conforming findings being agreed on as our sixth analytical category of ‘consumers’. Our findings from this domain are outlined in the section below following the results that fall within the existing five health policy domains identified by Pocock & Phua’s framework.
6.4. Results

In this section we organize our fieldwork findings according to the health system domains outlined in Pocock and Phua’s framework in order to facilitate comparison and discussion. Their domains are: governance, financing, delivery, regulation, and health human resources. Table 1 (above) provides a summary of how the framework characterized each domain and its associated policy implications. While we acknowledge the clear interrelationships between these five domains, we consider each separately in order to effectively engage with Pocock and Phua’s framework. Each section in our results briefly notes where the implications from the original framework are transferable to Jamaica’s experience, however we focus on the issues and impacts identified from our Jamaican fieldwork that were not part of Pocock and Phua’s original policy implications framework. We do so given their prominence in discussions with key-informants and in order to highlight and unpack these new considerations that warrant being factored into dialogues and future studies of the health policy implications raised by medical tourism.

Governance

With the exception of creating travel visa categories specifically for medical travellers, all of the policy implications resulting from the development of medical tourism outlined by Pocock and Phua’s conceptual framework are also found to be relevant to Jamaica’s sector planning. Our fieldwork revealed two additional impacts relevant to the governance domain not included in their original framework: 1) the expansion of ministerial responsibilities and convergence of inter-ministerial relationships; and 2) the involvement of international development organizations in initiating and sustaining interest in medical tourism. We separately expand on these two impacts below.

Jamaica’s national government has actively supported the development of a medical tourism sector in the country since at least 2007, with political leaders and government ministers from both main political parties expressing their support for specific hospital projects focusing on the international patient market and the broader idea of medical tourism as a viable strategy for economic growth. Most recently, the Ministry of Industry, Investment and Commerce, the Ministry of Tourism, and the Ministry
of Health have been jointly involved in laying the groundwork for a medical tourism sector. JAMPRO, an agency of the Ministry of Industry, Investment and Commerce that is responsible for attracting foreign direct investment and promoting Jamaican goods and services for export, has been the most active participant in spearheading sector development. For example, JAMPRO has recruited international consultants to assess the viability of medical tourism and directly participated in trade shows and conferences organized by the United States-based Medical Tourism Association and the regional Caribbean Export Development Agency. It has also convened national stakeholder meetings and drafted an incentive framework to develop policy and encourage private investment in the health services sector. Interview participants made it clear that JAMPRO has played the key leadership role in developing a vision for a Jamaican medical tourism sector and organizing policy development. Participants also indicated that the Ministries of Health and Tourism and the domestic private health sector, while supportive of medical tourism, have participated in a more limited consultative role rather than overseeing policy development or coordinating private investment in health facilities.

Another group of actors involved in medical tourism sector development and related to health sector governance that were raised in the interviews are international development organizations – a group not considered in Pocock and Phua’s framework. In conversations with participants, the Canadian International Development Agency (CIDA) and the Commonwealth Secretariat were both identified as having played some role in advancing the medical tourism sector. These economic development agencies have been directly implicated in the development of medical tourism by helping to fund regional Caribbean conferences on health tourism more broadly and in commissioning and funding the production of strategic reports that explore how to develop medical tourism in Jamaica. A participant further noted that funding provided by such agencies earmarked for economic development might be used in the future to commission additional studies or to offset tax incentives for growth in the medical tourism sector, demonstrating the potential scope and policy relevance of this consideration.
Financing

Our fieldwork found limited consideration of medical tourism’s likely influences on patterns of care financing. If discussed at all, out-of-pocket payments were understood to be the likely source of health care financing for any near-term plans for medical tourism. However, in light of Jamaica’s proximity to the United States and interest in attracting American patients and insurers, intersections between international hospital accreditation and international health insurance portability not identified in the original Pocock and Phua framework were regularly raised by participants from the medical sector. Progress on international health insurance portability was reported to be undermined by the lack of local medical facilities with international hospital accreditation. This was compounded by the significant financial barriers to successfully obtaining international accreditation facing medical facilities. As such, while accessing foreign insurance funds was perceived by most participants to be a long-term goal, out-of-pocket payments are understood to be the most likely financing method for international patients seeking care in the immediate future.

Delivery

Jamaica’s experience in planning for medical tourism thus far broadly confirms the applicability of Pocock and Phua’s anticipated policy-relevant issues in the delivery domain. Our fieldwork revealed three new implications relevant to this domain: 1) the utilization of existing, underutilized private sector supply; 2) an anticipated increase in for-profit health care delivery; and 3) the creation of ‘offshore’ medical facilities with deep ties to neighbouring health systems and foreign investment. These impacts are described below.

Our fieldwork found two distinct strategic models for the initial development of the Jamaican medical tourism sector being pursued simultaneously. In the first, medical tourism will primarily serve as an additional market for the existing stock of private hospitals. Jamaica has a number of private hospitals located in urban districts with nearby international airports. Participants reported that these existing private hospitals are both locally well-regarded as reputable and having under-utilized capacity. This excess capacity was identified by participants as being well suited to meeting the
demands of the international patient market because of the range and quality of services available. However, it was acknowledged that there are few international patients currently accessing these facilities outside of the Jamaican diaspora. International hospital accreditation was consistently identified as the largest barrier to immediately accessing the international market. This is because accreditation processes and the costs of the renovations they typically demand pose a large and immediate financial barrier.

A second project identified by participants as being spurred by the prospect of medical tourism involves the construction of a private wing within Cornwall Regional Hospital, an existing public hospital in Montego Bay. Planning for this new wing intends for it to be closely integrated into the infrastructure and operations of the existing public hospital, but for it to be privately financed and managed. Although it was noted by one participant that the primary reason for creating the wing is to both improve the quality of care available to tourists who injure themselves while visiting Montego Bay and to bring in medical tourists, they were careful to explain that its services would be available to private paying Jamaicans as well. It was also emphasized that the additional funds generated by private services would directly cross-subsidize a new public children’s hospital affiliated with Cornwall Regional Hospital, without which the new facility could not sustainably operate.

In the second model, new hospitals would be built primarily to serve (medical) tourists. This is evidenced in two recent projects. In the first project, American Global MD, a group of American physicians headed by a Jamaican-American, proposes an entirely new 75-bed private hospital explicitly framed as a medical tourism destination financed with foreign investment and built in Montego Bay, the largest city on the west coast. This facility would be staffed by American physicians, while the local population would fill nursing and ancillary positions. The second project is spearheaded by a charitable organization in the resort town of Negril, also on the west coast. The Negril International Hospital plans to serve as the hub of a larger retirement community that will target foreign and diasporic buyers. Its staffing model mirrors American Global MD’s approach, with foreign physicians supplying the specialty labour and medical tourists comprising the bulk of their cases. Local patients would be served in a charitable
capacity with medical tourists subsidizing their cost of care. This specific example of seasonal and year-round retirement migration supporting a medical tourism facility was favoured among numerous participants who see the realization of Jamaica’s existing plans to attract foreign and diasporic retirees to the country contingent on improving the quality of local medical care. Medical tourism is seen as providing the additional revenues required to viably sustain such health system improvements.

**Regulation**

Our fieldwork found that the issue of international hospital accreditation previously identified by Pocock and Phua’s framework was by far the most prominent regulatory issue raised in conversations with Jamaican stakeholders. Participants who had engaged with international consultants or workshops/conferences on medical tourism reported having the importance of hospital accreditation in internationally marketing hospitals emphasized to them. However, international hospital accreditation was widely perceived to be a large and costly barrier to attracting international patients, and concerns were shared that the accreditation might be clinically redundant to local standards already in place. This perception prompted some participants to raise the possibility of intra-regional coordination of health care standards and regulation as they relate to medical tourism, an issue not considered in Pocock and Phua’s framework. These same participants usually raised the example of harmonized health and safety standards developed for the spa and wellness tourism sector by the Caribbean Spa and Wellness Association as a model of how intra-regional coordination of the medical tourism sector at the pan-Caribbean scale could occur. With organizational assistance from CARICOM and funding from international development organizations, the Caribbean Spa and Wellness Association organized a committee to identify best practices from existing spa standards in North America, Europe, and Asia in order to address an existing regulatory gap. The result of this extensive review process was the creation of up-to-date health and safety regulations for spa and wellness service facilities shared across Caribbean countries. This case was presented as an example of successful regional regulation within the wider health tourism sector that could be copied in developing a regional hospital accreditation standard.
Health Human Resources

Discussions with Jamaican stakeholders and reviews of policy and media documents revealed that all health human resources-related policy implications identified by Pocock and Phua’s framework are relevant to Jamaica’s plans for an expanded medical tourism sector. We identified three additional policy-relevant issues pertaining to the health human resources domain: 1) health worker training as a marketing tool; 2) the increased overall demand for health human resources; and 3) the increasing international mobility and altered circulation of health human resources.

Jamaica’s health workers were repeatedly referred to by participants as the country’s greatest asset in developing the country’s medical tourism sector. This confidence stemmed from the long-standing international ties underpinning local training practices and standards that have produced high quality and culturally familiar medical traditions comparable to other Commonwealth countries. This confidence was also informed by the long history of Jamaican diaspora working as physicians and nurses in the health systems of Canada, the United Kingdom, and the United States. It was thought that the established familiarity of Jamaican health workers in these target medical tourist markets and their reputable and interpretable training backgrounds would serve as a powerful marketing tool for health service exports from Jamaica.

Participants were largely unconcerned by the potential for medical tourism to reduce the availability of physicians in the public health system due to increased demand. This perception was not the same across the two different models of medical tourism being discussed (i.e., domestic services export versus temporarily importing foreign health workers). With regard to the first model where Jamaican health care facilities and health workers provide the services, participants consistently reported that the existing arrangement between Jamaican private and public health care provides evidence that the two streams of delivery are not in competition, as most specialists participate in care delivery across both systems and nursing wages are comparable between them. Meanwhile, in the second model, facilities plan to recruit foreign physicians to work in Jamaica on a temporary basis at offshore hospitals focusing on medical tourists. This was seen as a way for foreign physicians and their families to go on vacation, to generate additional income or, as in the case of the Negril International
Hospital, to provide charitable care for locals as well. Thus, this second model was perceived as having limited potential to impact the existing Jamaican health system because of these facilities outsourcing much of their own specialist labour.

Given the extreme nursing shortage in Jamaica induced by extraordinary out-migration, participants generally gave deep consideration to the potential impacts on nursing availability in the public system resulting from additional demand for private health care, regardless of staffing formats for physicians. Nurse migration from Jamaica was chiefly presented as being motivated by a desire to earn more income abroad. Medical tourism was generally understood to be a counter-weight that would provide higher wages domestically, incentivizing nurses to remain in Jamaica and ultimately increasing the local availability of health workers. This widely shared outlook was contrasted by a minority who cautioned that the higher wages that could be supported by private care provision for international patients could serve to attract the most qualified or senior care providers from the public sector. Altogether, participants demonstrated greater sensitivity to medical tourism’s potential to impact the local availability of nurses than physicians.

Consumers

The domain of ‘consumers’ was not identified in Pocock and Phua’s original framework. Our fieldwork in Jamaica, however, raised a number of critical policy-relevant questions about how perceptions of the international patient market are compelling policy action and, in turn, how a larger volume of health service exports might alter the composition of health system users in medical destinations. Participants demonstrated a consistent vision of the composition of the international patient market and, consequently, the patients that Jamaican stakeholders are working to attract. There was a widespread perception that Jamaica will tap into a large market of under- or un-insured patients from the United States. While Canada and the United Kingdom were sometimes mentioned as additional markets, the United States is the predominant target market shaping stakeholders’ current expectations and planning efforts.

Participants typically did not identify patients from within the Latin American and Caribbean region or the Jamaican diaspora as potential medical tourists informing
current planning. Once prompted, participants generally expressed enthusiasm for attracting patients from wherever they might come, but it was clear that medical tourists are commonly interpreted as being patients from high-income settings who are not emigrants with ties to the country. This clarifies who are understood to be medical tourists among sector stakeholders in Jamaica and therefore which international patients are being most actively sought and planned for.

