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Collection d'études transdisciplinaires en santé des populations

Bon voyage: Essais sur le tourisme médical

Vol. 4 (1) 2013

Transdisciplinary Studies in Population Health Series

Travelling Well: Essays in Medical Tourism

Institut de recherche sur la santé des populations

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Transdisciplinary Studies in Population Health Series

Transdisciplinary is a comparatively new term, often used to replace the older and more commonly used concepts of interdisciplinary and multidisciplinary. A key difference is that while interdisciplinary and multidisciplinary research develops separate approaches to problems conducted in parallel, transdisciplinary research engages the disciplines, their basic assumptions and their methods, in dialogue to generate a new and synthesized understanding. The Latin root 'trans' means 'across', and the implications of this prefix suggest that a problem can be defined and researched, and solutions offered through an integrative and dialogical search for knowledge *across* disciplines. In its barest form, transdisciplinarity encourages scholars to think more broadly about problems, and to consider theoretical approaches that lie outside their disciplinary home thus opening doors to different theories and different paradigms of knowledge production.

Population differences in health outcomes, also referred to as health inequalities, health disparities and health inequities are deeply embedded in complex social systems that defy, or limit the usefulness, of simple, single interventions. Because of this complexity and the seeming inability of single disciplines to solve complex problems, transdisciplinary approaches appear to be particularly apt for the production of new knowledge to address problems of population health.

The Transdisciplinary Studies in Population Health Series is designed to raise and stimulate discussion of transdisciplinary population health. We do not prescribe approaches to shape transdisciplinary projects, but encourage reflexivity within the contributing disciplines to increase the possibility of flexibility and openness to transdisciplinary work. We do ask for rigor, openness, and tolerance, which we see as "the fundamental characteristics of the transdisciplinary attitude and vision. Rigor in argument, taking into account all existing data, is the best defense against possible distortions. Openness involves an acceptance of the unknown, the unexpected and the unforeseeable. Tolerance implies acknowledging the right to ideas and truths opposed to our own"[1].

We wholeheartedly invite and encourage discussion and comments on the published works.

transdis@uottawa.ca

[1] Article 14 Charter of Transdisciplinarity. http://nicol.club.fr/ciret/english/charten.htm

Collection d'études transdisciplinaires en santé des populations

Le terme *transdisciplinarité* est relativement nouveau; il sert souvent à remplacer les concepts bien répandus que sont l'interdisciplinarité et la multidisciplinarité. Une distinction importante s'impose, par contre : là où la recherche interdisciplinaire et multidisciplinaire adopte des approches distinctes pour examiner des questions en parallèle, la recherche transdisciplinaire fait intervenir les diverses disciplines, leurs hypothèses fondamentales et leurs méthodes dans un dialogue pour engendrer de nouvelles idées regroupées.

La racine latine « trans » signifiant « à travers », on comprendra que l'on peut définir et étudier un problème – et même trouver des solutions – au moyen d'une recherche du savoir intégrative et fondée sur le dialogue *à travers* ou entre les disciplines. Essentiellement, la transdisciplinarité encourage les chercheurs à poser un regard plus vaste sur les problèmes et à explorer des approches théoriques au-delà de leur discipline d'attache. Cela fait naître alors d'autres théories et paradigmes en matière de production des connaissances.

Les inégalités ou disparités dans l'état de santé des différents groupes de la population sont profondément ancrées dans des structures sociales complexes qui entravent ou restreignent l'utilité d'interventions uniques et simples. Étant donné cette complexité et l'apparente incapacité d'une seule discipline à résoudre des problèmes complexes, les approches transdisciplinaires se présentent comme une solution idéale pour produire de nouvelles connaissances permettant de se pencher sur les problèmes au chapitre de la santé des populations.

La collection d'études transdisciplinaires en santé des populations se veut un outil pour soulever les discussions transdisciplinaires dans ce domaine. Nous ne dictons pas des approches pour définir les projets transdisciplinaires, mais nous favorisons la réflexivité au sein des disciplines partenaires pour accroître l'ouverture et la souplesse concernant les travaux transdisciplinaires. Nous insistons sur la rigueur, l'ouverture et la tolérance qui, nous croyons, « sont les caractéristiques fondamentales de l'attitude et de la vision transdisciplinaires. La *rigueur* dans l'argumentation qui prend en compte toutes les données est le garde-fou à l'égard des dérives possibles. L'*ouverture* comporte l'acceptation de l'inconnu, de l'inattendu et de l'imprévisible. La *tolérance* est la reconnaissance du droit aux idées et vérités contraires aux nôtres. »[1]

Nous invitons donc la discussion et les commentaires sur les œuvres publiées.

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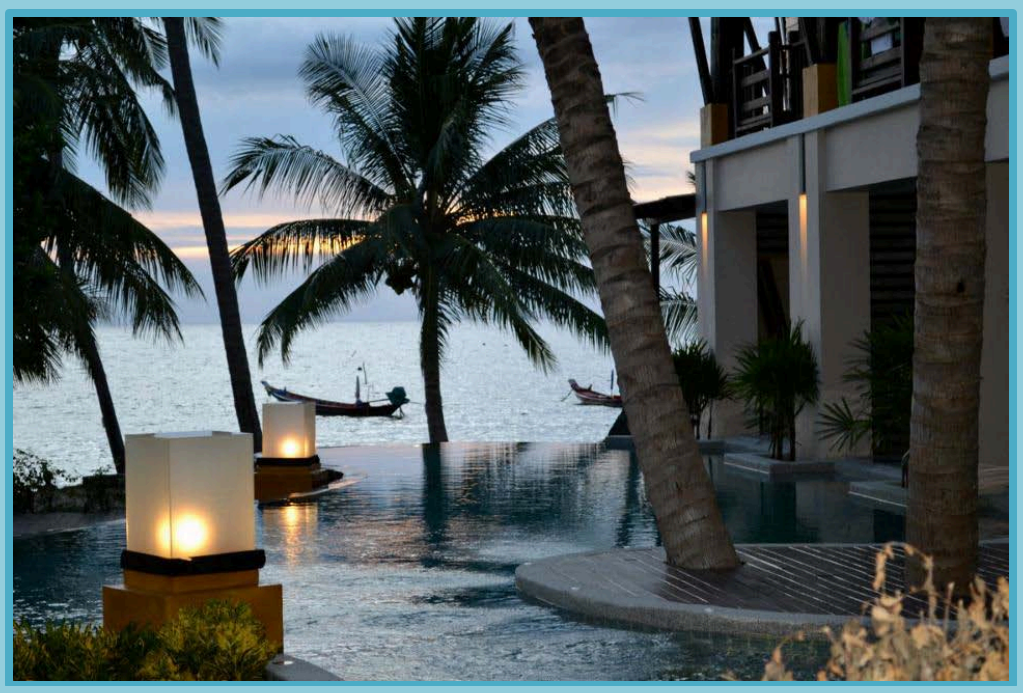
[1] Article 14 Chartre de la transdisciplinarité. http://basarab.nicolescu.perso.sfr.fr/ciret/chartfr.htm



Travelling Well:
Essays in Medical Tourism

Edited by
Ronald Labonté, Vivien Runnels,
Corinne Packer and Raywat Deonandan

Acknowledgements

This book draws from the collective efforts and thoughts of a collaboration of researchers interested in medical tourism, many of whom met together for the first time at a Symposium on the Implications of Medical Tourism for Canadian Health and Health Policy, funded by the Canadian Institutes of Health Research, and held in Ottawa in late 2009. During this meeting, we took part in wide-ranging discussions of aspects of medical tourism, and we proposed a plan that included the publication of a book, a number of ideas for research projects, an application for a CIHR operating grant, and the development of other research papers. This book is one product.

We, the editors, sincerely thank the authors for their contributions. We are pleased to say that the majority of the contributors to this book and others that attended the original meeting, continue to be involved in medical tourism research and publish their findings in a variety of venues. For some authors, it was their first foray into writing for academic audiences.

We received considerable assistance from Stefanie Collins and Natalie Nolan, both students at the University of Ottawa. Michelle Payne helped us to put the book together and organized the lay-out and design.

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We believe that the contents of this book, much of which is presented from a Canadian perspective, make a significant addition to the body of knowledge of medical tourism.

January 2013

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Table of Contents

List of Figures

List of Tables

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Abbreviations

ABC	American British Cowdray
ARTs	Assisted Reproductive Technologies
ASEAN	Association of Southeast Asian Nations
ASMBS	American Society for Metabolic and Bariatric Surgery
BMI	Body Mass Index
CABG	Coronary Artery Bypass Surgery
CanLII	Canadian Legal Information Institute
CCSVI	Chronic Cerebro-spinal Venous Insufficiency
CEO	Chief Executive Officer
CHSRF	Canadian Health Services and Research Foundation
CIHI	Canadian Institute for Health Information
CII	Confederation of Indian Industries
CIS	Commonwealth of Independent States
COPCAB	Conscious, Off-Pump Coronary Artery Bypass
CRO	Central Referral Office
DS	Duodenal Switch
EU	European Union
FICCI	Federation of Indian Chambers of Commerce and Industries
FTA	Free Trade Agreement
GATS	General Agreement of Trade in Services
GATT	General Agreement on Tariffs and Trade
GDP	Gross Domestic Product
HDI	Human Development Index
HSARB	Health Services Appeal and Review Board
ICSI	Intracytoplasmic Sperm Injection
IHC	International Hospital Corporation
IMSS	Mexican Social Security Institute
ISSSTE	Social Security Institute for State Workers

IVF	In Vitro Fertilization
JCAHO	Joint Commission on Accreditation for Healthcare Organizations
JCI	Joint Commission International
MOHLTC	Ontario Ministry of Health and Long-Term Care
MS	Multiple Sclerosis
NABH	National Accreditation Board for Hospitals
NHS	National Health Service
Netcare	Network Healthcare Holdings Limited
OECD	Organization for Economic Co-operation and Development
OHIP	Ontario Health Insurance Plan
OOCC	Out-of-country care
PEI	Prince Edward Island
PGD	Pre-Implantation Genetic Diagnosis
PHI	Popular Health Insurance
PPC	Personal Patient Consultant
RNY	Roux-en-Y
SADC	Southern African Development Community
SAMP	Southern African Migration Programme
SAT	South Africa Tourism
SSA	Statistics South Africa
TPAs	Third Party Arrangements
UAE	United Arab Emirates
UK	United Kingdom
US	United States
VBG	Vertical Banded Gastrectomy
VSG	Vertical Sleeve Gastrectomy
WTO	World Trade Organization

1 Introduction

Raywat Deonandan, Vivien Runnels, Ronald Labonté and Corinne Packer

The opening years of the 21st century have been characterized by a variety of technological, social, political and economic factors that have seen the disintegration of the meaning and importance of international borders. From the power of the Internet to link disparate populations, to the consolidation of blocs of politically intertwined nations such as the European Union (EU), and the rise of affordable international travel, forces have been combining to bring about a globalized world economy that was only theorized in decades past. An obvious facet of this new globalization is the permeability of borders to the movement of consumers seeking a variety of medical services, and providers willing to accommodate, if not also profit, from this demand.

The services sought span a surprisingly diverse array of medical products, interventions and technologies: the motivations of travellers seeking these services are equally as diverse. Travellers in search of organs for emergency transplantation are often driven by a shortage of timely, local donors. Travellers seeking non-emergency surgeries, like those travelling from Canada to Latin America for knee replacement surgery, are motivated by lowered costs and shorter waiting lists. Reproductive 'tourists' may seek maternal surrogates in India for a variety of complicated reasons, including cost reduction and the avoidance of legal restrictions at home.

Running throughout these diverse sets of services and motivators are a few ubiquitous threads. Among them is the strange marriage of medicine with global commerce and the challenges that this union poses to ethicists. There is also the powerful rhetoric of liberalization and global economic integration that provides the rationale and bolsters the discourse of the industry.

Many authors have attempted to define the term 'medical tourism,' and all definitions have their merits. The word 'tourism,' however, connotes a sense of frivolity and recreation that, in this book's analyses, is misleading and inappropriate. Thus, stress is placed on the travelling aspect of the phenomenon, yet consumers partaking in this global industry are often

doing so for profoundly worrying and serious health reasons. To be as specific as possible, and to incorporate the reasons for travel, our use of the term 'medical tourism' refers to situations wherein an individual makes a decision to physically travel to a location in another country for the purpose of obtaining medical treatment for which he or she has paid (out-of-pocket or through individual insurance plans). This treatment may or may not be accompanied by activities that traditional 'tourists' typically undertake. While this definition specifies travel abroad, some attention must be paid to domestic circumstances and to instances of intra-national travel for medical care. For example, within Canada, travelling for medical care is a conceptually complicated idea, due to this nation's diversity of geographies, healthcare densities, and provincial/territorial restrictions. In the Canadian territories of Nunavut, Northwest Territories and the Yukon, for instance, healthcare is not always available close to home and travel is often necessary. Travel is thus an integral part of care in the North.