6.5. Discussion

The policy implications raised by the planning for medical tourism in Jamaica and their significance are discussed below within the domains of Pocock and Phua’s existing framework. Table 4-3 provides a synthesis of our additional key considerations.
| Table 6-3 - Additional Policy Implications from Medical Tourism Development |
|-------------------------------------------------|---------------------------------|------------------------------------------------------------|
| **Original Policy Implications**                | **Additional Implications Identified from Jamaican Case** |
| Governance (Legislation and Planning)           | • number and content of health sector commitments in multi- and bilateral trade agreements |
|                                                 | • regional trade blocs promoting trade in health services |
|                                                 | • national medical tourism committees or agencies |
|                                                 | • creation of medical tourism travel visas |
| Financing (Fundraising and Payment)              | • expanding / conflicting ministerial responsibilities and novel inter-ministerial relationships |
|                                                 | • involvement of international development organizations and foreign for-profit industry organizations in developing medical tourism sectors |
| Delivery (Service Provision and Infrastructure)  | • intersections between international hospital accreditation and international health insurance portability |
|                                                 | • utilization of existing private sector oversupply |
|                                                 | • increased for-profit healthcare delivery |
|                                                 | • cross-subsidization schemes to explicitly benefit locals |
|                                                 | • development of enclavish medical tourism facilities |
| Regulation (Protocol Creation and Enforcement)   | • regional development and coordination of healthcare standards |
| Human Health Resources (Training and Supply of Care Personnel) | • health worker training as marketing tool |
|                                                 | • increasing international mobility and circulation of healthcare labour (including importation) |
|                                                 | • increased demand for different types of health human resources with varying supply |
| Consumers (Composition and Number of Patients)   | • narrow conceptions of international patient market and inflated projections informing sector development |
|                                                 | • increased utilization of health services by emigrant diaspora |
Governance

In a departure from Pocock and Phua’s original framework, the involvement of Jamaica’s Ministry of Tourism in planning for medical tourism sector development reinforces that, regardless of discursive debates around medical tourism versus medical travel (Kangas, 2011; Turner, 2013), the frame being used to develop policy for the sector in emerging destinations hinges on existing experience with recreational tourism. This approach is producing novel intersections between government ministries, evident in the involvement of both the Ministry of Health and Ministry of Tourism in the consultation and policy planning being led by Jamaica’s foreign investment and export promotion corporation, JAMPRO. These intersections may result in incoherent or competing priorities informing the development of the sector. This was suggested by the regular conflation among many stakeholders that were interviewed between their enthusiasm and plans for a ‘health tourism’ product – including wellness retreats, complementary and alternative treatments – with the narrower, biomedical focus of ‘medical tourism’. The Ministries involved and their respective roles demonstrate that medical tourism is being pursued primarily as an economic, not health system, development project in Jamaica. While the Ministry of Health’s support for the sector may result in outcomes that benefit and integrate with the local health system, its role in developing and regulating an emergent medical tourism sector could also serve as a distraction from its core mandate of overseeing local health (care) concerns.

The role of international aid and development agencies as well as professional medical tourism industry associations observed in the Jamaican context was also not previously captured in Pocock and Phua’s framework. We think their role most coherently fits within the domain of ‘governance’ given the role that the various groups and institutions have played in informing and supporting sector development. Because of the potential for medical tourism to negatively impact the equitable delivery of health care (Hopkins et al., 2010), the support of international development organizations for the medical tourism sector raises important questions for both their accountability and overall coherence of different initiatives’ goals. Any efforts by development organizations to promote medical tourism as an economic development strategy must work to ensure that health equity is not compromised. This could be through concurrent efforts to advance initiatives such as universalizing health insurance coverage and transparent
healthcare cross-subsidization schemes in jurisdictions that are encouraged to develop medical tourism.

**Financing**

Medical tourism’s anticipated impacts on health care financing in Jamaica are consistent with those highlighted by Pocock and Phua’s framework, but our results indicate financing impacts are likely to be staged according to phases of sector development. While out of pocket payments are perceived to be a matter of necessity, access to an increasingly portable American and European health insurance market was described as a key long term goal. The original framework does not capture the relationship between access to international insurance markets and international hospital accreditation that was identified by Jamaican interview participants. This widely shared perception helps to further explain the growing popularity of international hospital accreditation. Instead of only being framed as a market response to individual patient demands for recognizable seals of quality, international hospital accreditation also positions hospitals as viable participants in an emerging, internationally portable insurance environment (A. Whittaker, 2008). International accreditation may be critical in anticipating current and future flows of insured international patients. Should the volume of international medical travel grow significantly, it will make it increasingly important to have a clear understanding of the strengths and limitations of the various international hospital accreditation standards that are being used to underwrite the risks of international care.

**Delivery**

The numerous new private hospital projects being planned for in Jamaica that are reliant on foreign patients confirm the original framework’s general insight that increasing interest in medical tourism is accompanied by the growth of the private health sector. Our findings further demonstrate that medical tourism is also spurring significant qualitative changes to health services organization and delivery. For example, medical tourism’s direct role in informing the planning for a new private wing in a public hospital with the expectation that it will cross-subsidize public access to care is not captured by the broad original consideration of a growing private health sector. Similarly, in systems such as Jamaica where participants reported excess capacity in the private health care
sector (a key element in narratives explaining the shift towards the international market among Asian hospitals (Leng, 2010), turning to international patients in order to meet existing capacity can be interpreted as more efficient utilization of existing private resources rather than overall growth of the private sector. This alternate interpretation of how the private health sector might engage in or respond to medical tourism raises questions about how under-utilized private hospital beds inform interest in medical tourism among hospitals and governments.

In their plans to focus their services on international patients, the proposed ‘offshore’ hospitals in Jamaica invert the existing model of medical tourism as a niche market for established hospitals. These plans are echoed in other Caribbean projects such as Health City in the Cayman Islands and American World Clinics in Barbados. These projects raise important health equity concerns for the health systems that host them (Adams et al., 2014; Connell, 2013b; Ramírez de Arellano, 2011). In primarily employing foreign specialists and treating foreign patients, these facilities would present an especially severe form of two-tiered care, particularly if associated with the enclavistic communities being planned for foreign retirees. The focus on increasing foreign investment in the health sector that these offshore hospitals represent is likely to be amplified by Jamaica’s weak economic position. Interview participants from the existing private health sector (dominated by a mixture of not-for-profit hospitals and small, for-profit, physician-owned speciality clinics) clearly articulated concerns that they would face difficulty accessing the financial resources necessary to upgrade their facilities to the quality capable of attracting international patients, suggesting immediate future development may be driven by foreign investment.

This above contrast in local versus foreign financial capacity raises further questions regarding the scale and structure of foreign investment in health services relative to domestic ownership, not just an anticipated absolute increase. Given Jamaica’s already crowded private hospital market, how will new, foreign-owned private hospitals impact existing locally-owned ones, especially with their attendant for-profit structure? Medical tourism development strategies that focus on inviting new, foreign investment could ultimately diminish domestic ownership in the private healthcare market over time and consolidate foreign ownership of health services. Contextual
dynamics such as these demonstrate that while ‘increased foreign direct investment in health services’ is a fruitful point of departure for considering the impacts of medical tourism on a healthcare environment, providing even a rough outline of the existing private healthcare landscape prior to the development of medical tourism is critical to unpacking how such an outcome might actually unfold on the ground.

Regulation

As highlighted by Pocock and Phua’s model, international hospital accreditation is closely tied to Jamaica’s plans to develop a medical tourism sector. Stakeholder interviews demonstrated that established medical tourism destinations’ experiences with international accreditation are informing Jamaica’s policy development for the sector. International consultants and organizations promoting medical tourism have driven home the importance of obtaining international hospital accreditation to Jamaican medical tourism stakeholders by raising successful examples from Malaysia, Thailand, and Costa Rica. This suggests that international hospital accreditation’s growth may have, in part, achieved self-reinforcing momentum as it becomes a core ingredient in the standard development formula being disseminated by international consultants promoting medical tourism. This requires investigation to determine if its high costs, relative to the economic conditions of the destinations pursuing them, are justified by a clinically relevant improvement in service quality. The Caribbean Spa and Wellness Association’s success in creating their own set of therapeutic standards demonstrates that cooperation in regulating emerging economic sectors related to health and wellness most broadly is a viable route for Caribbean countries. Should medical tourism development follow suit and serve to initiate the development of a regional hospital accreditation scheme, the sector could ultimately standardize and improve the quality of hospital care in emerging destinations without incurring the costs of more expensive international accreditation regimes. This potential is unlikely to be realized, however, should marketing considerations and international insurance portability provide the dominant reasons for seeking accreditation.

Human Resources

The original Pocock and Phua framework focuses on medical tourism’s influence on specialist behaviour, particularly the potential for a larger private patient market to
further incentivize specialists to reduce their participation in the public healthcare sector. This impact was largely interpreted as a non-issue by the majority of interview participants, being explained in three interrelated ways. Firstly, the largest medical tourism projects being pursued in Jamaica plan to rely on foreign specialist labour, insulating the local health system from losing its own supply of workers. Secondly, the kinds of procedures envisioned as constituting the bulk of medical tourist cases were elective, particularly plastic surgery and orthopaedic care, and thereby thought to insulate critical care specialities from negative impacts. Lastly, there was reported to be a great degree of existing participation across the public and private systems among specialists. It was reported that specialists seek out cases (and thereby payment) wherever available and rarely opt to solely practise in the private sector.

While the paucity of information on public versus private sector participation by medical specialists makes it impossible to independently confirm these perceptions above, they illustrate the outlooks driving the acceptability of medical tourism in emerging destinations. If medical tourism is understood to primarily deal in elective treatments, the kinds of specialist labour in increased private demand are not perceived as a threat to health equity. Arguably, this dominant outlook understates potential health equity impacts by neglecting to engage with the inevitable linkages between facilities, specialities, and overall health resources that occur in real-world health systems. Participants’ heightened sensitivity to the potential for medical tourism to place stress on the insufficient local supply of nurses demonstrates the relevance of these linkages. Their concerns also highlight the need to differentiate the impacts of medical tourism on different health professions. Whereas Pocock and Phua’s original framework focuses on medical tourism’s impacts on specialists and largely ignores other groups of health workers, future research examining medical tourism’s impacts should seek to understand how it influences nurses, specialists, and generalists as they vary both in supply and in the degree of control they have over where and how often they work.

Lastly, we propose the addition of ‘health worker training as a marketing tool’ to the ‘human health resources’ domain because of both how often participants emphasized the quality and familiarity of Jamaican health workers as a justification for developing medical tourism sector and given the discussion of training elsewhere in the
literature as an asset to sector development (Ormond, 2013a; Walton-Roberts, 2015). This consideration is significant in understanding the factors that initiate and sustain interest in developing medical tourism and a key factor driving the perceived viability of the sector in Jamaica. Furthermore, formal and informal connections between health systems, particularly international patterns of health worker training and employment, are potentially powerful predictive precursors of international patient flows.

**Consumers**

Our fieldwork demonstrates that the beliefs surrounding who medical tourists are and the scope of their numbers are critical in understanding the enthusiasm among countries seeking to become medical tourism destinations. While there is no doubt that there are American patients willing to travel for medical care, the widespread uptake among health and tourism sector stakeholders in Jamaica of inflated projections that have been disseminated by industry promoters and consultants such as the Medical Tourism Association and Deloitte’s 2008 report on medical tourism (Deloitte Centre for Health Solutions, 2008) is alarming. These sources’ wide-ranging estimates and implicit expectation that the American health system will continue to fail in adequately insuring its own population have been critiqued as overly narrow and inaccurate elsewhere (e.g. Connell, 2013a; Ormond & Sulianti, 2014). Regardless, articulating who sector stakeholders are targeting when developing medical tourism is important in unpacking the likely economic returns and health system impacts that the sector will produce. For example, recent work from Lunt et al. (2014) and other scholars examining medical tourism (e.g. Noree, Hanefeld, & Smith, 2014; Ormond & Sulianti, 2014) suggest that the international patient market is most accurately understood as relatively small and reliant on existing social ties between particular ‘source’ and ‘destination’ countries, rather than a large, unattached market of atomised patient-consumers with a willingness to travel anywhere for the care they want. While less economically tantalizing, broadening the popular conception of medical tourists beyond the image of the uninsured American patient or wait-listed Canadian or Briton to focus on regional and diasporic populations could promote the development of health services exports that are likely to have greater uptake while also being more relevant and accessible to the domestic population.


**Study Limitations**

As researchers with no personal or cultural ties to Jamaica, the issues that were raised in interviews and the manner in which they were framed by participants may be different than those produced by a local researcher. Controversial issues or factors that might negatively impact foreign perception of Jamaica (e.g., high crime and violence rates) may have been omitted by participants, even unintentionally. As our findings emerged from a qualitative case study design, the policy implications raised here are not generalizable to all jurisdictions developing medical tourism sectors. This is not a true limitation, though, as qualitative research seeks to achieve transferability and not generalizability. Further to this, the considerations identified here and in the original framework are intended to raise implications for further investigation rather than serve as a prescriptive account.

### 6.6. Conclusions

This analysis demonstrates that the domains of Pocock and Phua’s framework for identifying policy-relevant implications of the medical tourism sector provide a useful common reference point for exploring the development of medical tourism in new contexts. The original framework’s inclusion of very specific issues (e.g. ‘creation of medical tourism visas’) alongside broad ones (e.g. ‘growth of private health sector’) and the absence of distinction between the drivers and impacts of medical tourism provides great latitude in adapting it to different locations and stages of development, including Caribbean countries like Jamaica. While its basic design does not supply explanatory power or trace the relationships between the pre-existing conditions that facilitate medical tourism and the impacts of the practice, the Pocock and Phua framework does provide a useful organizational scheme to identify and compile additional policy-relevant observations. For example, most of the additional policy implications that we identified in the Jamaican context are logical extensions of the original five domains in the framework. Our addition of ‘consumers’ to the framework as a new policy-relevant domain expands Pocock and Phua’s original conceptualization to capture issues emerging from our work in the Jamaican context. It is likely that the numerous previously
unidentified policy implications and new domain reported in the current analysis hold true for the wider Caribbean and are also relevant beyond the region.

We believe that future health services research examining medical tourism can further and meaningfully contribute to refining the Pocock and Phua framework by identifying additional implications emerging from the development and operation of the sector in other countries and regions beyond those already considered. Such research will assist in assessing the global transferability of the framework. Future studies can also advance our understanding of the policy implications of medical tourism development by undertaking comparative analyses of the implications specific to particular framework domains, which will help us to understand the role that local context plays in shaping how they are occurring in particular ways in specific places. At the same time, such research will further our understanding of common trends that are structuring the development of medical tourism worldwide and the scope of its health system impacts and policy implications despite such differences.

**Acknowledgements**

We are very grateful to the interview participants for their generous contribution of time and knowledge. This study was funded by a Planning Grant awarded by the Canadian Institutes for Health Research (FRN 122685). RJ holds a Banting and Best Doctoral Award from the Canadian Institutes for Health Research. VAC is funded by a Scholar Award from the Michael Smith Foundation for Health Research and holds the Canada Research Chair in Health Service Geographies.
Chapter 7. Expanding the Regional Scope

Temporally, Chapters 2, 4, and 6 are all tightly connected to one another. My analysis of the dataset in Chapter 2 coincided with the same period of time that my supervisor and I were preparing our research grant to visit Jamaica with Dr. Meghann Ormond, six months after our first visit to Barbados. Similarly, data collection for Chapter 4 was situated between my two periods of fieldwork in Jamaica that are documented in Chapter 6. My analyses of the data for Chapters 4 and 6 began within a season of one another. As such, the first three chapters are in close conversation with each other and are informed by my co-authors’ and my general state of knowledge of medical tourism in 2011-2013. While the time between Chapters 2-6 does capture a degree of evolution in my thinking about medical tourism in the Caribbean, they are all to some degree animated by the specificity of the offshore hospital model that was first articulated in Barbados and then picked up throughout the small-island states of the Caribbean.

The final analysis, Chapter 8, lies outside of the flurry of research activity that produced the earlier three analytic chapters. While the Barbados dataset it draws on was collected in the same summer as my second period of Jamaican fieldwork in 2013, it preceded the conclusion of data collection in Guatemala and Mexico and its complete transcription/translation by a full 18 months. This delay was by design. My role as a research assistant in Barbados was to pilot the research tools and protocols for the multi-country study this work would contribute to in order to identify and iron out any study-design flaws before our research collaborators used them in Guatemala and Mexico. This temporal delay, particularly when combined with my remove from the data collected in Guatemala and Mexico, and the tight word limit of the journal it was submitted to, gives the analysis presented in Chapter 8 the feel of a broad post-script that concisely articulates the wider relevance of some of the key issues identified in the first three dissertation chapters.
The long time I had to reflect on the issues that arose from my fieldwork in 2013, as well as the lessons learned from my Belizian fieldwork in February 2014, is reflected in the core issues brought to the fore in Chapter 8. When coding the full multi-country (Barbados, Mexico, Guatemala) dataset in the early winter of 2015, I was struck by the close parallel development experiences and health system environments described by the participants from countries representing such different economic, cultural, and health system contexts. In particular, the strong, informal connections shared between their health systems and that of the United States (and in some cases, one another) was at the forefront of my mind when interpreting the data. The collective accounts of the 150 interview participants trace the extra-territorial shadow system of Latin American and Caribbean patients and doctors already traveling for training and care in the United States. A full suite of integrated health system considerations encompassing care financing, worker training, patient expectations, care quality, and infrastructure capacity were all expressed relationally between the Caribbean countries and the United States. These considerations provide the foundations for anticipating and interpreting emergent international health systems, particularly in the private health sector.

Chapter 8 provides expansive confirmation that it is the dynamics of the existing relational, international healthcare environment that are shaping Caribbean medical tourism development. Medical tourism has emerged in the Caribbean as a ‘natural’ counterweight to the powerful influence the United States’ health system already exerts within the region through its exports of medical procedures and training. In particular, the widely shared goal of obtaining international hospital accreditation to access pools of private health insurance was echoed in Mexico, Guatemala, and Barbados despite it being first clearly articulated by participants in Jamaica. This speaks to the relatively narrow policy horizon stakeholders throughout the region are working within when identifying avenues to raise the additional funds necessary to improve relatively under-resourced health systems. The sole focus on private healthcare financing to address the health resource shortcomings signalled by the pursuit of medical tourism belies the potential wider range of policy approaches that could raise the necessary funds using regional patient pools. In particular, the final chapter and the dissertation as a whole suggest that turning inward within the Caribbean region to share funds and coordinate care for Caribbean patients between countries could be a viable alternative to solving
the core problem that medical tourism seeks to solve using a laissez-faire private market approach.
Chapter 8. Inbound Medical Tourism in Central America and the Caribbean: Factors Driving and Inhibiting Sector Development and Their Health Equity Implications

8.1. Abstract

Objective: To identify common social, economic, and health system factors shaping development of medical tourism in three Central America and Caribbean countries and their health equity implications.

Methods: In depth, semi-structured interviews were conducted in Mexico, Guatemala, and Barbados with 150 health system stakeholders. Participants were recruited from private and public sectors in: trade and economic development, health services delivery, training, and administration, and civil society. Transcribed interviews were coded using qualitative data management software and thematic analysis was used to identify cross-cutting issues regarding the drivers and inhibitors of medical tourism development.

Findings: Four common drivers of medical tourism development are: 1) unused capacity in existing private hospitals, 2) international portability of health insurance, vis-a-vis international hospital accreditation, 3) internationally trained physicians as both marketable assets and industry entrepreneurs, and 4) promotion of medical tourism by public export development corporations. Three common inhibitors to development of the sector were also identified: 1) the high expense of market entry, 2) poor sector-wide

planning, and 3) structural socio-economic issues such as insecurity or relatively high business costs and financial risks.

**Conclusion:** There are shared factors shaping the development of medical tourism in Central America and the Caribbean that help explain why it is being pursued by many hospitals and governments in the region. Development of the sector is primarily being driven by public investment promotion agencies and the private health sector seeking economic benefits with limited consideration and planning for the health equity concerns medical tourism raises.

### 8.2. Introduction

The number of patients traveling internationally for medical care is believed to have increased over the past decade (Connell, 2013a; Kannan, 2014; Lautier, 2014; Leng, 2010; NaRanong & NaRanong, 2011; Ormond, 2013b; Pocock & Phua, 2011; Shetty, 2010; Turner, 2007). This growth is attributed to the improved quality of medical care available worldwide and the relative ease of marketing and researching care online. While the actual number of patients traveling for care is unknown due to poor surveillance and inconsistencies in distinguishing the different modalities of international patient flows, this swell in health service exports has significant implications for the resources and operations of health systems globally (Connell, 2013a; Lautier, 2014; NaRanong & NaRanong, 2011; Ormond, 2013b; Pocock & Phua, 2011; Turner, 2007). In this article we focus on 'medical tourism,’ defined as the intentional, private purchase of elective biomedical services outside of a patient’s country of residence.

Many governments and health care providers worldwide are enthusiastic to develop medical tourism as a service export (Kannan, 2014; Leng, 2010; Shetty, 2010). Despite the popularity of this policy uptake, there is relatively little known about the specific local factors and discourses informing development of this sector. While there are studies of established medical tourism sectors, particularly from Southeast Asia (Leng, 2010; Ormond, 2013a; Pocock & Phua, 2011; Shetty, 2010), the existing literature has focused on theorizing the potential economic and health system impacts of the practice (Connell, 2013a; Lautier, 2014; NaRanong & NaRanong, 2011; Turner,
These analyses are predominately retrospective examinations of successful health services exporters; as such they have inherent limitations on the insights they offer into why medical tourism has taken root where it has and the implications for its development elsewhere.

This article draws from the first comparative case study of medical tourism in the Central American and Caribbean (CAC) region using primary qualitative data. This analysis examines common factors driving and inhibiting the contemporary development of medical tourism in Mexico, Guatemala, and Barbados\(^8\). These countries are all health service exporters, albeit on very different scales and in distinct socio-economic contexts, and have governments and hospitals working to increase the number of visits by medical tourists (Barbados Advocate, 2012; Figueroa, 2014; La Nación, 2011). We report here on the findings from interviews with public and private sector stakeholders in these countries’ health, tourism, trade, and civil society sectors that identify common factors informing the industry’s development. These factors illustrate why and how medical tourism is being actively promoted in CAC countries and articulates impacts it may have on regional health equity.

### 8.3. Methods

This analysis contributes to the second stage of a multi-country case study examining the health equity implications of medical tourism in Mexico, Guatemala, and Barbados\(^9\). This stage comprises 150 semi-structured interviews with stakeholders.

---

\(^8\) The varying magnitude of existing medical tourism among the three countries, as a function of health system capacity and quality, was purposely sought in order to explore the factors driving medical tourism across a range of developmental contexts. In Mexico, stakeholders were limited to Tijuana, Monterrey, and Mexico City as the former are known to be centres of health service exports and the latter is the administrative and economic centre of the country.

\(^9\) The first stage of the study documented retrospective accounts of existing medical tourism activity and sector development in each study site using secondary data. This stage was conducted over twelve months from June 2012 to June 2013 to provide a baseline understanding of medical tourism activity and discussions in each country. The third stage, conducted in the Autumn of 2014, consulted Canadian health system stakeholders about the second stage findings to explore their perspectives on the resulting kinds of responsibilities and planning responses by high-income countries implicated in medical tourism via foreign investment and international consumption of health services by their citizens.
involved in or affected by medical tourism, drawn equally from each country. Participants were sought from four broad domains: health human resources, government ministries and public companies, the private health and tourism sectors, and civil society (see Table 5-1).

Table 8-1 -Interview Participants’ Professional Domains

<table>
<thead>
<tr>
<th>Domain</th>
<th>Examples of Professional Expertise</th>
<th># per site</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Human Resources</td>
<td>Nursing and physician training, certification, professional organizations, frontline service delivery</td>
<td>15</td>
</tr>
<tr>
<td>Public Sector</td>
<td>Public policy development, health administration, research, or regulation, public investment and trade promotion organizations</td>
<td>15</td>
</tr>
<tr>
<td>Private Sector</td>
<td>Private hospital administration, tourism operators, private consultants, organizations and individuals involved in private healthcare investment and trade promotion</td>
<td>15</td>
</tr>
<tr>
<td>Civil Society</td>
<td>Non-governmental organizations with mandates including public health, journalists, academics</td>
<td>5</td>
</tr>
</tbody>
</table>

Ethics approval for the study design was granted by the research ethics boards of the lead researchers in each study site. See Box 1 for an overview of the ethical considerations incorporated into the research process.

Box 1 – Key Ethical Research Practices Implemented

- Review of study design by institutional research ethics boards in both the lead researcher’s university and ethics boards in study sites with review panels
- Study invitations clearly explained study rationale and goals and introduced both the international and local researchers, their affiliations and their associated research ethics’ boards, and contact information was provided for all parties
- Study invitations clearly stated the potential risks and benefits of participation and participants’ rights to not answer questions and to withdraw their contribution at any point
- Study invitations were sent prior to interview date for participant review and all participants maintained the right to withdraw their contribution at any point
Potential participants were identified from secondary data collected on medical tourism projects (Cerón, Flores, Crooks, Labonté, & Snyder, 2014; Johnston, Crooks, Snyder, Fraser, et al., 2013; Núñez et al., 2014), professional roles in relevant ministries, organizations, or companies, and rolling recruitment from participants. Each potential participant’s domain was classified by the interviewing researcher and confirmed by the site’s lead researcher. All participants remained enrolled in the study until conclusion.

The interview guide was created in English and translated to Spanish by a professional translator. The guide comprised a general set of opening questions regarding the participant’s background, health system knowledge, and general knowledge of medical tourism, followed by five sets of questions in key domains of medical tourism development and impact: health human resources, trade and investment, government involvement, the public health sector, and the private health sector. Following the opening questions, each participant was asked only questions from domains where they had knowledge so as to increase the specificity of their answers while reducing frustration by avoiding areas of questioning not relevant to their expertise.

An initial round of fieldwork by RJ, VAC, and JS was conducted in Barbados in the summer of 2013 to establish the usefulness of the interview guide. Interviews were then conducted on site by AC and a research assistant in Guatemala and EON and three research assistants in Mexico between August 2013 and November 2014. Interviews across all sites ran from 30-60 minutes in length. Interviews were digitally recorded and transcribed, with the Spanish interviews translated to English by the same two translators.

All transcriptions were uploaded to the qualitative data management software NVivo10 (QSR International, 2012) for coding. Following a review of five unique transcripts apiece, the lead investigators independently created an initial coding scheme.
A meeting was held to consolidate the codes into a single scheme, which was applied to six transcripts (two from each site) to identify redundant and missing codes and produce a final coding scheme following further discussion among the lead investigators. To maintain coding consistency and coherence across the dataset, RJ coded all 150 transcripts. The data coded for ‘drivers’ and ‘inhibitors’ of medical tourism development were reviewed by RJ and VAC to identify and compare cross-cutting themes and issues that emerged across the dataset and were discussed with the larger team to seek consensus on interpretation. This thematic analysis, as part of our comparative case study, was made possible through identical sampling and interview schedules used across the three countries.