Internationally, the landscape for medical tourism is complex. But if we consider this phenomenon using Frenk's framework for health systems (Frenk, 1994), some lucidity can be extracted from this otherwise daunting web. Frenk conceptualized the health system as a set of relationships between five actors: healthcare providers, the general population, government, organizations that generate resources, and other sectors that may produce health-related services or resources. In addition, Mills and Ranson's framework (Mills & Ranson, 2005) provides for the roles and responsibilities of Frenk's aforementioned actors, specifically that governments and professional bodies are responsible for regulation of health systems, while ancillary sectors play more of a financial role. In other words, there are four fundamental processes that dictate the interplay between actors: regulation and finance, system priorities, management, and the obvious, all-important clinical interface with the actual patients. In this book, then, we attempt to tease out the limitations, synergies and motivators of these actors. Where medical tourism varies from these schemas is that it frequently involves the tourism sector – both private actors (tourist or specifically medical tourist brokers) and government departments (where tourism departments are at least as, and sometimes more prominent, in promoting the industry). In these collected chapters, we scan the globe, examining systems, processes, experiences, ethics and, ultimately, equity considerations of the rise of medical

tourism, but seat our analyses ultimately within a construct relevant to the Canadian experience.

In his overview, Labonté provides a foundation for understanding the relevance of the medical tourism phenomenon, elucidating the dominating roles of both globalization and the shifting definition of healthcare as either a right or a commercial product. Three subsequent chapters by Crush, Chikanda and Maswika, Chanda and Galliani, respectively, explore the state of medical tourism in three key geographic loci: South Africa, India and Latin America. Most academic approaches to this topic fail to consider the personal and emotional aspects of the medical tourism phenomenon. We address that gap somewhat with two chapters, one by Johnston, Crooks and Snyder, who explore the experiences of Canadians travelling abroad for medical care, using a narrative analysis; and one by Hopkins, with a description of her personal journey through the medical tourism universe. Indeed, the personal impacts of cross-border care are an element that appears in other parts of this book, as well. This is important, since it cannot be forgotten that, ultimately, the topic at hand is one of direct impact on individual experience at a most profound and personal level.

The chapter by Runnels and Packer turns our analysis back to the domestic Canadian experience. It describes the processes of provincial and territorial insurance plans and their roles in providing Canadians with out-of-jurisdiction care funded by the same plans. Deonandan, Labonté and Blouin bring the focus to non-medical and non-political aspects of cross-border care. Deonandan presents an introduction to the ethical quandaries that complicate any view of international reproductive tourism, a relevant contribution given the current popularity of that topic in the mainstream media. Blouin's chapter teases out the role of international trade treaties in either accelerating or diminishing the flow of care-seekers, intentionally or otherwise. Labonté reports from one of the biggest industry-sponsored medical tourism conferences to provide a sense of scope, intent and attitude reflected by the larger global service providers. Lastly, our concluding chapter summarizes the perspectives explored in this volume, and points to a potential future for both the industry and its relationship with global society.

The intent of this book is neither to celebrate the medical tourism industry nor to chastise it. Rather, we describe the state of the global medical tourism phenomenon, explore its relevance to stakeholders, especially Canadians, and attempt to seat the industry's growth with other contemporary phenomena, among them trade liberalization, emerging perspectives in health equity, and medical and business ethics. As borders become more porous to people, services and ideas, what we see is an evolving concept of both the global citizen and the medical service provider; such a concept is formed in a context wherein neither trade nor medical relief are restricted by geography or domestic values, legalities and mores, but rather by whatever international frameworks the global community seeks to define and apply. With this volume, we seek to contribute a glimmer of comprehension toward that end.

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2 Overview: Medical Tourism Today: What, Who, Why and Where?

Ronald Labonté

INTRODUCTION

Travel for health reasons is not new. 'Taking the waters' has long been a pursuit of those who could afford the travel to spa destinations, often crossing borders to do so. There are numerous 18th century accounts of wealthy Europeans traveling to famous French spas or to the medicinal waters of Bath and Vichy for treatments for gout, skin ailments, liver disorders and other maladies, a practice that, by the 19th century, had trickled down to the middle classes (Lunt, et al., 2011). It was also customary in the pre-antibiotic era for people with certain infectious ills to be encouraged to rest in less stressful or polluted locales, an early form of enjoining 'medical' to 'tourism.' Travel for disease treatment was also commonplace, especially if few or no services were at hand and one had the means to be a mobile patient. But a literal sea change has been occurring in recent years. Growing technological sophistication and low labour costs in developing countries, combined with cheap airfares and a growing global demand for healthcare services, has created a burgeoning new entrepreneurial sector: medical tourism.

For an industry with an annual global value estimated to reach over US$100 billion in 2012 (Chambers, 2011), there is surprisingly little empirical literature on the topic of medical tourism, although this is slowly beginning to change. In this chapter we review what evidence there is, with a focus on the cross-border pursuit of more conventional or customary forms of healthcare (dental, surgical and diagnostic). Our findings are based upon a systematic evidence review of medical tourism, first undertaken in 2009 (Hopkins, Labonté, Runnels & Packer, 2010), and subsequently updated. All forms of medical tourism comprise the pursuit of cross-border care, whether across provincial, state or national borders. Our focus in this book lies more with patients seeking healthcare outside their country than with treatment shopping within the same country.

SCALE AND SCOPE

Hard data on medical tourism is hard to come by, and the physical scale of the industry is difficult to grasp. Its virtual (internet) presence, however, is immense. A search of the term 'medical tourism' in Google in early December 2012 elicited 68,100,000 results. 'Medical tourism brokers' produced 11,100,000 results. There are at least several hundred elaborate interactive websites that allow prospective patients to schedule their out-of-country services, contact their surgeon or other specialists, book airfare and accommodation, and arrange for tourist excursions. Some of these are managed by providers themselves, others by medical brokerage firms; almost all are commercial in nature, raising alarms about inaccurate or misleading claims, especially in more controversial areas such as stem cell therapy or transplantation. There are few, if any, non-commercial medical tourism sites (Lunt, et al., 2011; Turner, 2011).

There is no agreement on the size of the medical tourism market. Few countries track inbound or outbound medical travellers, and there are powerful vested interests in projecting a large market as one means of creating it. The Bumrungrad International Hospital in Thailand, as one example, claims to admit 400 thousand foreign patients annually (Bumrungrad International Hospital, n.d.). At the other extreme, a 2008 McKinsey report estimated global cross-border patients at not more than 60,000 to 85,000 per year, with most travelling to the United States (US) from Latin America, the Middle East, Europe and Canada respectively (Ehrbeck, Guevara & Mango, 2008). Both sets of estimates have been subject to critique. The McKinsey report in particular has been criticized for using a very small sample of accredited hospitals only, which heavily biased findings towards US markets, eliminating all United Kingdom (UK) sites, ignoring flows between developing countries and assuming that its hospital sample accounted for most of the market (Youngman, 2009). Estimates of a distinctly different order of magnitude emanate from forecast reports from Deloitte on outbound patients from the US. It forecasted 750,000 American medical tourists in 2007 (Deloitte Center for Health Solutions, 2008), with a projected growth to almost 16 million by 2017. In 2009, it adjusted its projections downwards with an estimated 580,000 outbound American patients in that year, due largely to the effects

of the recession on ability to pay, and a more modest 35 percent annual growth rate thereafter (Deloitte Center for Health Solutions, 2009). Assuming, as the McKinsey report did, that American medical tourists account for about 10 percent of the total market (Ehrbeck, et al., 2008), this extrapolates to almost 6 million patients who sought care beyond their borders in 2009. This number is close to the estimate of 5 million made by Youngman (2009) in response to the McKinsey Report's unconvincing low figures: Youngman's estimate excluded emergencies, expatriates, internal country travel and wellness, and used only the lowest possible official figures from countries while ignoring countries that are active but have no data. Although this figure of between 5 and 6 million medical tourists annually may be considered a reasonable guesstimate, all such figures should be regarded cautiously. The entrepreneurial dimension of medical tourism creates a marketing element in which estimates of high growth are used to create a self-fulfilling prophecy.

THE WHAT

The term 'medical tourism' may not be the best. It conflates what some distinguish as 'health travel' (which has more to do with maintaining or restoring wellbeing) from 'medical travel' (the pursuit of specific medical diagnosis or treatments often involving invasive surgical procedures) (Pocock & Phua, 2011). Economists studying the phenomenon[1] sometimes describe it in more arcane terms such as 'medical value travel exports' or 'medical tourism exports,' since the money foreign patients leave behind can be counted as a country's export earnings. Medical 'tourism' has also been criticized for minimizing the urgent care that some people seek by making it sound like an add-on to a holiday junket.[2] Many argue that 'medical travel' is a more appropriate concept (and one which we will use interchangeably with medical tourism); although in most destination countries actively recruiting foreign patients, the tourism angle is increasingly a prominent branding feature. In true branding style, 'medical tourism' has stuck and even propagated a bevy of offspring: transplant tourism, stem cell tourism, reproductive tourism, cosmetic surgery tourism, dental tourism, lipotourism and abortion

tourism, alongside the more traditional scions of wellness or spa tourism, and the oxymoronic suicide tourism.

THE WHO

While the scope of what medical tourism consists of remains grey, there is more agreement on *who* is a medical tourist. Most analysts exclude vacationers participating in spa therapies or alternative wellness regimes, individuals injured while on holiday, or expatriates receiving care in the country in which they (temporarily or permanently) reside. Even here, however, there is some blurring of definitional boundaries. In 2009, Spanish physicians' unions launched a tirade against British citizens with holiday homes in Spain, accusing them of engaging in 'scalpel tourism,' taking advantage of Spain's shorter queues for hip and cataract surgery and 'bleeding money out of Spain's health service' (Tremlett, 2009). At issue was the level of compensation such 'health tourists' were contributing back to Spain's health system.

Simplified, the medical tourism industry consists of three primary actors: patients seeking healthcare outside their country, providers in destination countries willing to offer it and medical brokers/facilitators linking the two. A fourth is often complicit, although not always central to the process, the travelling patient's personal physician who may provide the detailed medical history often required. There are several secondary actors: governments in destination countries who view the industry as a source of foreign revenue often offering generous subsidies as incentives; private and some public health insurers with interests in lowering costs through incentivizing cheaper services abroad (or minimizing complications on a patient's return); and the tourism industry in destination countries that increasingly partners with providers to create attractive package deals (Figure 2.1). Websites and industry conferences[3] become the glues that bind the parts together. The invisible people are those in destination countries whose own access to healthcare may be compromised by an emphasis on the more lucrative foreign market.

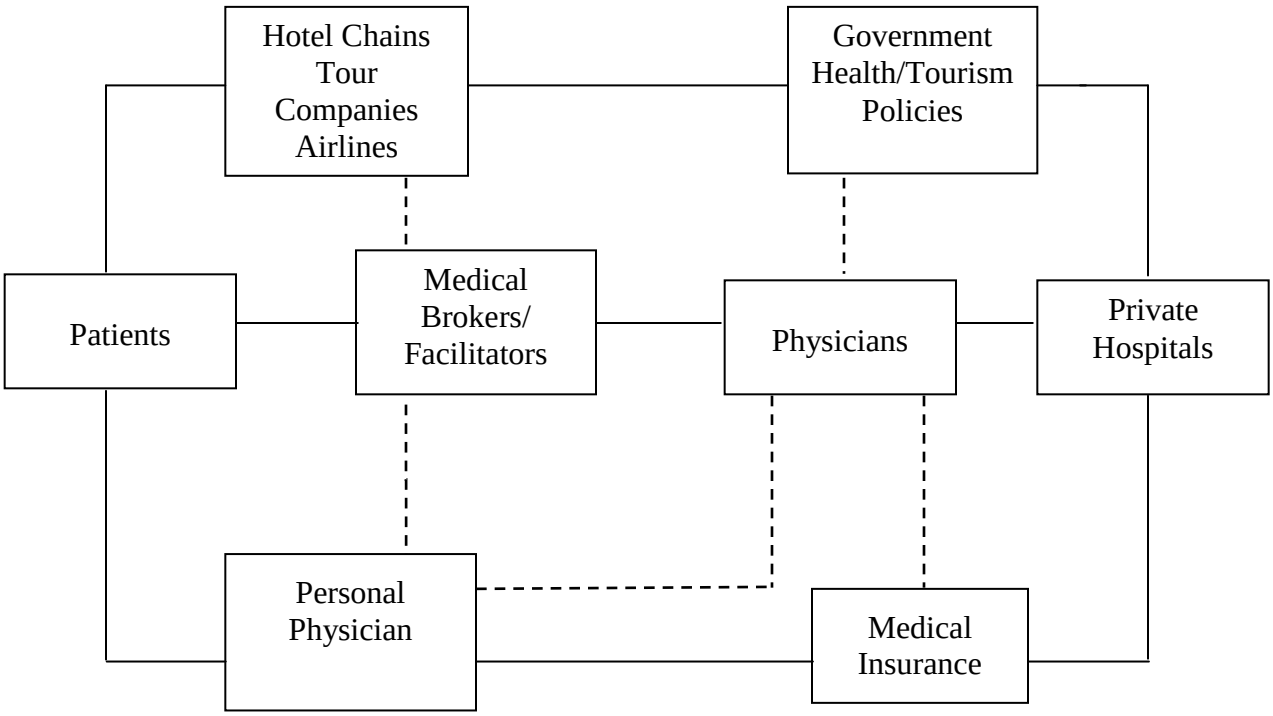

Figure 2.1 The Formal Medical Tourism Industry
Source: Author, adapted from a figure created by Crush, J., Chikanda, A., & Maswikwa, B.

THE WHY

If *what* is being sought in medical tourism varies considerably, and *who* partaking in medical tourism is not always completely clear, there is at least greater consensus on the *why*. The motivations for medical tourism, although varying with each individual, usually derive from a short list: affordability (lower cost), accessibility (reduced wait times), availability (services not offered domestically) and quality (services superior to what is available domestically). The industry that has grown up to meet this demand (if not also to create it) is increasingly linked with tourism activities to ease 'patients without borders' into new cultural environments and to occupy them and their travel companions during the pre- and post-operative periods.

Casual perusals of web sites for medical tourism, whether managed directly by the provider or by a medical tourism broker, cast little doubt on the prospective market: higher-income English-speaking people from the North. Cost is one of the main advertising lures, with countries in the South holding substantial cost-advantages to those in the North (see Table 2.1). Lower labour and living costs, the availability of inexpensive pharmaceuticals and the low cost or absence of malpractice insurance allow many developing countries to offer some procedures at 10 percent of the American price, inclusive of travel and accommodation. Similar price differences exist for other developed nations. A shoulder operation performed privately in the UK would cost €10,000, compared to only €1,700 in India, with only a little over a week's wait time in India from the initial contact (Sengupta & Nundy, 2005). A recent cost analysis based on surgical procedures for 15 non-acute health problems estimated annual savings (US Medicare vs. developing country facility) of US$1.4 billion (Mattoo & Rathindran, 2006). If coronary artery bypass surgery (CABG) were included, the cost savings would be over US$2 billion annually. A more inclusive list of procedures for which north-based consumers are known to travel abroad would have produced a substantially higher estimate of savings.

Cost is one of the most frequently cited reasons medical tourists give for seeking healthcare outside of their countries (Alsharif, Labonté & Lu, 2010; Crooks, Snyder, Johnston & Kingsbury, 2011), although uninsured Americans, sometimes thought to be a potential market, are less likely to consider medical tourism than are Americans who are insured or higher-earning (Deloitte Center for Health Solutions, 2010). Similarly, higher-earning Canadians are more likely to report willingness to travel internationally for elective or medically necessary surgery (Deloitte Center for Health Solutions, n.d.). Despite cost-advantages, medical tourism to developing country destinations remains primarily an option for those who can afford it.

Table 2.1 Cost of Selected Procedures in Various Countries around the World (US$)

Medical Procedure	USA	Mexico	South Africa	Costa Rica	India	Thailand	Korea
Angioplasty	57,000*	17,100	14,447	14,000	10,000	9,000	21,600
Heart Bypass	144,000*	21,100	50,000	26,000	10,000	26,000	26,000
Heart Valve Replacement	170,000*	31,000	40,000	31,000	3,000	24,000	38,000
Knee Replacement	50,000*	11,500	25,000	12,000	9,000	14,000	19,800
Hip Resurfacing	30,000*	13,400	---	13,000	10,000	18,000	22,900
Hip Replacement	43,000*	13,800	20,000	13,000	10,000	16,000	18,450
Special Fusion	100,000*	8,000	---	16,000	14,000	13,000	19,350
Face Lift	15,000*	8,000	6,120	6,500	9,000	8,600	5,000
Breast Implants	10,000*	9,000	7,000	4,000	6,500	5,700	13,600
Rhinoplasty	8,000*	5,000	5,686	6,000	5,500	5,400	6,000
Lap Band/Bariatric	30,000*	9,200	---	9,000	9,500	14,000	11,500
Hysterectomy	15,000*	7,500	---	6,000	7,500	7,000	11,000
Dental Implant	2,000 - 10,000*	1,000	---	1,100	1,000	1,000	2,000

Source: MedicalTourism.com http://www.medicaltourism.com/en/compare-cost.html
Note: * Up to Prices for countries other than the US are approximate and not actual prices and do not include estimated airfare for patient and companion.
Note: Data for South Africa was compiled from Medical Tourism Association Survey, 2010; Medical Tourism Websites

The reputation of physicians and quality of the facilities compete with cost for most frequently cited reasons for medical travel. Reputation and quality are prominent in web-sites which, whenever possible, reference the Western licensing and training of medical facilities, and their facilities' international accreditation by the Joint Commission on Accreditation for Healthcare Organizations (JCAHO) through its affiliate, Joint Commission International (JCI). JCI has been responsible for accrediting more than 400 medical facilities in over 50 countries across Asia, Europe, the Middle East, the Caribbean and South America (Joint Commission International, n.d.). This represents a near 4-fold increase over the past decade, reflecting in

part the growing popularity of medical tourism (Forgione & Smith, 2007). A number of developing country medical facilities have also partnered with Western medical teaching facilities and hospitals to signal quality to prospective medical consumers with prestigious and familiar names. Both Harvard Medical International and the Mayo Clinic are partnered with the Dubai Healthcare City. Wockhardt Group medical facility, one of the prominent chains of private healthcare facilities in India, has affiliated with Harvard Medical International. Their main competitor in India, the Apollo Hospitals group, partners with Johns Hopkins Medicine International[4, 5].

Apart from cost motivations (either self-paying or via private health insurers), medical travellers to facilities in developing countries sometimes pursue technologies and procedures that are not yet available or approved in their home countries. Until 2006, hip resurfacing, a less invasive alternative to hip replacement (Food and Drug Administration, 2008), was not approved in the US, although it was available in Canada, Europe and in some (much lower cost) Asian destination countries. In India, the Wockhardt Group of hospitals claims to have been the first in the world to perform COPCAB (conscious, off-pump coronary artery bypass), a heart surgery designed for individuals who are not good candidates for surgery using anesthesia (Dunn, 2007). Medical travellers from the developed world sometimes also seek medical procedures that are unavailable domestically due to legal constraints, which may include transplantation using living donors who are motivated by poverty or assisted reproduction using legally restricted technologies or paid surrogates.[6]

Several countries specifically advertise transplantation tourism, notably Colombia, India, Pakistan and the Philippines; although China, Bolivia, Brazil, Iraq, Israel, Moldova, Peru, South Africa and Turkey are also significant exporters of commercially donated organs (Shimazono, 2007; Turner, 2008). Normatively, cross border organ transplantation is deemed 'transplant tourism' only when travel for transplantation 'involves organ trafficking and/or transplant commercialism or if the resources (organs, professionals, and transplant centres) devoted to providing transplants to patients from outside a country undermines the country's ability to provide transplant services for its own population (Declaration of Istanbul, 2008). While all countries, except Iran, have banned payment for organs, 'reasonable reimbursements' for costs

related to organ donation or financial 'donations' to those offering their organs are permitted in many jurisdictions, effectively bypassing such legal restrictions (Turner, 2008). The Iranian exception is reported to have stringent rules on 'non-related living donor' exchanges to prevent abuses related to socioeconomic need or exploitation of vulnerable populations (Major, 2008), although anecdotal evidence suggests that economic need may still drive some donors to participate.

The majority of transplantations occur between live unrelated donors who are motivated by financial incentives (driven by extreme poverty) and individuals from affluent countries (with the ability to purchase) (Khamash & Gaston, 2008; Budiani-Saberi & Delmonico, 2008; Epstein, 2009). While donors from the South might technically consent to this transfer, the practice is deemed to be implicitly and explicitly coercive due to the fact that it involves vulnerable populations (Noorani, 2008; Cohen, 1999; Phadke & Anandh, 2002). Both China and India are considered 'hotspots' in organ trafficking (Turner, 2009). In China, 90% of all organs come from executed prisoners (Huang, 2007) although this may now be decreasing (Huang, Mao & Millis, 2008) due partly to international pressure. New protocols have been implemented to bring organ donation more in line with stringent medical and ethical policies in other countries (Huang, et al., 2008) although independent investigations cast some doubt on compliance with these policies claiming that deliberate 'harvesting' of organs from prisoners (notably practitioners of Falun Gong) is still occurring.[7] The Indian government, despite legislation restricting the commercial sale of organs, has been unable to monitor what is considered to be a sizeable market in illegal organ trade (Muraleedharan, Jan & Prasad, 2006). In Pakistan, where the transplantation tourism industry is unofficially sanctioned, over 2,000 kidney transplants are performed each year on foreign patients (Naqvi, Ali, Mazhar, Zafar & Rizvi, 2007). Although some contend that a seller's decision to avoid extreme poverty in a properly regulated and remunerated market should not be denied (Bakdash & Scheper-Hughes, 2006), the health status for the majority of financially-motivated donors worsens after the procedure, costing them more in lost employment or out of pocket remedial care than the (usually) minimal 'donation' they receive for offering their organ to a broker (Naqvi et al., 2007). Donors can also be subject to extreme forms of social ostracism (Scheper-Hughes,

2002). Of all forms of medical tourism, transplantation tourism raises the largest number of immediate ethical questions.

THE WHERE

Where do the medical travelers come from and where to do they go? The US-based Medical Tourism Association in a recent guidebook claims it is not possible to answer this question because "patients are travelling for medical tourism to and from almost every single country in the world" (Stephano & Edelheit, 2010, p. 21). This may (or may not) be true, with one recent estimate of approximately 50 countries offering some form of healthcare to international patients (NaRanong & NaRanong, 2011), and the Medical Tourism Association itself listing approximately 60 countries. Some of the pathways, however, are becoming better known and documented. These routes have been described and categorized as North-North (flows between developed countries north of the equator); South-North (the more traditional flows from developing to developed countries); South-South (the often ignored flows between developing countries south of the equator); and North-South (the newer flows from developed to developing countries). Although these routes are somewhat oversimplified, they are based for the most part on a characterization of the development status of nations, with an understanding that some southern medical tourism source and destination countries are highly developed while several northern source and destination countries share economic characteristics with many of the poorer countries in the south. As a heuristic, however, these compass ordinals serve as useful starting points.

North-North flows

The North-North route generally encompasses travel from one high-income country to another. The majority of this traffic occurs between nations of the EU. National boundaries became substantially more porous with the creation of the EU, with one outcome being an increase in cross border healthcare, primarily involving adjacent countries (Ninian, 2008). Although medical tourism within the EU remains in its infancy, accounting on average for only 1 percent of annual public healthcare spending (Ninian, 2008), enhanced patient mobility within

the EU suggests that this figure will rise. As one example, a 2002 poll found that to avoid lengthy wait times 15 percent of British citizens indicated willingness to travel anywhere in Europe for medical care (Beecham, 2002).