8.4. Findings

The interviews highlighted unique factors in Mexico, Guatemala, and Barbados that are informing the development of the medical tourism sectors in each country. The comparative thematic analysis identified four drivers and three inhibitors common to sector development in all three countries. Tables providing illustrative quotes of these factors accompany each section.

Factors Driving Sector Development

Stakeholders across Barbados, Guatemala, and Mexico understand medical tourism as, first and foremost, an economic issue. The sector is being developed in order to diversify tourism sectors and create economic returns. Very few stakeholders, even within public health sector authorities, framed medical tourism as an issue of health systems operations and planning. Four interrelated and cross-cutting factors driving the development of medical tourism were raised by stakeholders in all three countries: 1) excess capacity in the private health sector, 2) foreign trained health workers, 3) international hospital accreditation, and 4) medical tourism promotion and development initiatives by publicly owned investment and export promotion companies.
Excess Private Sector Capacity

Interview participants in all countries explained how insufficient local demand for private healthcare has stoked interest among private care providers in bringing international patients to fill underutilized hospital beds. While this lack of local demand was attributed to limited private insurance uptake and financial barriers to private care among local patients, the small population of Barbados was identified as an additional contributing factor because of the limits it places on local demand. Select private facilities with advanced infrastructure and staff with foreign training in all three countries were reported to be planning for or marketing to foreign patients.

Table 8-2 - Illustrative Quotes of Excess Private Sector Capacity

<table>
<thead>
<tr>
<th>Country</th>
<th>Quote</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Guatemala</td>
<td>...we really do have an opportunity here due to our good private local health services, they are not saturated.</td>
<td>(Private Sector - 08)</td>
</tr>
<tr>
<td>Mexico</td>
<td>Private hospitals, in this City and the rest of the country, don't work to the 100%, we work to the 65%, 70%. If we do great in one month, we might be at 85.</td>
<td>(Private Sector – DF - 02)</td>
</tr>
<tr>
<td>Barbados</td>
<td>I say to you come set up our clinic and yes there are thirty percent of your clients can be Barbadians but...even if the cases are there the persons to pay won't be there.</td>
<td>(Public Sector – 01)</td>
</tr>
<tr>
<td></td>
<td>Health and tourism is just an expansion of the private sector in the capacity of occupancy they have. Because right now their occupancy doesn't even reach 70%.</td>
<td>(Private Sector - 19)</td>
</tr>
<tr>
<td></td>
<td>...there are hospitals [that] have an inventory of available hospital rooms that are not being occupied, or areas of opportunity for their doctors or for specialty areas they have, then they say they can explore and participate in a percentage to direct their efforts to [medical tourism].</td>
<td>(Public Sector – MISC - 06)</td>
</tr>
<tr>
<td></td>
<td>Without medical tourism the kind of facility that we had in mind...simply could not survive on the million tourists that come in a year and the 280,000 people who live on the island, so it really had to have a medical tourism input [...they estimated that forty percent of the patient volume would come from overseas.]</td>
<td>(Private Sector - 07)</td>
</tr>
</tbody>
</table>
Foreign Trained Health Workers

Health workers with foreign training, particularly physicians educated in the United States and Europe, were frequently discussed in relation to medical tourism. Firstly, foreign trained health workers were framed as indicators of the quality of care available locally and understood to be an asset to marketing medical care to patients from high-income settings. Physicians with international training, particularly those who also own their facilities, were raised as key players in advancing private sector interest in marketing care to foreign patients. In addition to the prestige and interpretability of their qualifications for foreign patients, internationally trained physicians’ English language proficiency and motivation to maintain their skill set while practicing in high-end clinical environments were discussed as factors motivating medical tourism development.

Table 8-3 - Illustrative Quotes of Foreign Trained Health Workers

<table>
<thead>
<tr>
<th>Country</th>
<th>Quote</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Guatemala</td>
<td>Physicians that leave the country and develop outside of the country have very little local practice, community practice. This and the lack of regulation of all the private system has created corporate companies [with] the capacity to provide services similar to the quality offered abroad for very low prices, where even the physician have been trained in other countries.</td>
<td>(Human Health Resources - 07)</td>
</tr>
<tr>
<td>Mexico</td>
<td>We have a… physician with a lot of capacity [who] had the vision to go train in Italy with a physician who managed all those techniques…[for] bariatric surgery to treat obesity. In the United States these procedures were still under approval [and] during this process the physicians that knew him over there [in the USA] began to refer him patients.</td>
<td>(Private Sector – MTRY - 06)</td>
</tr>
<tr>
<td>Barbados</td>
<td>...to service an international patient you have to have an international mentality.</td>
<td>...the doctors that are brilliant and ambitious and want to learn more, want international recognition, they go abroad, they get specialized and then come back. So what happens? There are patients that will follow them because they know here they will charge less.</td>
</tr>
</tbody>
</table>
And a lot of the people that we hired were people who worked abroad... You know they have to have a bigger picture to be able to treat medical tourists.

(Private Sector - 06)

North American trained, but board certified within the region. So it’s a matter now of just seeing where the gaps are … and how we can get to that critical level where we can say yes, this is a sector we can confidently market to whatever target market we want.

(Public Sector - 05)

International Hospital Accreditation

Medical tourism is widely understood to be a ‘pay-to-play’ arena, where international hospital accreditation is the entry fee. Many large private hospitals in Mexico have been internationally accredited, two in Guatemala were seeking accreditation at the time of data collection, a clinic in Barbados has obtained such accreditation and development plans for a new private facility there note that international accreditation will be sought. It was reported that while international accreditation serves as a quality indicator for marketing to international patients, it was also widely understood to permit access to the American health insurance market, without which it would be difficult to be considered a legitimate care provider. Perhaps most significantly, Mexican stakeholders reported that domestic hospital accreditation is currently being harmonized with international hospital accreditation standards to improve care quality and facilitate insurance portability.

Table 8-4 - Illustrative Quotes of International Hospital Accreditation

<table>
<thead>
<tr>
<th>Guatemala</th>
<th>I used to say to myself, why do I need to be accredited if I have a pretty clinic? But there are certain regulations that we must comply with so…we can go with a company or a big insurance company and tell them, we want to sell you this service.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private Sector - 47</td>
<td></td>
</tr>
</tbody>
</table>

| We are right now fixing with some companies… due to the Obama law [Affordable Care Act], where they give many companies from the United States the power to choose the health services from other countries that are accredited, if they don’t like the prices of the health services in the United States. This is why it is important that we are organized and that we have our accreditations and that we have the support from the government. |
|-------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Private Sector - 48     |                                                                                                                                                                                                   |
**Mexico**

Most of the times [accreditations] are necessary because insurance companies are the ones who enforce this. And if hospitals don’t have accreditations, patients aren’t sent to those hospitals.

(Private Sector - TIJ - 05)

...because of the constant requirements done by insurance companies, medical tourism promoters, hospitals, and clinics have tended to obtain certifications with international organizations... it does give more confidence for the patient that comes from abroad.

(Private Sector - TIJ - 07)

**Barbados**

...the challenge that remains with us is that if a person is going to be traveling from the United States or Canada or any first world country the insurers are saying that the facility where you’re going to must be up to standards.

(Public Sector - 01)

...there’s a lot of insurance companies now that are looking at international portability of benefits, so it’s not as exotic as it once was. The thing is to show that you’ve got a quality product and show what your outcomes procedures are, and your accreditation.

(Private Sector - 11)

**Public Promotion of Private Medical Tourism Projects**

Public trade development corporations that promote exports and foreign investment have all been active in developing public policy and analyses for the sector in all three countries, disseminating information locally and advancing hospital and marketing projects internationally. ProMexico has identified ‘clusters’ of medical facilities in each state that they plan to advertise abroad as the best quality of care available in the country. INGUAT is coordinating private and public sector efforts to export health services from Guatemala while promoting its hospitals internationally. Invest Barbados has organized and attended medical tourism trade shows to promote the sector and facilitated the planning for a new private hospital that will be oriented to foreign patients. These export and investment development corporations are the common lead actors in sustaining the conversation around medical tourism in their home countries and promoting its development.
### Table 8-5 - Illustrative Quotes of Public Promotion of Private Medical Tourism Projects

<table>
<thead>
<tr>
<th>Country</th>
<th>Quote</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Guatemala</td>
<td>Each chamber is going to be in charge of a specific part of the market; but INGUAT is the one that coordinates all the effort that’s being made as a country. (<a href="http://inguat.gob.gt">INGUAT</a> are about bringing tour-operators or insurers, people specialized in this kind of tourism, so that they get familiar with Guatemala’s situation about medical tourism. Another <a href="http://www.inguat.gob.gt">strategy</a> is being part of different associations, like Medical Travel Association, the one responsible of gathering all specialists in medical tourism.</td>
<td>(Private Sector - 13)</td>
</tr>
<tr>
<td>Mexico</td>
<td>...<a href="http://www.promexico.com">Promexico</a> took the leadership, <a href="http://www.promexico.com">it does</a> commercial missions. At the end of this year and on September <a href="http://www.promexico.com">it is</a> about to begin <a href="http://www.promexico.com">its</a> commercial mission to United States with national hospital, large chain to contribute with, it is going to be like a matchmaking in a reunion with American insurance companies to start attack this market.</td>
<td>(Public Sector – MISC - 04)</td>
</tr>
<tr>
<td>Barbados</td>
<td>...in our promotional literature <a href="http://www.investbarbados.org">Invest Barbados</a> we included <a href="http://www.investbarbados.org">medical tourism</a> as one of the new sectors that we’re developing. In our overseas promotions when we speak to groups we’re actively promoting this as one of the areas that we would want to encourage.</td>
<td>(Public Sector - 06)</td>
</tr>
</tbody>
</table>
Inhibitors of Health Services Export

A common, cross-contextual narrative about the challenge of sustaining interest in medical tourism emerged from the Mexican, Guatemalan, and Barbadian stakeholders. Interviewees described an initial period of enthusiasm among private and public sector stakeholders for sector development, spurring workshops and inter-sectoral planning. However, in spite of the working groups, policy initiatives, and hospital projects that the enthusiasm for becoming medical destinations spurred, stakeholders consistently described significant setbacks in expanding their medical tourism sectors. Three cross-cutting inhibitors were found to be shared across the sites: 1) the high expense of entering the medical tourism market, 2) incoherent planning within and between the private and public sectors, and 3) structural socio-economic issues such as insecurity and relatively high business costs and financial risks.

High Expense of Market Entry

Participants identified the high cost of entry to the international health service market as a large and immediate barrier to sector development. Medical facilities looking to attract international patients were generally understood as having to be aesthetically modern with up-to-date technology, infrastructure, and safety protocols. Costs resulting from international hospital accreditation, both the process itself and upgrading to its requirements, were regularly raised by participants from the private health sector as the most significant barrier. As a result of the perceived high costs of competing for medical tourists, promotion of the sector is largely limited to the best-financed and equipped private facilities.
### Table 8-6 - Illustrative Quotes of the High Expense of Market Entry

<table>
<thead>
<tr>
<th>Country</th>
<th>Quote</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Guatemala</td>
<td>They were telling me that getting accredited is very expensive and it takes a very long time. And both statements are true. The expensive thing is not to pay the license, I pay $1,525 a year for my license. But for me to make the changes to get it I spent another $25,000.</td>
<td>(Private Sector - 47)</td>
</tr>
<tr>
<td></td>
<td>Accreditations are somewhat expensive. A hospital in Guatemala is about to get certified, but it has taken years and a lot of investment. That's definitely a barrier… Certifications and advertising are the most terrible barriers we have. If I want my clinic to be able to receive foreigner patients, I have to comply with a lot of requisites.</td>
<td>(Private Sector - 13)</td>
</tr>
<tr>
<td>Mexico</td>
<td>The Health Board was in contact with the [Joint Commission International] to negotiate and to homologate their certification, avoiding that way that the private hospitals had to realize a double effort, or that [Mexican] certification [would be seen] as second-[best]. One of the problems for [JCI] certification is the high cost that only a few hospitals of the country [could afford].</td>
<td>(Human Health Resources – DF - 04)</td>
</tr>
<tr>
<td></td>
<td>Certification… is something in which we cannot be flexible because this is what guarantees certain quality. There are the private hospitals that can [certify] because [they can] invest time… and money. There are hospitals that even had to invest around 2 million pesos or even 5 million pesos in order to do all the necessary adjustments that the certification was asking.</td>
<td>(Public Sector – MISC - 03)</td>
</tr>
<tr>
<td>Barbados</td>
<td>...the availability to funds is not there for everyone. So for a group of local doctors to get together and try to build a hundred million dollar facility it’s not going to happen... Or a twenty million dollar facility, it’s not going to happen.</td>
<td>(Human Health Resources - 08)</td>
</tr>
<tr>
<td></td>
<td>...[medical tourism] will need infrastructure, it will need training, it will need equipment and all those things require funds and with the economic condition in Barbados now they aren’t available.</td>
<td>(Public Sector - 01)</td>
</tr>
</tbody>
</table>
Incoherent Sector-Wide Planning