This mobility is also almost certain to rise following a series of court cases challenging restrictions on cross-border care within the EU. As early as 1998, the European Court of Justice began to field court cases challenging the requirement of prior approval and refusal of reimbursement for cross-border care, arguing that these restrictions violated trade agreements on the movement of goods and services, including healthcare (Healy, 2009). Subsequent European Court of Justice cases established the right of EU citizens to obtain reimbursement for cross-border medical treatment sought as a result of excessive domestic waiting times. To formalize the operational aspects of this traffic, the European Commission drafted a Directive on patient rights in cross-border care (Ninian, 2008; Commission of the European Communities, 2008; The European Parliament and the Council of the European Union, 2011) that was approved by the European Parliament in February, 2011 (Council of the European Union, 2011). The Parliament affirmed the right of all EU patients to seek healthcare in any member state, but with some restricting provisions: costs will only be reimbursed to the level covered in the patient's own country, and countries can require prior authorizations if the service entails overnight hospitalizations or a risk to the patient or population. Such authorization, however, should be granted "when the patient cannot be given such treatment within a time limit that is medically justifiable, taking account of his current state of health and the probable course of the condition" (The European Parliament and the Council of the European Union, 2011, para.31). Individuals will not be reimbursed for procedures not funded domestically, preventing them from obtaining a treatment considered unethical or unsafe in their own country. EU member states have until July 2013 to write this new Directive into their national legislation.

The same potential for North-North cross-border care could exist between the US and Canada, but is constrained by fundamental differences in healthcare provision and financing. These differences have not precluded Canadians seeking healthcare in the US (and other

developing country destinations),[8] or Americans seeking some forms of care in Canada (notably less expensive prescription drugs) (CBC News, 2009).

South-North flows

The more historical medical route has been one of wealthy patients from poorer countries seeking state-of-the-art medical care in richer ones (the US, UK, other European nations). The dominant form of cross-border care in the 20th century, these flows continue but may be declining. The UK saw its numbers of in-bound medical tourists, many from the Middle East, peak in the 1970s and 1980s with the rush of petrodollars. The number has fallen somewhat since, in the wake of 9/11 anti-terrorism concerns and the development of more sophisticated treatment options within the Middle East region. A 2010 study, focusing on destination hospitals in London (the main UK destination point), estimated that in 2009, London likely received 130,000 outpatient visits by medical travelers, resulting in 7,800 foreign inpatient stays. These paying patients generated between €280 and €330 million in direct revenue and almost €300 million in additional (touristic) spending (Team Tourism Consulting, 2010). Proposed plans to increase the portion that National Health Service (NHS) trusts can earn and retain from private paying patients are leading some hospitals to begin recruiting wealthy foreign patients with one hospital chief executive officer (CEO) arguing that, in terms of the global private healthcare market, the UK is "way behind the US, the Germans, Indian companies and Malaysian hospitals" (Ramesh & Williams, 2010).

Germany, another destination and regarded as one of the UK's main global medical tourism competitors, is attracting foreign patients primarily from Russia and Central European countries. It will soon face competition from Poland, which is pursuing its own brand of medical tourism and recently established its Polish Medical Tourism Chamber of Commerce and Association of Medical Tourism. Polish facilities are often in the public sector, indicative of the blurring between private and public that medical tourism is creating. Presently focusing on dental and cosmetic surgery, Poland, with its EU accession, is planning to compete with more distant ('South') destinations for intra-European medical tourists (Lunt, et al., 2011).

South-South flows

These flows are characterized by medically motivated travel from one low- or middle-income country into another, although three major 'South' destinations (Singapore, Hong Kong and United Arab Emirates (UAE)) are, in fact, high-income countries. Many low-income countries lack a health system infrastructure with adequate provision for primary healthcare or specialized health treatments and procedures. Given an ability to pay and to travel, individuals from these locales may seek services in other countries. For wealthy individuals, destinations such as the US and Western Europe are desirable (the South-North flow), although over the past two decades countries such as the UAE, Jordan, Thailand and Singapore have made significant efforts to attract such persons (Lautier, 2008).

South-South medical travel (similar to North-North flows) is often region-specific. As one example: Regional medical travel is a common experience for Yemeni, since the treatment infrastructure for cancer, heart disease and other serious medical conditions does not exist within their own country. Exact numbers of Yemeni medical travellers are unclear but range from 40,000 to 200,000 annually (out of a population of 17 million). The most popular destinations for Yemeni medical travelers are India and Jordan, with Mumbai in India being the least expensive and most common destination of choice. The North African country of Tunisia, as another example, has attracted an increasing number of medical tourists due to its relative sophistication in healthcare, and is thought to have the most potential for providing medical tourism services for Europeans and West African patients. In 2003, approximately 42,000 foreigners visited Tunisia for health purposes, 34,000 of whom were from neighbouring Libya (Lautier, 2008).[9]

For many Middle Eastern and North African medical tourists, Jordan remains the most popular destination due to its relatively sophisticated medical infrastructure and affordable rates. The World Bank ranks Jordan first for medical tourism in the region and fifth globally (Thomas White Global Investing, 2009). A survey of medical tourists in that country found that over 70 percent of the sample came from within the Middle Eastern region (Alsharif, et al., 2010). A slightly older study found that approximately 87 percent of Jordan's health service exports are provided to individuals from neighbouring countries. By one estimate, these foreign

patients occupy roughly one-quarter of all available hospital beds (World Health Organization-Eastern Mediterranean Office [WHO-EMRO], 2005). This figure foreshadows the equity issue associated with medical tourism, since Jordan has only 1.9 hospital beds/1,000, well below the global average of 3.0/1,000 (WHO-EMRO, 2007). If paying foreign patients have a substantial claim on this scarce resource, what does this mean for access for poorer Jordanians? Jordan's pre-eminence as a medical tourism destination may also be under regional challenge: the UAE continues to expand and promote its US$500 million Dubai Healthcare City complex, a high-end, tourism-linked set of facilities (Alsharif, et al., 2010) featuring what have become dubbed 'hospihotels' – private hospital rooms decked out in 5 star hotel luxury.

In the Latin American and Caribbean region, Cuba is a choice destination for many medical travellers, 80 percent of whom originate in neighbouring countries. To encourage medical tourism, the Cuban government formed *Servimed*, a company that facilitates foreign access to healthcare in Cuba; and continues to negotiate bilateral agreements with neighbouring nations to further attract foreign patients. Operating entirely within a public system (an anomaly in the privately dominated industry) Cuba's medical tourism also includes the provision of sophisticated healthcare at no cost to poor individuals within Latin America and other poor regions of the world as part of its international health solidarity work. One example, initiated in 2004, is surgery to reverse vision loss, which by 2008 had provided over 1,000,000 free interventions to poor persons from 32 countries. Over 260,000 surgeries were provided for free to foreign patients within Cuba, including all costs of patients getting to and from the country (Gorry, 2008).[10]

Other countries in the region are also striving to enter the market: Barbados, which presently has a facility specializing in fertility treatments but also wants to establish a medical tourism hospital for cardiac patients (PR Newswire, 2011); Guatemala, which purports to serve already over 500 medical tourists annually, many seeking radiation and stem cell therapy (CIDNEWSMEDIA.COM, 2011); Panama, which offers cosmetic surgeries, knee and hip replacements, dental care and cardiovascular surgery to about 3,000 medical travellers annually Panama Medical Tourism, n.d.); Cancun, Merida and the Mayan Riviera in Yucatan, Mexico, promising investments of US$50 million to refurbish or expand 10 hospitals and clinics already

catering to foreign patients; and Costa Rica, for some years a destination for the controversial 'liberation' therapy to treat multiple sclerosis (MS). Medical tourism facilities in Mexico are frequented by Mexican émigrés who live and work (legally or informally) in bordering US states. One study estimated that one million Californians seek medical and dental care and inexpensive prescription drugs in Mexico each year, about half of whom are Mexican émigrés who often lack US health insurance coverage (Stephano & Edelheit, 2010; Lunt, et al., 2011). Mexico is now looking to promote itself as a destination for patients coming from Canada, the US and Europe. In South America, medical travellers from neighbouring Bolivia, Peru and Ecuador frequently access Chilean health facilities (Cortez, 2008), although Peru is now entering the medical tourism business itself. Colombia is seeking to establish itself as a major South American player in the industry, although it is not known the extent to which it seeks regional flows as distinct from foreign patients from Canada, the US and Europe. Brazil is also becoming a major player, reportedly attracting 49,000 medical tourists in 2005. Its medical tourism websites, however, appear to target primarily American foreign patients and to promote the country's private hospitals. Ferreyra, in this volume, illustrates Argentina's similar attempts to secure a spot in the medical tourism complex.

Turning to Asia, just three countries (India, Thailand and Singapore) are estimated to account for 90 percent of all medical tourism within the continent, much of it regional in origin (NaRanong & NaRanong, 2011). India has been developing its medical tourism industry for over a decade, and is an established destination for patients from neighbouring countries such as Sri Lanka, Bangladesh, Nepal, Bhutan and Pakistan. In the late 2000s, an estimated 50,000 neighbouring Bangladeshi annually crossed borders for care in India (Whittaker, 2008). The prevalence of English in India's healthcare facilities also lends itself to aggressive marketing for foreign patients from English-speaking high-income countries (the UK, the USA, Canada, Australia). Regional flows are more evident in South East Asia, where Malaysia, Thailand and Singapore combined attracted over 2 million medical tourists in 2006-2007, generating US$3 billion in revenues (Pocock & Phua, 2011). Most medical travellers to these three countries came from within the Association of Southeast Asian Nations (ASEAN) region, although Thailand saw the largest share of its foreign patients come from Japan.[11] Thailand remains the

world's leader in medical tourism, treating over 1.5 million foreign patients in 2010 (twice the number of runner-up India), of which between 420,000 and 500,000 travelled specifically for medical treatment (NaRanong & NaRanong, 2011).[12] There is also brisk cross-border medical traffic between Indonesia and both Singapore and Malaysia; while Cambodians unable to access high quality care in their country often seek it in Vietnam (Pocock & Phua, 2011).

Cost is a factor in these South-South health migrations, as it is in the North-South flow discussed below. But more often it is access to quality care or to services that simply are unavailable in medical travelers' own countries.[13] This poses two dilemmas. First, as an ethnographic review of medical travel originating in Yemen relates poignantly, families are often forced to sell property, including land, livestock, and jewels, and to borrow heavily from friends and family members to finance medical trips for competent and specialist care that they desperately need (Kangas, 2007). Second, the revenues earned by hospitals in Jordan treating Yemeni represent capital no longer available (as direct payments or through taxation) to develop the health systems of Yemen, entrenching a spiral of patients seeking healthcare outside their country. While individuals are able to get the care they need (though not without substantial personal cost if they are poor), there is less funding available to improve health systems in their own poorly serviced countries. There is also less political pressure to reform such health systems with medical tourism functioning as a 'safety valve' for unmet healthcare needs.[14] To the extent that medical travellers represent a middle-class with the resources to finance their personal health journeys, their exit of the under-resourced public system in their own country further erodes the basis of social solidarity that underpins the cross-subsidization (healthy to sick, rich to poor) of all publicly financed healthcare.

This dilemma does not preclude the potential advantages of pooling health resources in border areas, especially for poorer countries. An exploratory study of cross-border care collaboration between the resource-constrained settings of the border regions of Pakistan, Afghanistan, and Tajikistan could improve maternal and child health by exerting a multiplying effect on present (and inadequate) services (Walraven, Manaseki-Holland, Hussain & Tomaro, 2009). Stakeholder interviews affirmed the feasibility of attempting such provision, although it remains to be tested empirically.

North-South flows

The flow that has captured most attention recently is the gold rush of primarily private, but also some public, providers in low- and middle-income countries attempting to capitalize on what they perceive to be an unfilled demand from the wealthier and demographically aging North. The growth of such facilities is attributed, in part, to observations of private patient hospitals in the US (and to a lesser extent private wings in UK facilities) catering to wealthy fee-paying patients through an emphasis on quality and consumer-focused service. While Asian countries were first to embrace this new healthcare industry, many Middle Eastern and several South American countries have begun aggressively promoting a range of medical tourism services to markets well beyond their regions. Although all high-income countries are the foci of such outreach, the US, "by being one of the only countries that does not have socialized or nationalized medicine," is "one of the biggest targets for medical tourism" (Stephano & Edelheit, 2010). By one leading medical brokerage's assessment, at least 42 foreign medical sites have been deemed to provide value and quality for American patients travelling abroad (Patients Beyond Borders, n.d.; Deloitte Center for Health Solutions, 2009).

Empirical data on the North-South flow (how many are going from which country to which destination) is sketchy, but some evidence is slowly trickling in. Medical tourism to South Africa is dominated by people travelling from within the continent, but also records substantial numbers coming from the UK, other European countries, the US and Australia.[15] A recent study of 770 patients travelling to four destination countries (India, China, Jordan and the UAE) found that the majority of medical tourists to India and China came from the North, although the pattern reversed for Jordan and the UAE (Alsharif, et al., 2010). The Bumrungrad Hospital in Thailand, which advertises over 200 US certified physicians, claims to have treated 55,000 patients from the US (De Arellano, 2007). Between 10 and 15 percent of India's medical tourists (variously estimated to fall between 150,000 and 500,000 annually) emanate from the US (Cortez, 2008.) The Deloitte consulting firm in its most recent ('recession-adjusted') estimate of the US medical tourism market concluded that 878,000 Americans sought healthcare outside their country in 2010, and projected this to rise to 1.6 million by 2012. Almost all of this medical travel will be to low- or middle-income countries (Deloitte Center

for Health Solutions, 2010; Medical Tourism Association, 2011). Most observers also predict an increase in the North-South flow, as the wealthier population ages and healthcare costs and rationing risk extending wait-times. Not coincidentally, the majority of the medical travellers in the four-country study cited earlier were over 45 years of age (Alsharif, et al., 2010).

THE MULTINATIONAL BUSINESS OF MEDICAL TOURISM

Contemporary medical tourism is referred to in this book as an industry. This was a deliberate choice in terminology as its practice is primarily developing along the lines of a private, commercial enterprise. Both supply- and demand-side factors fuel its growth; one of them being the infusion of foreign direct investment into the private hospital chains seeking international patients. Destination countries, such as India and Thailand, but also ones trying to break into the market such as Indonesia and Nepal, have lowered restrictions on foreign direct investment in recent years, hoping to encourage growth in their commercial health sectors (Cortez, 2008; Chanda, 2007).

Thailand was among the first developing countries to enter the medical tourism market (Lunt, et al., 2011). It did so in response to a rapid growth in private hospitals in the 1980s that followed a government policy encouraging foreign direct investment. These hospitals were threatened with failure when the 1997 Asian financial crisis occurred at the same time as the government's '30 baht/visit' public health insurance scheme (a scheme designed to move many people away from the private to the public health sector) was introduced (Lunt, et al., 2011).[16] In 2003, the Thai Government announced a campaign to ensure that the country would become the 'Medical Hub of Asia,' actively promoting a combination of its high-end medical treatment and its traditional spas, massage and herbal remedies. Medical tourism became the means to prop up demand for private providers and generated US$2 billion in 2008 (NaRanong & NaRanong, 2011), equivalent to about 0.4% of the country's GDP. This is not a negligible sum, although it is hardly a driver of economic growth. In 2006, only one Thai hospital was JCI accredited: this number now stands at four, indicative of the surge that is occurring as well as Thai government policy to take on medical tourism as a means of accumulating foreign currency

(Pocock & Phua, 2011). Public hospitals still outnumber private hospitals and are not involved in medical tourism, although medical tourism's draw on the country's aggregate health resources (notably healthcare providers) is substantial.

Singapore and Malaysia, two other popular ASEAN destinations, developed their medical tourism industries for reasons similar to those of Thailand. In Singapore's case it was also recognition that its own population base was insufficient to finance the high-end medical care it wished to establish and retain (Otley, 2007); fee-paying international patients would be required. The government has set a target of one million medical tourists by 2012 (Pocock & Phua, 2011). In Malaysia, medical tourism is viewed primarily as an industrial growth strategy rather than as an issue of healthcare access. Governments in both countries have been active in supporting industry growth through marketing, trade shows and, in the case of Malaysia, generous tax incentives. Private hospitals catering to medical tourists can double deductions for their marketing expenses and enjoy (as of 2010) a 100 percent tax holiday on revenues earned from treating foreign patients (Chee, 2010). Both countries have well developed public and private health systems, although growth in the latter is now outpacing expansion of the former. Similarly, in both countries, sovereign wealth funds are invested in private medical tourism – another instance of the blurring between public and private in this rapidly emerging industry. As concluded by two analysts, this represents "an apparent convergence in trade, tourism and health ministry priorities…reflective of growing acceptance of health as a private good globally" (Pocock & Phua, 2011, p. 6).

South Korea, a new competitor in the same region, is adopting similar policies of direct government promotion and subsidization of its medical tourism facilities, intending to develop 'health cities' along the lines of Dubai. This support includes encouragement of for-profit hospitals in special economic (tax-free) zones. About half of all health expenditures in South Korea are publicly subsidized, but most facilities, including hospitals and clinics, are private and out-of-pocket payments remain high (Chun, Kim, Lee & Lee, 2009). While targeting American and European markets, one of the government's strategies is to focus on Korean expats living in the US and New Zealand, encouraging them to seek treatment back 'home' (Lunt, et al., 2010).

As in Thailand, India's move into medical tourism was an outgrowth of economic interests within its private health sector. The Confederation of Indian Industry lobbied for an official government policy on medical tourism, which was adopted by the Indian state as part of its national health policy in 2002 (Saligram, 2009). The government subsidizes growth in this sector through tax and land concessions, duty and tax concessions on various imports, income tax holidays for those investing in the industry and special 'M' visas for medical tourists (Chanda, 2002; Saligram, 2009. It actively markets the country as a medical tourism destination ('Incredible India – the global healthcare destination'): a case in point being the involvement of many Indian government departments in a major medical tourism conference in Canada in 2009 (Runnels & Turner, 2011). The government also offers credit for hospitals with more than 100 beds (Chanda, 2002; Saligram, 2009) and subsidizes the training costs of physicians, the majority of whom work in the private healthcare sector (Chanda, 2002). The value of these public training subsidies to the private medical sector is estimated to be US$100 million annually (Sengupta & Nundy, 2005). At least thirteen of India's private hospitals are now JCI accredited, with the sector dominated by three chains (Apollo, Wockhardt and Fortis). The largest is the Apollo Hospital chain with 43 hospitals and over 10,000 beds, reportedly treating 60,000 foreign patients from 55 countries between 2003 and 2008 (Saligram, 2009). It has established partnerships with tourism and insurance businesses, and developed bilateral agreements with the governments of Tanzania and Mauritius to treat their citizens (Whittaker, 2008).[17] The Apollo Chain is 12.5 percent owned by Malaysia's sovereign wealth fund (Chee, 2010).

Mexico presents an interesting Latin American case. It now has 11 JCI accredited hospitals, an increase from the 2 reported in 2008 (Vequist & Valdez, 2008). The country's largest private hospital chain, Grup Star Medica, partly owned by the world's wealthiest man (Carlos Slim Helu), is planning to invest US$700 million or more to construct up to 15 more hospitals partly to attract patients from the US. The Texas-based Catholic not-for-profit hospital group, Christus Health, half-owns a recently established Mexican operation, CHRISTUS MUGUERZA®, which operates 8 hospitals and is seeking to expand its medical tourism business (Vequist & Valdez, 2008). The Christus group differentiates itself from other medical tourism businesses by targeting Hispanics living in the US, and integrating its profit-making medical

business with traditional Catholic charitable services to poorer populations.[18] At the same time, its medical tourism side is run on a profit-seeking, 'high-volume market' basis (Christus Health, 2010.) In 2010 the Mexican Minister of Tourism announced his intent to make the country a major medical tourism destination with a goal of 450,000 medical tourists by 2015, and 650,000 by 2020. This follows a pattern in most destination countries: government support for the industry arises primarily from tourism or industrial development ministries, with ministries of health often a secondary or minor partner. Tourism ministries in Latin America in recent years have been partnering with the US-based Medical Tourism Association to fund 'Familiarization Tours,' in which insurance companies and medical tourism brokers, primarily from the USA, are hosted by private hospitals, local health insurers and government officials in an effort to strengthen referral networks (Stephano & Edelheit, 2010) (see Box: Medical Tourism Association).

Medical Tourism Association

The Medical Tourism Association, a non-profit organization, promotes the interests of healthcare provider and medical tourism facilitator members. It manages MedicalTourism.com, a "free, confidential, independent resource for patients and industry providers," (MedicalTourism.com, 2011a), publishes the association's trade journal, the *Medical Tourism Magazine,* and convenes annual conferences bringing together countries developing medical tourism industries, hospitals catering to international patients, broker firms and insurance companies.[19] Its web-site lists close to 50 countries which are described as "the most popular medical tourism destinations around the world" (MedicalTourism.com, 2011b). These include G8 countries, France, Germany, UK, US and Italy. Canada is also listed but no details are available and the text on its web page suggests they are "coming soon" (MedicalTourism.com, 2011c). Other literature suggests that another G8 country, Japan, is showing an interest in developing medical tourism, with Italy yet to establish itself on the medical tourism map.

In addition to countries mentioned elsewhere in this volume, others listed on the medicaltourism.com website include the South American nations of Ecuador, which offers popular services including plastic surgery, orthopedics, bariatric surgery and dental procedures, and Guatemala, described as "a newcomer to the medical tourism industry"

(MedicalTourism.com, 2011d). Another 'newcomer' is Greece, with Athens serving as the major centre and the government reportedly working on developing other popular tourist locations. The Philippines is promoted for its procedures which are available "for a fraction of the cost in developed countries" (MedicalTourism.com, 2011e). Advertised as "the underdog in the medical tourism industry," (MedicalTourism.com, 2011f) Vietnam offers "health spas, cosmetic, bariatric, and dental procedures" (MedicalTourism.com, 2011f) which are reported as popular among medical tourists. However, the webpage for Vietnam does note that "cosmetic surgery is a relatively new phenomenon" (MedicalTourism.com, 2011f) and thus there is a lack of official controls on the practice.

The descriptions of many of the countries emphasize tourism over healthcare, suggesting that medical tourists first choose the country based on their interest in tourism (such as the Galapagos Islands in Ecuador), and then check into the medical services available.

THE INSURANCE ISSUE

Unsurprisingly, the private health insurance industry, notably American, is being encouraged to exploit the cost advantages of medical tourism (Deloitte Center for Health Solutions, 2008). Some economists argue that a combination of importing foreign trained health workers (something at which the US already excels) and exporting patients to developing countries is the simplest and most cost-efficient solution to its healthcare problems (Bhagwati & Madan, 2008). Medical tourism brokerages operating out of the US (Planet Hospital and Med Retreat, as examples) have started negotiating with insurance providers to develop policies for their client/patients, recognizing that the non-portability of insurance coverage poses one of the most significant barriers to the growth of medical tourism (York, 2008). Both self-insured companies and large insurance firms are attracted to the low-cost provider networks offered by the medical tourism industry, but not without opposition. An attempt by a South Carolina company in 2007 to offer financial inducements to employees accepting treatment in India was rescinded after the union condemned the policy out of concern about lax overseas medical

malpractice laws (Cortez, 2008; McLean, 2007; Higgins, 2007). An effort in 2006 to incorporate a similar policy in West Virginia for its state employees also failed (Turner 2007). At the same time, a European owned supermarket chain in the US successfully initiated a similar policy out of concern with the high costs of US-based healthcare (Carroll, 2008). More recently, Blue Shield of California and the health insurance company Health Net are now selling discounted health insurance policies that encourage patients to get most of their care in Mexico;[20] and insurers in three other US states (Florida, Wisconsin and South Carolina) have entered agreements to insure patients at JCI-accredited hospitals in India and Thailand. Whether these small initiatives begin to diffuse across US healthcare more generally remains to be seen.

South-South flows also involve insurance portability issues. Singapore now allows (indeed encourages) its citizens to use their 'Medisave' accounts to access healthcare in Malaysia, which is considerably cheaper. Medisave is a legally mandated personal insurance program, with joint contributions paid by employers and employees. All contributions are tax-exempt, representing tax expenditures in the program by the Singapore State (Massaro & Wong, 1996). Again indicative of the confluence of public and private interests: Singapore residents wishing to maintain a health balance in their health insurance fund by using services in Malaysia may do so, but only at private hospitals in Malaysia that happen to be owned by Singapore private hospital chains (Chee, 2010).

The reluctance of private health insurers to more fully embrace medical travel is understandable. Even though quality of care and accreditation is improving in many developing country destinations (or so the JCI and hospital claims would attest), some countries have limited malpractice protection and weak mechanisms for medical liability or for pursuit of compensation claims.[21] To date, there appears even less interest by public health insurers to accept the risks inherent in availing of the lower-cost 'safety valve' of medical treatments offered by developing country hospitals, regardless of accreditation. The lack of insurance portability may be the greatest single damper on growth in medical tourism;[22] as one indication, a survey of Canadians reported that 60 percent would travel internationally for healthcare if it was covered by public health insurance, but only 20 percent would consider such an option if it were self-paid (Deloitte Center for Health Solutions, n.d.).