In each country, participants identified two sources of incoherence in advancing the medical tourism sector. Firstly, intra-governmental responsibilities and goals for the sector are not well-defined, with initiatives poorly coordinated between different levels of government, ministries, and public trade promotion corporations. Concerted efforts to bolster medical tourism ultimately failed to outlive the tenure of cabinet ministers who initiated them. Secondly, hospitals and physicians in the private health sector are described as wary of one another’s efforts. In Guatemala and Mexico, existing private hospitals have established rivalries and do not want to benefit competitors through sector-wide coordination. In Barbados, many physicians are wary of large-scale medical tourism projects that plan to import foreign physicians, introducing additional private-sector competition for local patients.
<table>
<thead>
<tr>
<th>Country</th>
<th>Illustrative Quotes of Incoherent Sector-Wide Planning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Guatemala</td>
<td>...the problem is that there's no follow up. Once we've reached an agreement with a director or head office, or whatever, sometime later he/she gets removed from his/her position and we lose all the progress. It's like what we had built so far, crumbles. The problem is that there's no continuity in programs, there's not enough support. (Private Sector - 04)</td>
</tr>
<tr>
<td>Mexico</td>
<td>It is important that Tourism, Health, Economics and Promexico organize between them to see what they have to offer and...that we all understand the business theme and the need to organize with business for this to work out. You cannot dictate guidelines from the Government without taking the businessmen into account. ...A year ago there was a forum in Tijuana for medical tourism organized by the Government and you could see that there where all of the Secretariats and the bunch of States but where were the businessmen? (Private Sector – MISC - 02)</td>
</tr>
<tr>
<td>Barbados</td>
<td>[Medical tourism promotion] happens but it has not really been as structured as perhaps it could be. And then the other thing... is that you have silos, so one entity is doing something, the next entity is doing something and they’re not really coming together. (Public Sector – 3&amp;4)</td>
</tr>
<tr>
<td></td>
<td>...for now there are four organizations at a national level that I know of working in the field of medical tourism and all these are being grouped in a committee by INGUAT...It is still in process of maturity as everyone has their own ideas and there is still no integration of all four organizations to move to specific goals. To be able to change policies and get this going to make it attractive for business, we have to work as a group. (Private Sector - 04)</td>
</tr>
<tr>
<td></td>
<td>Hospitals are not willing to agree to everything, especially costs. On the other hand, there are hospitals A, B, C, D, to avoid naming. And so A comes and says &quot;I'll wait what B and C say, to see if I'm willing to agree&quot;. So as long as there is no group work, it's too difficult to sell [medical tourism... There is no a communion between us. (Public Sector – DF - 02)</td>
</tr>
<tr>
<td></td>
<td>...even when the government doesn't change the Ministers of Health could change... So then the new Minister of Health, he now starts dealing with the whole thing over again...that's one of the hindrances to [medical tourism] moving forward. The other thing too is...there's a caution about not having a good feel of how the local physicians would interact [with foreign physicians practicing locally] (Private Sector - 09)</td>
</tr>
</tbody>
</table>
Local Insecurity and High Cost of Care

Two perceived socio-economic inhibitors identified by participants were country specific. Insecurity was the most frequent social issue raised by Mexican and Guatemalan participants as inhibiting the development of medical tourism in their countries. It is thought that ongoing local violence would deter international patients. Barbados was distinct from the other sites as low rates of violent crime have been identified as a strength in developing medical tourism. However, the high operating and labour costs relative to Barbados’ regional CAC competitors played a similar (albeit much less prominent) role in participants’ discussions of endemic barriers to sector development.

Table 8-8 - Illustrative Quotes of Local Insecurity and High Cost of Care

<table>
<thead>
<tr>
<th>Location</th>
<th>Quote</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Guatemala</td>
<td>We shouldn’t waste our time in going to the US to promote and sell our packages - even if American Airlines gives us free tickets - because we are more expensive than the rest of the region and no one will want to come. There’s also another matter… it’s very unsafe in the country.</td>
<td>(Private Sector - 16)</td>
</tr>
<tr>
<td>Mexico</td>
<td>One of the things that affected us was the time of insecurity that we lived almost 3 years ago. We saw how the [medical tourism] demand decreased...We still had patients but we had to reinforce that we were located is a very secure area and that nothing had ever happened here.</td>
<td>(Private Sector – MTRY - 05)</td>
</tr>
<tr>
<td></td>
<td>We (doctors) can do our job wonderfully, but if you ask about medical tourism in Tijuana, many would rather run away to India before stepping into Tijuana because of the general insecurity situation, in all border [areas]. That’s something the federal, state and all governments in general have to work on together, to bring the country’s security back.</td>
<td>(Private Sector – TIJ - 06)</td>
</tr>
<tr>
<td>Barbados</td>
<td>I don’t foresee [medical tourism] happening here... We don’t have the volume because even if it’s cheaper to go, our prices are quite high too, because we’re in close approximation to the States and everything is imported from the States</td>
<td>(Human Health Resources - 12)</td>
</tr>
<tr>
<td></td>
<td>...the fact there’s no legislation allowing anybody who’s building a medical facility to set it up with those kind of concessions, you bear the brunt of what the local costs are and the local costs are high, very high.</td>
<td>(Private Sector - 15)</td>
</tr>
</tbody>
</table>
8.5. Discussion

Our findings are consistent with key elements of existing accounts of medical tourism development elsewhere (e.g. Ackerman, 2010; Lautier, 2008; Leng, 2010; Ormond, 2013b; Shetty, 2010), supporting their relevance and attendant implications in new contexts. In particular, three of the driving factors identified by our analysis, private sector oversupply, local availability of internationally trained physicians, and international hospital accreditation, echo what has been documented in the literature (Connell, 2013a; Crooks, Turner, Snyder, Johnston, & Kingsbury, 2011; Lautier, 2014; Leng, 2010; NaRanong & NaRanong, 2011; Ormond, 2013b; Pocock & Phua, 2011; Shetty, 2010; Turner, 2007, 2010a). However, participants’ accounts emphasize different facets of each driver that have not been identified in previous analyses, such as the coordination of local hospital standards with international accreditation, the role of international hospital accreditation in supporting internationally portable health insurance, and interest in the sector being driven in part by internationally trained specialists seeking to maintain their skills and practice in resource intensive clinical settings.

In the CAC region medical tourism is understood to be a solution to address unused capacity in the private health sector (Connell, 2013b; Johnston, Crooks, & Ormond, 2015). For Guatemala and Mexico, this capacity already exists and is seeking utilization; for Barbados, the demonstrated viability of tapping into the international market to reach a sufficient catchment of private patients is facilitating planning for new private facilities. On the surface, this supports the idea that medical tourism can be a relatively benign source of additional revenue for health systems that bolsters health infrastructure and economic development (Lautier, 2014). However, as it is the existence of severely inequitable distribution of medical resources domestically that has given rise to the rationale for private medical providers to turn to international patients, the benefits associated with medical tourism are unlikely to reach beyond the silo of the private health sector without accompanying redistributive policies. Developing and enforcing redistributive policies thus remain a priority for governments pursuing medical tourism if they intend to ensure that their health systems for the local population are strengthened by sector development (Chen & Flood, 2013; Shetty, 2010).
The driving role of attracting and retaining highly trained health workers has been highlighted as a key factor in accounts of the development of medical tourism elsewhere (Crooks et al., 2011; Lautier, 2014; Turner, 2010a; A. Whittaker, 2008). Previously, these accounts have focused on internationally trained health workers as internationally marketable assets, framing their role in driving development of the industry as relatively passive resources to be drawn on (Kannan, 2014; Lautier, 2008; A. Whittaker, 2008). Our interviewees emphasized the active, entrepreneurial role of internationally trained physicians in stoking interest in the sector. This entrepreneurship was articulated in terms of profit seeking, but perhaps of more interest, also in terms of a desire to operate in excellent clinical environments while retaining and further developing their skills. These findings support the notion that medical tourism is one means to attract and retain health workers who might otherwise emigrate, but teases out the multi-faceted rationale by which it may do so beyond its potential to support higher wages. The findings also raise further questions of how health system planners are to engage the skills of foreign trained health workers within the local epidemiologic and health system context if medical tourism supports highly skilled practitioners to opt out of treating the most pressing domestic needs (Leng, 2010; NaRanong & NaRanong, 2011; Pocock & Phua, 2011; Turner, 2007).

The third driving factor identified by the findings, international hospital accreditation, is unsurprising as it is found throughout the existing literature as a standard ‘ingredient’ in the developmental formula for medical tourism (Kannan, 2014; Lautier, 2014; Leng, 2010; NaRanong & NaRanong, 2011; Ormond, 2013b; Pocock & Phua, 2011; Runnels & Carrera, 2012; Shetty, 2010; Turner, 2007). However, participants clarified the role international hospital accreditation is playing in planning for the sector in the CAC region. Whereas existing discussion of international hospital accreditation focuses on its role as a marketable credential and means to improve and standardize quality of care, many participants emphasized international hospital accreditation as a precursor to accessing private insurance funds outside of their countries. International hospital accreditation should thus not only be understood as an emerging standard of care, but also as a precursor to scaling up flows of international patients into the future (Johnston, Crooks, & Ormond, 2015; Andrea Whittaker, Manderson, & Cartwright, 2010).
The fourth driving factor that emerged from this analysis, promotion and planning for medical tourism by public export development and investment corporations, is not well reflected in existing accounts of sector development. While instances of medical tourism being coordinated and promoted by government agencies are found in the literature (Johnston, Crooks, & Ormond, 2015; Leng, 2010; Ormond, 2013b; Pocock & Phua, 2011; Shetty, 2010), the parallel roles of the public export and investments promotions corporations in all three countries are striking in their formulaic recurrence and its consequent implications for health policy in each country and across the region. As the most visible government organizations driving medical tourism in CAC are both removed from health systems planning and approaching medical tourism solely as an economic development project, the risk of the sector developing with only cursory consideration of the many health equity concerns medical tourism raises (Johnston et al., 2010; Lautier, 2014; Leng, 2010; NaRanong & NaRanong, 2011; Ormond, 2013b; Pocock & Phua, 2011; Shetty, 2010; Turner, 2007) is significantly heightened. If well-managed by a wide range of organizations and stakeholders, it is argued elsewhere that medical tourism has the capacity to benefit the overall health system, in the form of cross-subsidization of care, advanced infrastructure, and support for a wide range of specialities (Johnston et al., 2010; Lautier, 2014). However, the narrow frame of reference and expertise that is informing the development of the sector in CAC reduces the likelihood of achieving these wider systemic gains.

Lastly, the inhibitors raised by participants, those of high costs to market entry, incoherent planning, and endemic socio-economic burdens, raise larger questions of the suitability of a wholesale health services export sector for the CAC region. High costs of market entry will likely restrict the revenues of medical tourism to the already best resourced facilities and further narrow the potential benefits of the sector. Incoherent planning that has proceeded in spurts in all three countries is preventing a comprehensive vision for what the sector aims to achieve, both in terms of economic and health development, its potential pitfalls, and which parties should oversee its development. Neglecting to address these barriers while the underlying driving factors push development of medical tourism ahead will further entrench the inequitable tiers of care that have given rise to the phenomenon. The factors identified here as currently shaping the industry in CAC should be incorporated into planning for the sector to
ensure that the wider potential gains of medical tourism are channelled into the health system as a whole.

Acknowledgements

This study was funded by an operating grant from the Canadian Institutes of Health Research (CIHR). RJ is funded by a doctoral fellowship from CIHR. VAC is funded by a Scholar Award from the Michael Smith Foundation for Health Research and holds the Canada Research Chair in Health Service Geographies. RL holds the Canada Research Chair in Globalization & Health Equity.
Chapter 9. Conclusion

9.1. Chapter Overview

The four core analytic chapters of my dissertation have explored the key perspectives, factors, and processes that are informing the development of medical tourism in four Caribbean countries. While my research predominantly focused on the nascent medical tourism industries of the Commonwealth small island states of Barbados and Jamaica, the final analysis incorporated the experiences of two Latin American countries, Mexico and Guatemala, which border the Caribbean Sea and are members of the Greater Caribbean community (Association of Caribbean States, 2012). This last chapter builds upon the findings and issues laid out earlier in the dissertation, examining their wider relevance, identifying shared trends, and discussing their systemic significance.

When taken together, the four previous chapters meet the three research objectives of this dissertation that were laid out in the introductory chapter, to 1) incorporate an extensive scope of perspectives and knowledge on medical tourism development, including stakeholder groups who have not been consulted in the existing medical tourism literature, 2) examine the early prospective development of medical tourism in Caribbean countries using qualitative research methods to understand why and how it the practice is being advanced, and 3) articulate the health system and health equity implications of medical tourism development in the Caribbean and their transferability to other contexts. In the remainder of this chapter I will review how the analyses meet the dissertation objectives, discussing common themes and unique issues raised by each while comparing and situating them in the wider literature. I will conclude with a reflection on the limitations of my research and suggestions for relevant future research directions.
9.2. Review of Dissertation Objectives

Objective 1: To consult an expansive scope of stakeholders regarding the development of medical tourism in the Caribbean, including stakeholder groups who have not been consulted in the existing medical tourism literature.