THE MALPRACTICE ISSUE

The risks inherent in seeking healthcare outside their country apply to patients as well as to insurers. There is little or no independent statistical data on complication rates from medical procedures obtained in medical tourism destination countries, but anecdotal accounts of malpractice or medical misadventure are frequent in the literature (Newman, Camberos & Ascherman, 2005; Healy, 2009), including novel infections (some of which may be extensively drug-resistant (XDR) forms of diseases such as tuberculosis or 'golden staph') and post-operative complications. The subsequent financial costs borne by the public health systems of patients' home countries are argued to be extensive (Jeevan & Armstrong, 2008). A lack or lax enforcement of malpractice laws in developing countries poses another risk. Little or no malpractice insurance costs allow developing country practitioners and facilities to maintain low prices but leave medical tourists with few options if malpractice is suspected. In Singapore and Malaysia, courts overseeing malpractice suits defer to the opinions of attending physicians, essentially requiring a physician to 'confess' to malpractice in order for any compensatory damages to be awarded (Forgione & Smith, 2007).

THE HEALTH EQUITY ISSUE

Alongside the risks one must also set the benefits. For international patients wanting to jump queues or to obtain care otherwise not available to them, and assuming that care is both affordable and of high standards, the personal benefits are obvious. From the destination country perspective, the benefits are generally argued under the umbrella heading of 'trickle down' economics: the industry increases an inward flow of foreign currency which supports growth in health, tourism and infrastructure industries, improving aggregate economic development and sophisticated healthcare facilities that eventually benefits the greater population (Smith, 2004; Bookman & Bookman, 2007). While the estimated annual earnings for four major Asian destinations and not (yet) huge, they are substantial (see Table 2.2).

Moreover, the fact that these industries are in large part foreign owned means that little of the revenue remains in the country for public health purposes.

Table 2.2 Estimated Medical Tourism Earnings in Selected Countries

Country	**Estimated earnings (US$)**	**Major services provided**
Thailand	1.1 billion (2006)	Cosmetic surgery, organ transplants, dental treatment, joint replacements
India	480 million (2005)	Cardiac surgery, joint replacements, eye surgery
Singapore	1.2 billion (2007)	Liver transplants, joint replacements, cardiac surgery
Malaysia	90 million (2008)	Cardiology, cardio-thoracic surgery, cosmetic surgery

Source: Adapted from ESCAP 2007; DiscoverMedicalTourism.com; Health-Tourism.com; Pocock and Phua (2011); Chee, 2010

Other claimed benefits include private investment in state-of-the-art medical technology, and a slow-down or reversal of the migration of medical professionals to developed countries. The Apollo group in India, for instance, claims to have attracted more than 123 expatriate medical professionals to return by offering more competitive salaries and the opportunity to live and work in their country of origin while still being able to practice advanced healthcare (Cortez, 2008). To put this figure into perspective: it represents just 10 percent of the number of Indian-trained physicians entering US medical residencies each year (Mullan, 2006) and

scarcely a dent in the estimated need for 800,000 more physicians in India over the next decade (Otley, 2007).

Moreover, these benefits may be overshadowed by costs in healthcare access for local people. Policies and regulations which would ensure that revenues generated through medical tourism are taxed sufficiently and reinvested back into public healthcare are absent or unenforced in most developing nations (Sengupta, 2008); and benefits purported to occur from medical tourism have yet to be realized by the majority of the population of such countries. In India, private hospitals catering to both national and foreign fee-paying patients that received lucrative land and tax concessions from the government are obliged to provide 10 percent of inpatient and 25 percent of outpatient beds for free use by the poor (Saligram, 2009). However, there is little evidence that such beds are actually made available (Connell, 2008). A 2005 report by the Indian Government's public accounts committee found that many Delhi hospitals were non-compliant with this obligation, and concluded that "what started with a grand idea of benefiting the poor turned out to be a hunting ground for the rich in the garb of public charitable interests" (Shetty, 2010, p. 672). In September, 2011, a Supreme Court in India ruled that private hospitals in Delhi serving national and foreign patients were, indeed, bound by their agreements to operate on public lands to make these beds available. Several of the hospitals had argued that illnesses such as cancer and cardiovascular disease were too costly to treat for free (Headlines Today Bureau, 2011). Even assuming there is compliance with this ruling, access to healthcare for the majority of India's poor remains costly and highly inadequate.

In Thailand, the high quality medical care that is available to medical tourists remains financially out of reach for the majority of the Thai population (Saniotis, 2007). Thailand also provides evidence for another concern: that medical tourism will weaken public healthcare by incentivizing an internal brain drain of providers to private facilities that offer higher salaries and better working conditions. Almost 6,000 positions for medical practitioners in Thailand's public system were unfilled in 2005, as an increasing number of physicians (already undersupplied in the country) followed the higher wages and more attractive settings available in private care (Saniotis, 2007). The Thai Rural Doctors Society blames foreign medical expansion for this drift, complaining that Bangkok (where most private hospitals for international patients are located)

already has eight times the number of doctors/capita than poorer served rural provinces (Chambers, 2011). For countries such as Ghana, Pakistan and South Africa, which lose approximately half of their medical graduates every year to external migration, the addition of internal brain drain from public to private healthcare can be especially damaging (Cortez, 2008).

A further financial burden to the public is the cost of training medical practitioners who end up working in the medical tourism industry. In India, medical professionals are trained in highly subsidized public facilities (Sengupta & Nundy, 2005). The annual value of these public training subsidies to the private sector where many physicians eventually work is estimated at over US$100 million (Sengupta & Nundy, 2005), at least some of which accrues to the medical tourism industry (Sengupta, 2008). This diverts public funds to private care for more affluent individuals that might otherwise have gone into improving public healthcare provision for the poor. This is a particular concern in India, where public health expenditures are very low even by developing country standards, and where almost all growth in the sector is now driven by the private enterprise (Chanda, 2007). Similar arguments have been made about Thai health workers whose training is heavily tax-subsidized being unavailable to provide services to those who pay the taxes (NaRanong & NaRanong, 2011). Finally, there are concerns that medical tourism imposes a specific Western biomedical model on developing nations, which may undermine culturally specific and traditional approaches to healing and wellness (Saniotis, 2007); or give greater emphasis to acute or tertiary care over preventative or primary care.

The global entrenchment of two-tiered healthcare arising in the wake of medical tourism poses the broader and larger health equity concern. The UAE, for example, is designated a high-income country but it has very low overall healthcare spending (0.6% of GDP and 7% of total public spending in 2002) (World Health Organization – Eastern Mediterranean Regional Office [WHO-EMRO], 2006). Its public system, which finances 81% of healthcare spending (United Arab Emirates Ministry of Health, 2010), provides just one bed, 0.33 doctors and just over one nurse per 1,000 population; very low by international standards. The country, like Jordan, has a shortage of qualified healthcare workers (WHO-EMRO, 2006) and is expanding rather than contracting the privatization of its healthcare systems, partly to attract international patients. The crowding out of local access to a very low supply of hospital beds by

medical travellers to Jordan has already been commented on. Such crowding out takes on even more significance given a study in Thailand that estimated that the medical resources required to treat one foreign patient were equivalent to what would be needed to treat four or five Thai patients (Wilbulpropasert , Pachanee, Pitayarangsarit & Hempisut, 2004).

CONCLUSION

Medical travel may not be new, but the shape it is now taking does differ from earlier eras. Our review of existing searchable knowledge about the 'what, who, why and where' medical tourism allows several summary points:

- a shift in the flows with developing countries becoming more prominent destinations competing for wealthier patients from neighbouring nations or developed countries, notably the US
- an emerging consensus that these flows are likely to increase as demographic pressures in advanced economies create more wait-time problems in public healthcare facilities
- the creation of major 'health cities' in many destination countries offering a large range of state-of-the-art medical and surgical services
- persisting ethical issues related to who benefits most, and how controversial procedures such as organ transplantation or surrogacy might be better managed
- the balance, if any can be achieved, between the global and entrepreneurial nature of private medical tourism and the national and redistributive aims of public health systems

These themes are taken up in many of the chapters in this book. And while there is a growing literature on these issues, the most striking conclusion of our overview is the lack of hard data on the magnitude of medical tourism, with anecdotes, brokerage claims and theoretical conjectures standing in for more deliberative study.

There is a significant lack of reliable data on the scale of the revenues generated, both directly and indirectly, and on detailed accounts of who is benefiting and who may be losing (if

at all) from the likely (though not definitively established) growth of this industry. National health and economic statistics can assist in developing metrics of public/private revenues, benefits and aggregate welfare gains arising from medical tourism, although detailed within-country studies would be needed to ascertain the distributional impact of net health gains and losses. Some measure of patient flows could be estimated from data collected by medical tourism brokerages or destination country healthcare facilities; but such information may be considered confidential or the companies involved may be unwilling to release it. Surveys of patients obtaining cross-border care are other potential sources of useful data, but this again requires the cooperation of medical tourism facilities.

In brief, obtaining a competent empirical handle on the nature of this industry will not be easy. Moreover, any new research on medical tourism should also locate its questions and analyses within the broader frame of global health sector reform, which for the past several decades has been characterized by decreasing public or not-for-profit provision and increasing private sector involvement which the weight of evidence suggests is not well-regulated and is highly inequitable in access and impact (Gilson, Doherty, Loewenson & Francis, 2007; World Health Organization, 2008).

At base, the key question about medical tourism is whether the ability of elites to benefit from it imposes costs on access for poorer groups. That this question underpins many other aspects of health systems and policy, and indeed of contemporary globalization itself, does not make it any less important or urgent to address.

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[1] See the Chapters by Chanda and Blouin, this volume.
[2] This is sometimes the case; and even if not, the planned tourist activities may be compromised by complications or by the severity of the procedure being sought by foreign patients. See the Chapter by Johnston, Crooks and Snyder, this volume.
[3] See the Chapter by Labonté, this volume, for an account of a 2011 medical tourism conference.
[4] More detailed discussion of these partnerships can be found in the Chapters by Crush, Chikanda and Maswikwa (South Africa); Chanda (India); and Ferreyra (Mexico), this volume.
[5] Interestingly, the four destination country survey found that fewer than half of respondents rated accreditation or affiliation with an American or European hospital as an 'important' or 'very important' factor in choosing medical tourism (Alsharif, Labonté and Lu, 2010).

Accreditation and brand affiliation are nonetheless considered to be important by providers and governments supporting the growth of medical tourism in developing countries.

[6] See the Chapter on reproductive tourism by Deonandan, this volume.

[7] For more information, see the Matas/Kilgour Release New Evidence on Organ Harvesting in China article at http://organharvestinvestigation.net/release/pr-2008-08-22.htm.

[8] See the Chapter by Hopkins, this volume, for a description of a patient seeking healthcare outside her country with reference to bariatric surgery; and to the Chapter by Runnels and Packer for a discussion of administrative and legal issues pertaining to Canadians seeking to have out of country care (OOCC) approved by their provincial public health insurance programs.

[9] It is not known what impact the 'Arab Spring' of 2011 has had on such patient flows, although a business report claimed that over 250,000 medical travelers visited Tunisia in 2009. See Stephano & Edelheit, 2010.

[10] For a sympathetic yet critical review of Cuban medical tourism, see the Chapter by Ferreyra, this volume.

[11] The Japanese government is attempting to grow its own medical tourism industry and has relaxed entry visas for this purpose, but the low ratio of physicians/population and the high cost of treatment militate against this (Lunt et al, 2011).

[12] Many of the foreign patients (the higher 1.5 million figure) were expats or tourists and so are not considered medical tourists. The lower figure for medical tourists is still significant, since an important point about medical tourists is that they generally seek more intensive forms of care than the routine health services provided to expats or regular tourists, and so place more strain on a country's medical resources.

[13] An interesting exception arising from the four-country study was the UAE (Alsharif, et al., 2010), where privacy was cited as the most important reason for seeking care in that country. Given that this was the one destination country in this study where women medical tourists outnumbered men by 2:1, the emphasis on privacy may have something to do with gender politics in the source countries of these women. All but 4 of the 34 female respondents in the UAE sample came from an Arabic country. In 2007 the UAE ranked 25th on the UN Gender Empowerment Measure (comprised of economic and political participation/decision-making and control over economic resources), while ranks for the primary source countries of its (many female) medical tourists, Oman, Qatar and Yemen, were 87, 88 and 109 respectively (UN Gender Empower site: http://hdrstats.undp.org/en/indicators/125.html, Accessed June 4 2010).

[14] This 'safety valve' function is particularly highlighted in Canadian OOCC, described in the Chapter by Runnels and Packer, this volume.

[15] See the Chapter by Crush, Chikanda and Maswikwa, this volume.

[16] See the Chapter on trade treaties and medical tourism by Blouin, this volume. Unlike other ASEAN countries, and certainly unlike India, the majority of health spending in Thailand is public (approximately 75 percent), and has been rising as a share of total spending since 2002 (Pocock & Phua, 2011).

[17] See the Chapters by Deonandan for an account of surrogacy tourism in India, and by Chanda for an overview of the Indian health system and prospects for medical tourism growth, this volume.
[18] See the Chapter by Ferreyra, this volume, for a discussion of this particular hospital group.
[19] See the Chapter by Labonté, this volume, for an account of the 2011 Medical Tourism conference.
[20] See the Chapter by Ferreyra, this volume.
[21] See the Chapter by Chanda, this volume, for a discussion of insurance limitations as they apply to India' medical tourism industry.
[22] See the Chapter by Blouin, this volume.

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3 South-South and North-South Medical Tourism: The Case of South Africa

Jonathan Crush, Abel Chikanda and Belinda Maswikwa

INTRODUCTION

In November 2010, the private South African hospital group, Network Healthcare Holdings Limited (), admitted to 102 counts of fraud, serious assault and contravention of the country's Organized Crime Act for performing illegal organ transplants at its St. Augustine's Hospital in Durban between 2001 and 2003 (Allain, 2011). Brazilian and Romanian donors (who were paid as little as US$5,000 per kidney) were flown to South Africa for their removal. A game safari was often thrown into the bargain (Scheper-Hughes, 2011). The kidneys were sold to wealthy Israeli citizens for up to US$120,000 who travelled to South Africa at the same time for the transplant operation. In order to comply with South African laws, documents were forged to show that the recipient and donor were related. An estimated 300 operations were performed in three cities but only the St Augustine's operation was targeted by prosecutors (Kockett, 2010).

After denying knowledge and wrongdoing for several years, Netcare made a plea bargain with the state in late 2010. The group was fined ZAR4 million (US$590,000) and forfeited the ZAR3.8 million (US$560,500) that it had supposedly made from the operations. Charges against the Netcare Chair, Dr. Richard Friedland, however, were withdrawn (Sidley, 2010). Eight people involved in the scam, including five doctors, subsequently appeared in the Durban Regional Court on charges of fraud, forgery, assault and contraventions under the Human Tissues Act (Kockett, 2010). An interpreter, Samuel Ziegler, pleaded guilty and was fined ZAR50,000. A nephrologist, Dr. Jeffrey Kallmeyer (now practicing in Toronto, Canada), pleaded guilty on 90 counts and was fined ZAR150,000. Two coordinators and four transplant surgeons await trial (in mid-2011). They claim that Netcare had full knowledge of and endorsed the program, leading the South African media to dub the case 'kidneygate.' Journalists from the South African *Mail and Guardian* newspaper have suggested that "the biggest scandal of the case is the absence from the dock of any decision-maker from Netcare" (Hassan & Sole, 2011).

The global traffic in illegal organs, of which this is only one sordid example, represents the dark side of the global medical tourism industry and has significantly tarnished South Africa's reputation as a medical tourism destination (Budiana-Saberil & Delmonico, 2008; Scheper-Hughes, 2008). In 2009, the South African government promised a national policy on medical tourism would be crafted by the end of that year; the policy has still not appeared. This suggests that the government is still very sensitive to the negative international publicity that the case attracted and remains highly ambiguous about giving its support to the private sector-driven medical tourism industry with its focus on high-end North-South (developed to developing country) elective procedures and cosmetic surgery.

Despite the fall-out from this abuse of law and medical ethics, Netcare continues to thrive. As South Africa's largest private hospital group, it is positioned to play a major role in South Africa's expanding medical tourism industry.[1] South Africa has a dual private and public health system. Rooted in the country's apartheid past, access to the private sector is largely restricted to medically insured South Africans, who compose approximately 16 percent of the population and are more likely to be White and Asian (Ahwireng-Obeng and van Loggerenberg, 2010, p. 2). The private sector has 22 percent of all hospital beds in the country, absorbs 60 percent of all health spending and employs 73 percent of all physicians (Mortensen, 2008, pp. 11-12; American International Health Alliance [AIHA], 2011, p. 4). The standard of care in private hospitals is consequently far superior to public facilities and compares favourably to medical facilities in developed countries (McIntyre et al, 2007; Mooney & McIntyre, 2008). Most medical tourism to South Africa is to the private health sector, however the public sector is also accessed by patients from other African countries.

In South Africa, industry is far more heterogeneous and complex than is suggested by its popular image as an archetypal 'sea, sun, sand, surgery' (and safari) destination for medical travellers from Northern countries (Connell, 2006; Stolk, 2009; Mazzaschi, 2011). Over the last decade, South Africa has become a major destination for 'medical tourists' from the rest of Africa and therefore provides an important opportunity to examine the dynamics of South-South and intra-African travel for medical treatment. This chapter begins with an overview of the volume and various types of medical tourism to South Africa as a way of highlighting the

information and data deficiencies for medical tourism, and also highlights the differences between North-South and South-South medical travel to South Africa. In particular, we draw attention to the increasing importance of South-South medical tourism to the country. The final section examines the significance of the emergence of inter-governmental agreements on medical treatment between South Africa and other African countries. The conclusion discusses the implications of the South African case study for our understanding of South-South medical tourism.

DIMENSIONS OF MEDICAL TOURISM TO SOUTH AFRICA

Estimates of the number of medical tourists to South Africa vary widely. For 2003, Maaka (2006, p. 103) put the number at only 8,000 annually with an industry value of ZAR123 million (US$17.5 million). For 2006, one source placed the number of medical tourists to South Africa at 50,000 (Prasad, 2007, p. 256). For the year 2007, a different source estimated that there were 30,000 medical tourists a year, who generated approximately ZAR3 billion or US$429 million (Tourism KwaZulu Natal, 2008, p. 9). In contrast, the President of the South African Association for Plastic and Reconstructive Surgeons said that as many as 200,000 medical tourists visited South Africa in 2006, generating approximately ZAR260 million (Gilfellan, 2008, p. 65). Such widely varying estimates reflect an underlying reality that reliable and consistent data on the size of the medical tourism industry is difficult to find.

Official tourism data on travellers to South Africa is of limited use in determining the numbers of medical tourists. Although, the 2002 Immigration Act provides 'medical permits' only to people who intend to stay in South Africa for periods in excess of three months.[2] Because the vast majority of medical tourists enter the country for shorter periods, any statistics on the issue of medical permits can only capture a small proportion of the market. Entry data is also unhelpful as there is no medical 'purpose of visit' option on visa applications or entry and customs forms. Most people entering the country for medical purposes give 'holiday' as their reason for coming to South Africa, which generally entitles them to a 90 day

(renewable) stay. Therefore, medical tourists are indistinguishable in tourism statistics from other temporary entrants.

Statistics South Africa and South Africa Tourism (SAT) do, however, conduct a regular Tourism Departure Survey (Statistics South Africa [SSA], 2007). The Survey uses a stratified random sample to select respondents who are departing from both land and air ports of entry. A face to face interviewing method is used and questions are asked using a structured questionnaire. Information is collected on (a) country of residence and citizenship; (b) the main purpose of entry ('medical/health' being one of the options); (c) the length of stay in the country; (d) the number of nights spent in various facilities in different provinces ('hospitals' being an option); (e) activities engaged in (a broad range of activities are listed including medical (e.g. treatment in clinic/hospital) and health (e.g. hydro, spa, beauty centre, health farm); (f) reasons for being attracted to South Africa (includes 'medical facilities' as an option); (g) travel arrangements; and (h) amount spent (including on 'medical expenses') (SSA, 2007, p. 267-80). Raw survey data are not available but the information extracted by SAT from the survey is extremely helpful in building a general picture of medical tourism flows to South Africa.

The proportion of surveyed foreign tourists who said they had entered for medical reasons (4.5 percent on average between 2006 and 2010) is well below those who came to shop (25.1 percent), on holiday (23.8 percent), to visit family and friends (23.6 percent) and on business (17.5 percent) (see Table 3.1). However, the number of medical tourists increased from 327,000 in 2003 to 410,000 in 2009 and then fell in 2010 to 330,000 (see Figure 3.1).[3] In relative terms, the proportion of medical tourists rose from 3.9 percent in 2006 to 5.0 percent in 2010.

The UK was the most important source of medical tourists from the North: a total of 122,000 between 2003 and 2008 (approximately 20,000 per annum) (see Table 3.2). Next was Germany (8,000 per annum), followed by the US (6,500 per annum) and the Netherlands (3,500 per annum). Other source countries in the North included Australia, France, Canada, Italy and Sweden. Smaller numbers also entered from countries in the South including India, China and Brazil.

Table 3.1 Purpose of Visit of Tourists to South Africa 2006-2010

Year	Holiday	Shopping-Personal	Shopping-Business	Business	Medical	VFR*	Religion	Other
2006	28.6	11.2	14.5	16.5	3.9	22.4	1.9	2.9
2007	25.3	11.8	12.2	19.2	4.5	24.2	1.1	3.0
2008	20.0	12.6	13.8	18.1	4.3	25.1	0.3	5.7
2009	22.1	13.5	11.2	18.8	4.6	22.7	0.3	6.8
2010	22.9	13.2	11.3	18.3	5.0	23.6	0.6	5.1
2006-2010	**23.8**	**12.5**	**12.6**	**17.5**	**4.5**	**23.6**	**0.8**	**4.7**

Source: Adapted from South Africa Annual Tourism Reports (SAT, 2007; 2008; 2009, 2010a, 2011)
Notes: VFR= Visiting Friends and Relatives

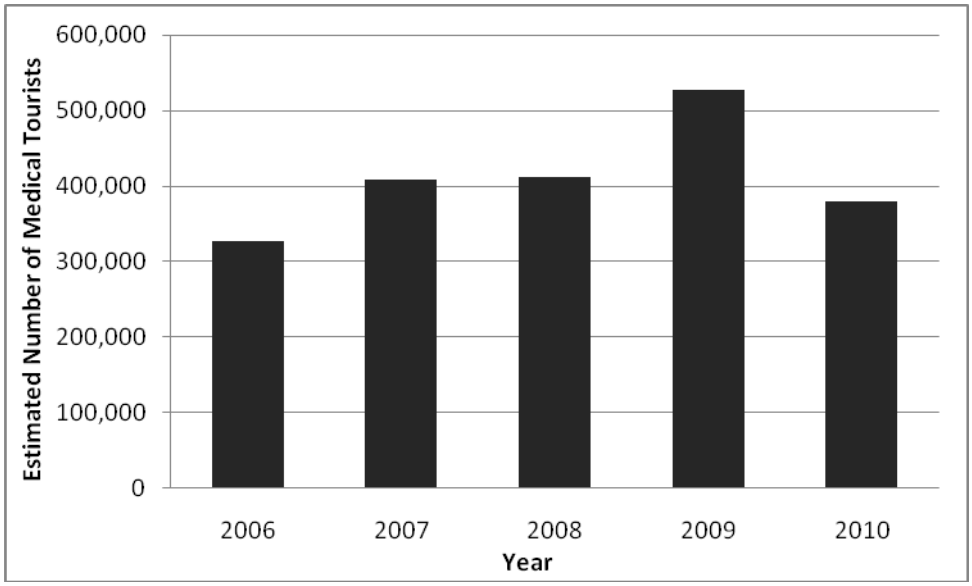

Figure 3.1 Number of Medical Tourists to South Africa 2006-2010
Source: Adapted from South Africa Annual Tourism Reports (SAT, 2007;2008;2009;2010a;2011)

Table 3.2 Detailed Purpose of Visit by Source Country and Region 2003-2008

	Total Tourists	**Total Medical**	**Percent Medical**
NORTH			
UK	2,849,029	122 000	4.3
Germany	1,496,133	47 000	3.1
USA	1,451,732	41 000	2.8
Netherlands	718,368	21 000	2.9
Australia	499,416	14 000	2.8
France	677,502	13 000	1.9
Canada	265,699	9 000	3.4
Italy	303,606	7 000	2.3
Sweden	207,693	5 000	2.4
Japan	166,622	2 000	1.2
SOUTH			
India	239,108	7 000	2.9
China	264,227	6 000	2.2
Brazil	150,188	5 300	3.7
AFRICA			
Africa Air	800,000	38,000	4.7
Africa Land	33,200,000	2,158,000	6.5

Source: Adapted from South African Tourism Country Reports (SAT, 2010b-2010p)

What is most striking, however, is that over two million medical tourists entered South Africa from the rest of Africa compared with only 300,000 from non-African countries. In other words, 85 percent of South Africa's medical tourists are actually from other African countries, not the North. South-South medical tourism therefore dominates the South African industry.[4] The following three sections will compare the main characteristics of North-South and South-South medical tourism to South Africa.