As noted in the introductory chapter, medical tourism to countries in the Global South has been regularly examined by researchers located in the Global North (e.g. Chen & Flood, 2013; Kangas, 2007; Lunt, Hardey, & Mannion, 2010; Ormond, 2011; Turner, 2007). This dissertation continues this vantage and the inherent limitations it brings to data collection and analysis. However, in using primary qualitative data, employing an expansive definition of medical tourism ‘stakeholder’ across the datasets, and closely collaborating with local researchers in two of the four analyses, the first research objective works against the worst of the limitations produced by the contextual remove many of the earlier studies of medical tourism work from. By drawing on primary qualitative data that consults a wider range of stakeholders in data collection than what is commonly found in the existing literature, I believe a more nuanced analysis of the social, political, and economic landscape prospectively informing contemporary medical tourism development processes can be produced than by studying the topic at a remove, with secondary data, and / or limiting data collection only to participants most centrally involved in sector development.

Chapter 3 provides the clearest example of the expanded scope of stakeholders consulted for the dissertation. The focus groups were intended to solicit input from two stakeholder groups, health system users and workers, which are typically configured as subject to the harmful impacts of medical tourism in existing discussions of the phenomenon (e.g. NaRanong & NaRanong, 2011; Pocock & Phua, 2011; Sen Gupta, 2011; Turner, 2007). Chapter 3 represents the first example of a direct consultation with these stakeholder groups that are subject to, not authors of, medical tourism development projects and policies in Barbados. Chapters 2, 4, and 5 each draw on interview data with individuals in Barbados, Jamaica, Mexico, and Guatemala respectively, who have direct knowledge of the development processes driving medical tourism development or have professional insights on the existing health systems,
tourism sectors, or governance environments in these countries. With over 175 interviews between them, the datasets used in these chapters comprise both a broad and deep body of qualitative data on Caribbean medical tourism development, incorporating the perspectives and knowledge of government employees, hospital administrators, citizens, tourism consultants, physicians, civil society advocates, nurses, and academics on this issue.

The broad range of perspectives and knowledge brought to bear on the issue of medical tourism came together in all four chapters in their consistent highlighting of two existing modes of international medical travel. These are the longstanding international travels patients and physicians within and outside of the region for care and training that long predate the development process for inbound medical tourism. Existing outbound travel by Caribbean patients was inconsistently identified as ‘medical tourism’ per se, the term typically being reserved for the patients traveling North to South, but the widespread regional familiarity with medical travel renders efforts to promote inbound medical tourism as a natural inverse and relatively immune to comment or critique. Indeed, a commonly presented rationale for pursuing health service export development provided by participants from all four countries was for it to counter the persistent loss of local resources from health service imports. My identification of this endemic local conception of health systems as already internationally connected and my articulation of its role in informing medical tourism development efforts is a direct result of the first research objective. It contributes to emerging findings from recent academic work that highlights the predominance of South-South (Crush & Chikanda, 2015; Kangas, 2011; Ormond & Sulianti, 2014) and diasporic patient flows (Hanefeld, Lunt, Smith, & Horsfall, 2015; Horton & Cole, 2011; Lunt et al., 2014; Nielsen, Yazici, Petersen, Blaakilde, & Krasnik, 2012) in international trade in health services by providing another example of their relatively invisible ubiquity and their role in priming care providers, governments, and their citizens for supporting the development of medical tourism.

The role of international medical training and practice in informing interest in exporting health services is an additional existing international health system connection only briefly considered in the literature elsewhere as a factor in medical tourism development (Connell, 2006; Jenner, 2008; Lautier, 2014) but extensively discussed by
Caribbean stakeholders from all backgrounds. Where it has been raised, internationally trained medical workers have often been discussed in relation to the higher wages medical tourism can support, thereby inducing return migration among nationals trained as physicians in higher-income settings (Vijaya, 2010). My interviews with stakeholders confirm that a desire for higher wages and return migration is a relevant consideration in medical tourism sector development, but that an existing local pool medical labour trained in the health care systems of the United States, Canada, and European countries is an equally important one (Chapters 2-5). The strong international professional connections between these health care systems and the Caribbean resulting from medical training and labour migration provide the common standards of practice necessary to commoditize a medical service while also serving as a similar naturalizing role as the existing international flows of patients, where the equivalent technical skills were regularly cited as reason alone to compete. Equally importantly, personal exposure to both systems by health workers who had trained abroad provided a personal point of comparison that underscores the health resource disparities between practice in the North and South. A desire for additional health resources to upgrade or maintain technologically advanced practice environments was as powerful a rationale for support among health workers for medical tourism development as higher professional wages. The nurses consulted in Chapter 3 provide an additional element to this aspirational narrative, expressing a desire for medical tourism to initiate reforms that introduce more rigorous, technically extensive professional standards and greater respect for the profession.

This professionally aspirational element to medical tourism development discussed by Caribbean health workers in my interviews and focus groups is not adequately reflected in the existing literature on medical tourism in its predominant focus on monetary incentives in driving interest in sector development (e.g. NaRanong & NaRanong, 2011; Vijaya, 2010). Meeting objective one reveals a cosmopolitan professional desire among many in the Caribbean medical community to practice to the best of their abilities and advance their skills in a well-resourced clinical environment that is hoping to be met through the pursuit of medical tourism. These underlying resource issues could perhaps be addressed through alternative health policy measures focusing on improvements in raising, integrating and distributing health resources nationally.
and/or regionally instead of promoting international competition among the private sector alone. As a legacy of the short lived West Indies Federation, I believe the internationally-distributed and administered University of the West Indies (Sylvester, 2008) provides a relevant precedent for the resource pooling required for improving the delivery of public goods in the balkanized health resource contexts of Barbados, Jamaica and their small island counterparts (Huff-Rousselle, Lalta, & Fiedler, 1998). For all the countries studied, pursuing policy measures to integrate internal healthcare markets and universalize health coverage, rather than entrenching further balkanization by encouraging private competition internationally, could simultaneously address the underlying professional dissatisfactions motivating interest in medical tourism in the care provider community while improving regional measures of health equity.

**Objective 2: To comprehensively examine the prospective development of medical tourism in the Caribbean using qualitative research methods to understand why and how it the practice is being advanced**

My second objective is a broad unifying goal that informed the design and intent of each of chapter. The four analyses all use a different set of stakeholder perspectives to identify trends and factors, locally and internationally, that are prospectively informing why and how medical tourism is being targeted for development in many Caribbean countries at this time. In order of focus and depth, Chapters 2, 3 and 5 together provide a comprehensive account of development in Barbados, Chapter 4 documents medical tourism development from Jamaica, a country with many economic, cultural, and health system similarities to Barbados, and Chapter 5 comparatively examines developmental considerations shared among stakeholders in Barbados, Mexico, and Guatemala that are shaping the sector.

The medical tourism development processes in each country I have examined share in both their relative proximity and their primary focus on the United States as the target market for health services export. This common relational hub for the research topic brings the development processes, economies, and health systems of each of the countries studied into association with another, allowing for the identification of cross-cutting issues and implications associated with the development of medical tourism in
the shared region. Thus, moving from the focus on Barbados in Chapters 2 and 3 focus through Chapters 4 and 5, each builds upon earlier findings to produce an increasingly comprehensive regional perspective, identifying parallel processes and factors at play as well as unique issues for consideration. Together, the varying breadth and depth of the qualitative data used in these analyses provide the most comprehensive account to date of why medical tourism has emerged on the economic agenda of many Caribbean countries at this time.

The prospective design identified numerous health system and economic factors prefiguring interest in medical tourism as well as three distinct developmental processes informing early development of the sector. These factors and processes are discussed in my review of the third objective while this section reflects upon how the prospective research design identified medical tourism to be a faddish and overly broad concept motivating incohesive and relatively empty planning initiatives by governments and hospitals in a similar fashion across all of the countries studied.

A Repeating Medical Tourism Development Narrative

My analyses of the early development activity and goals surrounding medical tourism in each of the countries studied supplies a strikingly reductive formula of analogue organizations, reports, and tools driving medical tourism development in the Caribbean. In my initial visits to each country and then again upon reviewing the interview transcripts, I was regularly struck by the simplistic and a-contextual development 'recipe' repeated by stakeholders in each country: (1) secure international hospital accreditation for existing private clinics or construct a new private hospital with international accreditation informing its design, (2) internationally market care using websites and through connections with medical tourism facilitators and health insurance companies, and (3) American medical tourists, an order of magnitude more valuable than recreational tourists, pushed by a more expensive care environment and pulled by a tropical setting would begin arriving in short order. This simple conceptualization was powerful enough to motivate the creation of official medical tourism committees made up of public servants and local physicians in each country but too vague and divorced from specific challenges to produce a cohesive and actionable local policy response.
The situation above repeated itself in each country despite, or perhaps because of, a lack of information exchange between the stakeholders consulted. While interview participants closely involved in the sector planning process from each country reported involvement by state delegations in the World Medical Tourism and Global Healthcare Congress, the annual international trade conference promoting medical tourism organized by the Medical Tourism Association, their accounts do not ascribe any clear cause and effect relationship between participation in the event and subsequent initiation of planning efforts. Instead, they described attendance at the annual trade as a low-barrier action for nascent destinations to try and develop business connections to jumpstart the sector rather than a site of hierarchical policy transmission or substantive horizontal information exchange. Similarly, while international economic development organizations such as the Commonwealth Secretariat and the former Canadian International Development Agency were involved in sustaining interest in medical tourism in both Barbados and Jamaica, there was no evidence that any of their activities initiated planning processes, instead providing financial assistance to further organize existing local interest. Lastly, while some members of the medical community were consistently involved in the planning process, they were inconsistently situated in the various narratives explaining the origin of planning efforts.

Thus, no clean lines of policy ‘transfer’ or policy ‘mobility’ mediated by internationally connected agents or referencing of common policy models (Dolowitz & Marsh, 2000; Larner & Laurie, 2010) derived from successful medical tourism destinations were ever clearly established in any of the locations examined. My early outside impression at the beginning of the research process of a neat policy framework supportive of medical tourism being disseminated among disparate Caribbean planners by a common set of centralized policy entrepreneurs within shared professional communities was shown to have little support by the conclusion of my fieldwork and analysis. Instead, analogous conditions and organizations paralleled one another in each country as a repeating institutional and contextual assemblage (Allen & Cochrane, 2007), motivated by a common reductive conceptualization of medical tourism shared among, but infrequently communicated between, different actors operating locally, regionally, and internationally. In the absence of coherent industrial strategies or clear unifying goals for medical tourism supported by specific policies, this repeating
assemblage produced a remarkably similar range of early developmental responses and outlooks among sector planners and stakeholders in each country.

In a variation of the ‘fast policy’ environment and process (Peck, 2002), the idea of medical tourism has been taken up by Caribbean health, tourism, and trade stakeholders as an ideologically acceptable market-based quick fix for endemic economic and health system problems while ignoring the systemic complexities of hospitals and countries that have become ‘successful’ health service exporters. The absence of an accompanying package of specific policy goals or reforms in concert with each Caribbean country’s proximity and close professional ties between the American healthcare system, existing resource shortfalls in local health systems, and enormous existing recreational tourism sector, have produced at least three overlapping but identifiably distinct understandings of what medical tourism in the Caribbean should constitute and what it is intended to achieve among different stakeholder groups. This provides an excellent example of the highly mutable policy environments in contemporary neoliberal governance where sufficiently market-oriented policy objectives can support all means to meet them, even where they conflict and undermine one another’s own goals, as long as existing structural relationships of political and economic power are not threatened (Brenner, Peck, & Theodore, 2010).

The three distinct notions of medical tourism structuring Caribbean medical tourism sector development, one informed by recreational tourism’s drive for diversification and expansion, another by local medical communities’ desire to improve their working conditions, and the third by foreign medical interests’ wish for a less onerous regulatory and taxation environment, are each promoting a different range or format of health services export. The implications of these three approaches to development converge with the health systems and equity issues discussed below.

**Objective 3:** To articulate the health system and health equity implications of medical tourism development in the Caribbean and their transferability to other contexts

As outlined in the introductory chapter and the beginning of all other chapters, medical tourism poses significant opportunities and challenges to the operation of
equitable and effective health systems (Hopkins et al., 2010; Johnston et al., 2010). Each of the analyses in this dissertation explored the relevance of impacts associated with medical tourism that have previously been identified by research in other geographic contexts, such as public / private sector distribution of medical labour (NaRanong & NaRanong, 2011), and contributes new considerations to the literature, particularly the intersection of international hospital accreditation with insurance mobility. The four cases studied demonstrate three distinctly different approaches to sector development with significant variation in the knowledge being mobilized and intended outcomes from pursuing medical tourism. The systemic and health equity implications raised by these three differing sector development processes occurring in the Caribbean are explored below.

**Tourism Expertise and Expectations in Medical Tourism Planning**

My four analyses demonstrate that the Caribbean’s established economic success from, reliance on, and experience with recreational tourism is shaping public sector efforts to export health services in the region. As a term, medical tourism is being strikingly interpreted at face value by many Caribbean planners and citizens outside of the medical sector because the enormous regional recreational tourism sector serves as a predominant driver behind pursuing medical tourism. This is in stark contrast to existing developmental accounts of medical tourism in established destinations, where marketing to international patients was initiated and led by a medical sector experiencing sudden funding shocks, as in the 1997 Southeast Asian Financial Crisis for Thailand and Singapore and the collapse of Soviet support for Cuba (Ormond, 2011; Ramírez de Arellano, 2011). Reductive economic comparisons between medical tourists and recreational tourists were regularly made by interview participants who emphasized medical tourists’ much higher revenue values. These comparisons demonstrate that the two kinds of visitors occupy a shared conceptual category in the planning process, as does planners’ equivocal conceptualization of ‘health tourism’ that blandly homogenizes spa therapies, experimental biomedical interventions such as stem cell treatments, herbal medicine, and elective surgeries. Similarly, the makeshift extension of existing Barbadian tax legislation to incentivise private investment in tourism services to include medical clinics serving foreign patients (Carrington, 2013) demonstrates how conceptual
and legal boundaries between the two very different service sectors are being dissolved within the economic logic of and cultural familiarity with recreational tourism.

Broadly speaking, the effects of medical tourism are almost without exception understood by Caribbean stakeholders outside of the health system in narrow economic terms that focus on the spillover benefits it will provide existing economic sectors serving recreational tourism. It was rare for participants in any country to identify any health equity concerns when asked about medical tourism’s impacts, with the dominant discussion of impacts reliably turning to its parallels with the recreational tourism sector and positive economic returns. As later iterations of medical tourism development occurring in economies with large tourism industries, the Caribbean countries examined here demonstrate a reverse emphasis on tourism when compared with accounts of early-established health service exporters such as Cuba, Thailand, and Singapore that focus on medical expertise being leveraged internationally (Arunanondchai & Fink, 2006; Ramírez de Arellano, 2011). Instead, medical tourism development in the Caribbean has been in equal part conceived of as a tourism diversification project conducted by professionals at a remove from the medical sector. As noted throughout the dissertation, I believe the dominance of tourism and economic concerns in formal efforts to further develop Caribbean medical tourism and the corresponding peripheral involvement of medical expertise in public planning initiatives undermines the capacity for planners to produce both effective policies capable of scaling up health services export sector or anticipating the health system impacts of the sector (Pocock & Phua, 2011; Turner, 2013), particularly in light of the regular equivocation of wellness services most broadly conceived with biomedical treatments specifically by this stakeholder group.

The central involvement of tourism in mobilizing development of medical tourism may also be emblematic of later waves of interest in and public sector planning for the sector, particularly if the tourism management literature is an indication of the current epistemic environment motivating health services export initiatives (e.g. Han, 2013; Jonas-Berki, Csapo, Palfi, & Aubert, 2015; Viladrich & Baron-Faust, 2014). Alternatively, the conceptual and planning role of tourism in organizing the Caribbean medical tourism sector may be an indication of an omission by earlier development accounts that have focused on the role of the medical sector in developing medical tourism. Early medical
tourism destinations have all been established tourism destinations at the time of developing their health service export sectors, suggesting that recreational tourism may play a more significant role in initiating health service exports than has been previously recognized. Regardless, both of these possible interpretations underscore the relevance of the tourism industry in supporting contemporary initiatives to export health services and serve as an important indication of the usefulness of retaining ‘medical tourism’ as a term when exploring the phenomenon and translating concerns about its impacts to those promoting its development.

Lastly, an additional consideration raised by the close involvement of tourism interests in promoting medical tourism is an increase in the volume of ‘noise’ about the phenomenon that drowns out clear signals of actual health service exports. The cases of Guatemala, Jamaica, and Barbados each demonstrate that marketing efforts for medical tourism, in the form of press releases and broad promotion of non-medical health services, are preceding significant volumes of health service exports. While these countries were partly chosen as cases for my research for this very reason, anyone examining medical tourism should be aware that these highly visible promotional efforts may serve as false positives that are not accurate indications of active or ‘successful’ exports of health services.

Caribbean Care Providers Seeking Larger Markets

In contrast to the tourism informed conceptualization of medical tourism described above, interest in exporting medical services among Caribbean medical stakeholders is primarily being motivated by existing local resource limitations that they wish to address with access to a larger private healthcare market. As briefly touched upon above when discussing the first objective, the greater number of private patients provided by the international market is intended to support medical infrastructure upgrades, a greater range of medical specialities, and higher wages. Treating these same patients is intended to overcome local epidemiological constraints and inherently small healthcare markets in small-island states (Huff-Rousselle et al., 1998; Oyerinde & Baravilala, 2014) and the limited local demand for private hospital care in each of the countries studied. These factors both introduce new considerations not previously identified in the literature regarding the medical motivations for developing medical
tourism in settings with small populations and confirm the relevance of resource shortfalls in the private health sector for motivating interest in medical tourism. In contrast with the well known cases of acute resource shortfalls from sudden economic crises prompting radical development of medical tourism in Southeast Asia and Cuba (Pocock & Phua, 2011; Ramírez de Arellano, 2011), this dissertation demonstrates the relevance of chronic unused capacity in private hospitals as an equally important systemic consideration for why medical tourism is being promoted in the Caribbean, and elsewhere, at this time.

Local Caribbean health care providers were present in each of the formal development processes studied, but the resource limitations motivating their support for the medical tourism sector simultaneously serve to undermine the viability of their interest. The majority of private Caribbean care providers looking to compete internationally indicated that the costs associated with international hospital accreditation were prohibitive for them. For private care providers not interested in medical tourism, the cost of international accreditation alone was often enough to stifle their interest. This bind has paralyzed most local export, with public international investment and export promotion companies in Jamaica and Barbados choosing to focus on the former half of their mandate in developing medical tourism given the steep up-front difficulties of successfully exporting services from the majority of local hospitals.

The issue of international hospital accreditation is at once understood to be the signifier of care quality and the key to marketing care internationally, particularly among non-medical stakeholders, a relatively insurmountable financial barrier for the majority of local private care providers, some of whom expressed a willingness to explore or develop alternative accreditation regimes, and a cost of doing business internationally among the best resourced private care providers. The singular prominence of international hospital accreditation in planning efforts makes particular sense in the dominance of the American patient market in Caribbean planning for medical tourism. Rather than the entire international market informing interest in the private health sector, participants in my fieldwork typically narrowly interpreted medical tourists as Americans without ties to the region. As international hospital accreditation is both understood as both a means of marketing to individual American patients and tapping into the American
health insurance market, it has secured a dominant position in all planning efforts. Other proximate markets, particularly intra-Caribbean, Latin American, and diasporic, are not widely interpreted as ‘medical tourism’ by development stakeholders, both medical and non-medical, and have been subsequently ignored in planning discussions to date. One notable exception to this was a project among Guatemalan planners to market health insurance to Guatemalan migrants in the United States for use in Guatemalan hospitals (Garcia, 2013), although even here the underlying patchwork dysfunction of the American health system that limits universal coverage plays a role (Marmor & Oberlander, 2011; Sommers, 2013).

Many of the Caribbean physicians and private hospital administrators supportive of medical tourism may be more accurately said to be both interested in establishing more formal private cross-border care agreements with larger health systems in the long term as well as individual, privately paying medical tourists in the immediate future. As I believe institutional cross-border care arrangements are more amenable to regulatory oversight and management than private individuals seeking medical treatments are, this approach could more readily incorporate and address health equity concerns while more predictably supporting the systemic improvements that are motivating interest in health service exports among the Caribbean medical community. As noted by one nurse my focus group in Barbados, moving towards a policy focus of regional coordination for the delivery of training and specialist services to reduce the existing outflow of Caribbean patients to the American health system could be a more equitable, efficient, and effective first step in marshalling existing resources to improve local clinical environments, use existing capacity in the private health sector, and deliver economic returns to the region. Similarly, I believe Caribbean development efforts can productively harness local interest in medical tourism within the medical community by reducing barriers to hospital accreditation by developing equivalent regional hospital accreditation standards to reduce accreditation costs, as successfully done by the Malaysian government (Leng, 2010). Both of these approaches demand a more detailed and coherent understanding of what health services export is intended to achieve beyond economic returns, thereby requiring planning stakeholders to frame medical tourism and cross-border care both in the terms of health services organization and trade development.
Caribbean Medical Tourism as Offshore Medicine

International medical corporations hoping to develop offshore hospitals focused on the international market in the Caribbean provide the third conceptualization of medical tourism circulating in the region. While the case of Barbados’ American World Clinics described in Chapters 2 and 3 was an early example of this model, the opening of Health City Cayman in 2014 has made the Cayman Islands the first Caribbean jurisdiction to host a new hospital built with the intent to employ non-Caribbean physicians and serve the American healthcare market. Planning for this form of offshore medical arrangement clearly has traction within the Caribbean as similar proposals have been developed in the Bahamas (Xerri, 2014) and are being entertained in Jamaica (Collinder, 2013) and Grenada (Isacoff, 2014). This idea of medical tourism is informed by a very different rationale than its Caribbean medical counterparts as it is motivated by a desire for Caribbean countries to provide less onerous regulatory and taxation environments than is found in the markets it intends to serve.

The appeal of this medical tourism development approach to foreign investors and physicians is clear and mirrors the intersecting rationales of regulatory, currency, and labour arbitrage motivating similar outsourcing and offshoring of capital from high income to lower income contexts seen in other industries (Barkin, 2015; Duanmu, 2014). An additional consideration raised by the few American participants from this sector I was able to interview was a desire for a more rewarding, less micro-managed work environment than can be found in American hospitals due to the restrictions on freedom of practice imposed by private insurers, legal concerns, and public regulations. Setting aside the classic colonial imaginary informing this outlook, the desire for medical tourism to serve as a means to overcome entrenched structural shortcomings and dysfunction in professional practice mirrors the desires of Caribbean physicians described in the previous section. The vision of a de-territorialized international patient, resource laden and free from regulatory strings, is being pursued as a simple panacea for health system ills by both the Caribbean and the American medical community with limited consideration of or will to address the deep, territorially-rooted systemic conditions underlying these desires to turn to the free-floating international market.
While the advantages of offshoring medical services into the Caribbean are clear for foreign investors and physicians, the advantages to local Caribbean communities that would host them are less apparent. The subsequent rounds of fieldwork to Barbados demonstrated the shifting will to pursue this avenue for developing medical tourism as the initial ‘alignment’ of local and international forces described by stakeholders in the first round of fieldwork in 2011 had decayed by my final trip in 2013. The fundamental appeal of this development approach that remained throughout the visits, and was repeated by similarly situated trade-development stakeholders in Jamaica, is the large pool of foreign investment and labour supporting it and the perception of a relatively low degree of interaction between foreign owned and operated hospitals and the local health system, preserving local resources for the local population. However, the development approach was divisive among Caribbean physicians as the benefits of this form of medical tourism, both in terms of local working conditions and greater economic opportunity, were seen as not being accessible to many local specialists. The better resourced facilities being planned for, compounded with the duty waivers and tax concessions being offered to foreign investors to incentivize new hospital development, were understood by many local physicians as producing an uneven local healthcare market that would undermine their own competitiveness for local patients. The contrasting economic implications between this foreign-investment led medical tourism versus that of local export is a longstanding challenge in Caribbean economic development where foreign wealth can overtake the relatively small and globally uncompetitive local economic sectors and undermine their capacity (Klak, 1995; Moreno, 2005). The significance of the incohesion underlying these very different economic visions is briefly discussed below to conclude this section.

**Incohesive Developmental Goals Heightening Threats to Health Equity**

Early medical tourism destinations, neither modeling themselves or their health service exports literally nor primarily aiming for one dominant and wealthy healthcare market, initially established their exports without central organization but within common conceptual boundaries. In contrast, the three interpretations of Caribbean medical tourism, medical-tourism-as-specialized-tourism, medical tourism-as-local-export, and medical-tourism-as-offshore-services, have each emerged from the general concept of medical tourism but remain unreconciled into a coherent export development or health
systems policy. Definitional incoherence, siloed planning efforts, and competition and disagreement among healthcare providers have all contributed to the conceptual and policy incohesion that is a hallmark of the medical tourism development process in the Caribbean countries studied. These difficulties have been compounded by the Caribbean's close proximity to the United States. The combined enormity and exceptionally liberal characteristics of the nearby American healthcare market are uniquely powerful factors animating the planning for a medical tourism sector in each country studied. One result of this is an eclipsing of the existing regional flows of Caribbean patients within and outside of the region among local planners by the imagined quantity and value of tapping into the American healthcare market.

In each country studied, public investment and export promotion agencies serve as organizational focal points for national medical tourism committees. These agencies simultaneously oversee local policy development regarding taxation and regulatory reforms, field input from government ministries deemed relevant to the process, court international investors seeking to build new hospitals, and promote service export by local hospitals and clinics. These activities demonstrate each of the development approaches and kinds of health service export being drawn together by the notion of medical tourism in the Caribbean. This trade-led approach to medical tourism development has been shown throughout this dissertation as prone to potentially producing many negative health equity and health system impacts, including the export of ineffective or harmful treatments (Chapters 2 and 4), reducing local control of the health system (Chapters 2-4), and committing scarce health resources to infrastructure or accreditation of dubious clinical or public health value (Chapters 2-5). Conversely, the Caribbean medical stakeholders I have spoken with have identified a range of pertinent health resource issues that could be addressed with access to larger numbers of patients, particularly greater local access to medical specialities (Chapters 2-4), reduced outflow of local health resources to the American health system (Chapters 2-5), and better working conditions for local care providers (Chapters 3 and 4). I contend that reframing medical tourism / cross border care / health services export in the Caribbean primarily as a health policy issue and secondarily as a matter of trade and tourism development can harness the local expertise that is present within a clearer understanding of the health system challenges the practice is intended to address in
order to support more efficient, effective, and equitable health systems than are already operating.

9.3. Limitations

There a number of limitations shared among the analyses in this dissertation. My position as an outsider to the Caribbean, the reliance on thematic analysis, the non-generalizability of the overall findings, and the difficulties inherent in studying a phenomenon largely being discussed and planned for rather than concretely enacted each impose limits on how the findings should be interpreted and applied elsewhere. These limitations and discussion of their significance follows below.

As recounted in the introductory chapter, my interest in studying the Caribbean developed as a series of serendipitous events that produced a research question by the time I returned to Vancouver after the Medical Tourism Association’s Chicago trade show in 2010. My existing exposure and ties to the Caribbean, either through family or personal history, ties with Caribbean-Canadians, or personal interest, were almost nonexistent at that time. While I have since developed a basic knowledge of the Caribbean through extensive reading and five months of living in three Caribbean countries over four years, I am aware that my knowledge of the region is only of sufficient, not excellent, quality for gathering and interpreting the data used in this dissertation.

My position as an outsider to the Caribbean no doubt informed what information was shared with me and the manner by which it was relayed by each participant. For example, while issues of race were not a part of the research question, there were moments where the deep racist history and colonial prejudices of the Caribbean were on full display with what White interviewees shared with me, a White man, and how they did so. For example, one clinician shared with me, laden with knowing undertones, their belief in the importance of having staff who did not ‘axe’ but ‘asked’ questions of patients, while another discussed their perception of a racial hierarchy among physicians in the region that drives some elite Black Caribbean patients to seek out White doctors that are perceived to be of the higher quality than Black physicians. Another ascribed resistance to the American World Clinics project in Barbados among some Barbadian
physicians as stemming from its neo-colonial undertones. These moments, while not common, were brief breaks in otherwise culturally cosmopolitan, ostensibly value-neutral, professional interviews that highlighted both my status as an outsider and an entire body of local knowledge and practices I was too ignorant to anticipate asking about or effectively question further.

Similarly, openly identifying a gay male since young adolescence, my time living in the Caribbean was a personally disorienting period spent in the closet given widely held local antipathy towards queer identity and behaviour (Gaskins Jr, 2013). This limited the comfortable cultivation of deep personal relationships with locals over the time I was there given the self-policing I performed, compounding my outsider status and limiting my ability to develop informal local knowledge and ties that would assist conducting research and interpreting data. Thus, my status as an outsider to the Caribbean and the highly formal encounters where the interview and focus group data were collected should be taken into account when interpreting the circumstances data was shared with me, its content, and my interpretation of it.

While the use of thematic analysis in each of the chapters was chosen as the most appropriate analytic approach to each dataset used given the research questions posed, using varied set of analytic methods such as discursive or content analyses would have produced a greater range of analyses to complement the existing work presented here. For example, a content analysis of written reports gathered or a discursive analysis of the transcripts from sub-population of interviewees could explore how particular language is being used to inform development of medical tourism and how it may simultaneously privilege and omit different bodies of knowledge and ideological assumptions (Starks & Trinidad, 2007). In particular, the ‘normalization’ of medical tourism referred to in this conclusion is a high level assessment of the kinds of talk going on that could be better understood through close discursive analysis that examines how it operates. Another issue arising from my reliance on thematic analysis for each dataset is that my reliance on reviewing coded data for cross-cutting themes combined with my own evolving perspective on the issues at hand ran the risk of heightening my awareness to particular themes recurring in later datasets while potentially ignoring unique or nuanced ones. The severity of this problem has been
mitigated by including multiple researchers throughout the creation of each coding scheme, coding process, and review of the coded data (Farmer, Robinson, Elliott, & Eyles, 2006), but remains a relevant analytic limitation.

Another limitation shared among all of the analyses emerges from a unique strength of the study design, that of the temporal perspective chosen to examine the medical tourism development process. As outlined in the second research objective, with the exception of Mexico the countries examined in the dissertation were purposely selected to focus on those with small or non-existent medical tourism sectors in order to critically examine and compare the factors and actors driving and shaping early development of the sector. This vantage was productive in identifying numerous new issues informing medical tourism development in the Caribbean that are relevant worldwide, but places clear limits on interpreting their relevance in regard to realized health system impacts and equity implications. Many of the implications are logical extensions of the issues raised by participants but are not grounded in concrete examples given the early state of the industry. This should be a guiding consideration among readers when interpreting the implications of medical tourism development raised and discussed throughout the dissertation.

Lastly, the designs of all of the analyses do not seek, and cannot, produce generalizable statements about the factors informing medical tourism development in any of the countries studied or for the wider the Caribbean. Neither the use of interview and focus group data, the non-representative sample of participants and their selection process, nor the thematic analytic approach aim to or are capable of producing generalized findings suitable to universalized theories or totalizing representations of the phenomenon (Morse, Barrett, Mayan, Olson, & Spiers, 2002). However, the relevance and rigor of qualitative case study research are not gauged by generalizability but instead by the findings’ internal coherence within the dataset is derived, their relevance to the participants and context it is derived from, and their transferability to situations elsewhere (Morse et al., 2002; Sin, 2010). As such, the findings of each analysis should not be used as the final say on the topic at hand, but instead as fruitful departure points for future research, critical discussion, and policies responding to the issue of medical
tourism, its development process, and their associated impacts on health systems and health equity.

9.4. Future Research Directions

My dissertation highlights a number of issues surrounding international trade in health services that can benefit from future research. Perhaps most strikingly, the existing internationally outbound movements of Caribbean patients for medical care, particularly the regional care networks centred on Miami and Cuba, were not in participants’ conceptual foreground in relation to medical tourism and were most often raised as an afterthought or side issue during interviews. These existing patient flows are a ubiquitous yet relatively invisible issue in each of the countries studied that, while widely known about informally, are inadequately traced or officially documented (R. D. Smith et al., 2009; Walters et al., 1993). This suggests at least two productive avenues for future academic work, one empirical and the other conceptual.

Health services research examining care availability and access can benefit from a more robust empirical record of existing cross-jurisdictional movements of patients for health care everywhere. The development of robust and fine-grained datasets of international health service exports and care networks, particularly using quantitative measures, will help to more accurately illustrate where care is being used, who is able to access it, and the balance of international trade in health services. This dissertation and other recent work (e.g. Crush & Chikanda, 2015; Horton & Cole, 2011; Ormond & Sulianti, 2014) suggest that these poorly understood international care networks are existing informal regional health care systems among proximate countries or between spatially distant but culturally tied global communities that lack administrative coordination and regulation. Analyses of such data would be capable of identifying local shortcomings in health care availability or quality where patients are regularly exiting their domestic systems for care elsewhere, highlight inequities in service availability where private resources are determining differential access to medically necessary care, and accurately inform national and regional estimates of health care spending. Detailed analyses of each of these issues could improve the efficiency, effectiveness, and fairness of health systems and their services.
Conceptually, development of a non-national or a-jurisdictional health system research and policy framework would potentially identify reforms that can help produce health systems that are both more efficient and equitable. The traditional post-war notion that the creation and maintenance of robust and responsive health systems is a core responsibility of the state to its citizens is increasingly undermined by neoliberal conceptualizations of citizenship (McGregor, 2001; Navarro, 2008). As has been noted by others (Ormond, 2011; K. Smith, 2012), medical tourism is just one expression of this increasingly fraught ideal as it ruptures the relationship between states’ duties and citizens’ rights by divorcing health care from its surrounding social context and rendering it a commodity provided and purchased by private interests. However, as demonstrated by the unremarkability of long-standing outbound medical tourism in the Caribbean among participants interviewed for this dissertation, the realization of the ideal of a robust comprehensive national health system has been uneven and sometimes impossible to achieve within the epidemiological, economic, or physical limitations of a country with small populations and territory.

These jurisdictional limitations do not mean the ideal of universal access to good quality health care should be discarded or incoherently reconciled to dominant neoliberal prescriptions that dissolve collective responsibilities and supply market solutions as policy cure-alls in their wake (Navarro, 2008), but it may demand researchers step outside the existing conceptual confines of (sub-)national states in relation to their traditional responsibilities financing, administrating, regulating, and delivering health care in order to identify effective and equitable solutions. For example, health services research informed by less rigid systemic-territorial borders may identify more efficient and equitable methods of care delivery by identifying the epidemiologically necessary catchments to deliver sub-specialities and support intensive specialization across jurisdictional boundaries. Similarly, the efficiencies of scale and effective risk pooling provided by consolidated single payer health financing schemes (Hsiao, 2007; Kwon, 2003) could benefit health systems globally by integrating those operating in relatively inefficient isolation or linking spatially proximate providers and patients separated by bordered systems. The legal, administrative, technical, and political barriers to such radical operational overhauls of existing systems requires a great deal of research and conceptual labour to determine its desirability and feasibility.
Less ambitiously, findings in each chapter emphasize the dissonance between the knowledge gap surrounding international hospital accreditation and the fervent interest in securing it among medical tourism stakeholders. The significant health resource burden international hospital accreditation imposes is striking when juxtaposed against a limited body of weak evidence assessing the impact of hospital accreditation programs on clinical outcomes in their domestic contexts (Ammar et al., 2013; Brubakk, Vist, Bukholm, Barach, & Tjømsholm, 2015; Shaw, Groene, Mora, & Sunol, 2010) and the absolute dearth of evidence on the effectiveness of international accreditation regimes derived from their domestic counterparts (Woodhead, 2013). Longitudinal studies of clinical outcomes prior to and following accreditation processes across multiple hospitals would be capable of assessing their costs and benefits relative to other health investments, thereby confirming their assumed worth or suggesting potential alternatives.

Lastly, the widespread targeting of health services as an export sector for development by tourism-dependent economies suggests a productive site for future collaboration between health and tourism researchers. As demonstrated by the conceptual latitude informing medical tourism’s development across the stakeholders consulted in this dissertation, a wider interest in ‘health tourism’ encompassing non-biomedical treatments is one dominant development approach behind the push to develop medical tourism. Caribbean tourism destinations’ shared drive to commodify and export local healing traditions (e.g. Chambers & McIntosh, 2008; Phillips, 2007), attract retirement migrants (e.g. Beltraide, 2012; Collinder, 2010; van Noorloos, 2011), and develop tourism sectors that support visits by disabled individuals all emerged as forms of ‘health tourism’ promotion. Just these three examples capture numerous intersections between existing issues and concepts in tourism and health research such as therapeutic landscapes (Olafsdottir, 2013; A. Williams, 2010), affective and embodied geographies (Hall, 2000; Thien, 2005), tourism’s role in intercultural exposure and commodification (Deutschlander & Miller, 2003; Scher, 2011), the economic and social influences of cyclical migration (Hanley, Gravel, Bernstein, Villanueva, & Villarreal, 2015; Yow, Garces-Ozanne, & Audas, 2015), and international interactions between health systems (Brouwer, van Exel, Hermans, & Stoop, 2003; Yow et al., 2015). Both tourism and health research would benefit from a collaborative effort to document and analyse
the contemporary interest in health tourism among development agencies, private companies, and governments and the social and economic implications of its various expressions.

### 9.5. Conclusion

This dissertation contributes to the ongoing examination of medical tourism and its impacts on health systems and health equity. By focusing on countries not yet known as medical tourism destinations but within a common geographic region and sharing competing ambitions to export greater volumes of health services, its findings highlight a range of underlying economic and health system factors that are motivating and shaping the development of the sector. The resulting portrait illustrates the differing visions of what ‘medical tourism’ is and what its development means to achieve among the different Caribbean stakeholders consulted.

Through primary data collection and on-site fieldwork, this dissertation has situated and grounded the phenomenon of medical tourism in the real-world health system and economic contexts. This approach has produced a better understanding the professional perspectives, health system practices, and economic environments that are informing Caribbean interest in medical tourism, thereby clarifying the underlying systemic issues that its proponents intend it to address. In addition to further advancing the existing conversation about medical tourism’s health system and health equity impacts, this dissertation contributes to the wider field of health geography by examining the multiple health mobilities underlying Caribbean interest in medical tourism and engaging with the policy processes and health systems characteristics informing enthusiasm for health services exports. Together, this both gives these issues the consideration they deserve while improving the relevance of analyses and critiques of medical tourism’s impacts on health systems and health equity by providing a sound empirical basis from which to suggest policy alternatives.
Bibliography


160


http://doi.org/10.1371/journal.pone.0070406

http://doi.org/10.1016/j.socscimed.2014.05.016

http://doi.org/10.1016/j.tourman.2012.11.016


Johnston, R., Crooks, V. A., Snyder, J., & Dharamsi, S. (2013). Canadian family doctors’ roles and responsibilities toward outbound medical tourists “Our true role is ... within the confines of our system.” *Canadian Family Physician, 59*(12), 1314–1319.


http://doi.org/10.1136/bmj.328.7452.1338

http://doi.org/10.1093/jnlecg/lbh012

http://doi.org/10.2471/BLT.09.072249

http://doi.org/10.1177/146801810800802003


http://doi.org/10.1186/1744-8603-10-29

http://doi.org/10.2471/BLT.14.152165


186