NORTH-SOUTH MEDICAL TOURISM

The North-South medical tourism industry to South Africa comprises a number of inter-linked players. Medical services for medical tourists in South Africa are provided by individual physicians, private medical practices, and public clinics and hospitals. Government regulations affect South African doctors' ability to attract international patients. Physicians in South Africa are not allowed to market or advertise their services, post a photograph of themselves on their website or make claims about the quality of their work, other than that they undertake it (Otley, 2008; Stolk, 2009, p. 68). However, many ignore this rule. In addition, though some doctors offer 'international patient services' they cannot act as medical tourism facilitators. For example, they may refer a patient to a hotel but should not accept payment for these services. South African physicians build an international clientele through a combination of their personal websites, medical facilitators, hospital referrals, referrals from colleagues abroad and word of mouth referrals from satisfied patients. Treating these patients is not without risk according to a dental surgeon, Dr. Peter Galatis, who says that his insurers "double the premium and halve the indemnity" for overseas patients (Otley, 2008).

The industry is therefore largely driven by small-scale medical tourism facilitators working independently to market the country as a destination for foreign patients. This is in contrast with major destinations such as India and Thailand where private hospitals, policy makers and tourism agencies work together to invest in, develop and promote the industry. As a result, these other destinations are often viewed as having more established, better marketed and better managed medical tourism industries (Runckel, 2007; Stolk, 2009).

The South African medical tourism industry has two types of medical facilitator groups and is not as diverse as the Asian industry (Keckley & Underwood, 2008, p. 12). South African facilitators are a mixture of travel agencies and provider groups, acting as intermediaries for international patients and offering a wide range of services. Each company performs one or more of the following roles: international patient marketing for physicians, or acting as a travel agent and medical liaison for patients. In other words, they can act as a patient referral service for physicians, helping them to build and maintain 'high-calibre' or 'repeat' international clientele. For patients, facilitator roles range from organising flights, visas and vacations, to acting as a personal advisor on a wide variety of issues such as quality concerns or patient rights (Keckley & Underwood, 2008; Stolk, 2009). There are currently no industry-wide definitions, standards or accreditations of South African facilitators.

A web search in early 2011 revealed the existence of at least twenty South African based medical facilitators, although the industry is dominated by a smaller number who have managed to find a niche market. Surgeon and Safari, for example, focuses on the UK market and has offices on the prestigious Harley Street, London. Although Netcare uses external facilitators, they have an in-house Central Referral Office (CRO) that acts as a Provider Group Medical Facilitator. This CRO has a foreign patient liaison officer, arranges agreements with local guesthouses, uses an online enquiry form and markets the hospital internationally. The CRO is eligible to receive a referral fee from doctors because it is able to make medical evaluations and accept medical liability.

The three largest private hospital groups, Life, Medi-Clinic and Netcare, operate 165 private hospitals between them. At the same time, the overall importance of medical tourism to the operating revenue and profits of the three groups is presently not large. Corporate expansion outside South Africa has proven to be a much more lucrative business strategy (Mortensen, 2008). Netcare, for example, has opened a private hospital network in the UK; Life Healthcare provides services to NHS patients in the UK; and Medi-Clinic has opened subsidiaries in the UAE and Switzerland (Mortensen, 2008; Otley, 2008). The success of overseas expansion (medical tourism 'in reverse' where providers go to the patients instead) may have somewhat decreased the attractiveness of medical tourism in South Africa, and may

help to explain why private South African hospitals are not driving the expansion of the medical tourism industry, unlike their more aggressive Asian counterparts (Connell, 2011; Shetty, 2010).

A new development in the South African industry concerns Discovery Health, the country's largest health insurance scheme. Discovery Health launched a medical insurance company in the US called 'Destiny Health' in the year 2000 but pulled out in 2008 after failing to capture a significant portion of the market (Discovery, 2012). Discovery Health also entered the UK market as PruHealth, a joint partnership with Prudential, a large multi-purpose insurance company. PruHealth currently has over 700,000 members or a market share of 11 percent (PR Newswire, 2010). In 2009, Discovery Health announced its plan to buy a 25 percent stake in China's 'Ping An Property and Casualty Insurance.' South Africa's health insurance is also globalising and facilitators, physicians, insurers and hospitals could form 'outsourcing' partnerships similar to those developing between the American, European and Indian markets. The difference is that members in countries served by such outsourced partners would have the option of getting surgery in South Africa.

South Africa certainly cannot compete with most other medical tourist destinations on price alone. A survey of the cost of different procedures in South Africa, compared to India, Thailand and Mexico shows that advertised non-elective surgery prices in South Africa are, on average, higher than in the other three destination countries (Keckly & Underwood, 2008, p. 6).[5] For example, a knee replacement surgery costing US$50,000 in the US would cost US$25,000 in South Africa but only US$14,000 in Thailand, US$11,500 in Mexico and US$9,000 in India (see Table 2.1 in Chapter 2 of this volume). Similarly, a combined hip replacement and heart bypass in the US costs on average US$187,000, compared to US$34,900 in South Africa and only US$20,000 in India.

MARKETING SOUTH AFRICA

Advertising for South Africa as a medical tourism destination situates the country as an authentic 'medical tourism' experience combining a medical procedure with the opportunity for a recuperative vacation in idyllic surroundings. MedRetreat (the motto is "where smart

medicine and exotic travel come together") compares several destination countries and notes that:

> South African hospitals and clinics are vying to attract more international medical tourism patients from around the world. ... Although the cost of medical treatment is not as price competitive as many of the other popular medical travel destinations, the quality of treatment is world-class and available tourist attractions are astounding (MedRetreat, 2012).

A very common advertising motif for medical tourism to South Africa is the combination of medical procedures and game safaris. Indeed, many websites advertising medical tourism contain gratuitous photo images of wild animals:

> The country boasts sunshine throughout the year, extraordinary scenery, and of course, a wide variety of wild animals in their native habitats. … Many healthcare providers and private clinics in South Africa have realized that their country's natural wonders can have a positive impact on the recovery process for their patients and encourage both post-operative relaxation and exploration (Discover Medical Tourism, 2011).

The city of Cape Town, in particular, is portrayed as the ideal location to combine cosmetic surgery with twenty-four hour 'pampering':

> The water breaks on the shores of Camps Bay on yet another perfect morning in Cape Town. Medical tourism in South Africa is booming – not only due to the prevailing sunshine that beats down on the country, but thanks in no small part to events such as the FIFA World Cup lighting up the continent with a glow that has enveloped each and every one. … Take the time to browse our many options of things to do and enjoy your all-encompassing trip to Cape Town…Our skilled team of surgeons is only matched by the endless help that our tourism, accommodation and safari specialists that we have on beck and call (Surgical Bliss, 2008).

While ordinary tourism advertising places great stress on the country's history and the opportunity to visit iconic landmarks, townships and learn more about anti-apartheid struggles, this is almost completely absent from medical tourism advertising where escapism rather than harsh realities, past or present, are paramount. At the same time, advertisers and promoters

are only too aware of the bad press generated by the country's crime rate and its place at the epicentre of the global HIV and AIDS pandemic. These issues are either ignored by promoters or attempts are made to reassure the hesitant.

> A common perception of South Africa for foreign travelers is the fear of giving or taking blood in a country so broadcasted for its HIV and AIDS scares. South Africa has one of the most stringent guidelines for blood donation and acquisition in the whole world. … Another perception of South Africa is the crime rates and random power cuts. There is a lack of information being given to the consumer about the world class medical expertise and tourism benefits the country has to offer (Johnson, 2009).

These are major image obstacles to overcome, especially when studies show that contracting HIV at work is a major fear of South African health care providers themselves (Shisana, Hall, Maluleke, Chauveau & Schwabe, 2004; Zelnick & O'Donnell, 2005) and the crime rate and lack of security in the country is driving the 'brain flight' of South African health care professionals to Europe and North America (Crush & Pendleton, 2010).

SOUTH-SOUTH MEDICAL TRAVEL

In recent years, there have been several high profile cases of African leaders and politicians going to South Africa for medical treatment, the most recent being President Robert Mugabe of Zimbabwe (Mathuthu, 2009; Zhangazha, 2011). Interestingly, when his spouse required treatment for a hip injury, the Mugabes, at the government's expense, headed for Singapore. However, it is not only high-profile African political figures who head to South Africa for treatment. Table 3.2 shows that in the period between 2003 and 2008, 38,000 medical travellers flew from the rest of Africa to South Africa and over two million medical travellers entered South Africa from neighbouring countries.

Other than the numbers involved, there is very little information on South-South tourism to South Africa and much more research is urgently needed. Anecdotal evidence suggests that middle-class African medical travellers from non-Southern African Development Community (SADC) countries travel to South Africa mainly to obtain medically necessary

procedures such as reconstructive surgery and chemotherapy. Fairly typical are the 320 African women receiving breast cancer treatment at the Netcare Breast Care Centre of Excellence at Milpark Hospital in Johannesburg who were interviewed in a recent study (Ahwireng-Obeng & Van Loggerenberg, 2010).[6] The two primary reasons for coming to South Africa were doctor referral and quality of treatment. Cost was not a significant factor.

In recent years, the high demand and large informal flow of patients from neighbouring countries has prompted the South African government to try and formalize arrangements for medical travel to South Africa's public hospitals and clinics through inter-country agreements. South Africa has now entered into twenty bilateral health agreements with eighteen countries in Sub-Saharan Africa. It is difficult to obtain precise details about many of these health agreements, as the majority are tied to general health protocols and larger economic investment agreements. Nevertheless, agreements with Swaziland, Lesotho, Mozambique and Burundi do have specific medical travel provisions (see Table 3.3).

Patients from these countries can be referred to South African public hospitals for specialised medical care mostly for cancer treatments, reconstructive surgery and cardiovascular disease. They are admitted in the same way as South African patients, in that they are allowed to access treatment without paying in full in advance (Khumalo, 2010). Any upfront payments required are assessed according to the user fee schedule for South Africans.

Table 3.3 Sample Bilateral Health Agreements

Country	**Name of Agreement**	**Details**
Swaziland	Agreement between the Government of the Republic of South Africa and the Government of the Kingdom of Swaziland on Cooperation in the Field of Health. Effective: 10 May 2010	Swazi citizens may be referred to Government of South African public hospitals for specialised medical treatment. Swazis have to bring their own donors for organ transplants. They can pay the same price that South Africans pay for public health access.
Malawi	Agreement between the Republic of South Africa and the Government of the Republic of Malawi in the Field of Health. Effective: 12 February 2009	Malawians may be admitted to South African public hospitals at subsidized fees (pay the same price that South Africans pay). Will provide specialised medical treatment not available in Malawi.
Burundi	Agreement between the Government of the Republic of South Africa and the Government of the Republic of Burundi on Cooperation in the Field of Health Matters. Effective: 16 September 2008	Provision for the referral of Burundians to South African public hospitals for medical treatment. Under consideration: request for Burundians to access public sector treatment at the same price that South Africans pay.

Source: Adapted from Department of Cooperation and International Affairs (2011).

According to the Department of Health, the all-inclusive, fully subsidized rate for all treatments is currently ZAR39 (US$6) for an outpatient or ZAR194 (US$28) for up to 30 days admission in a public hospital. Their respective governments are then billed for the full costs of treatment and hospitalisation, as well as patient travel and accommodation expenses (Department Of Health, 2005).[7]

The South African policy of concluding bilateral agreements with other African countries can also be seen as an example of health diplomacy. This usually refers to a government's purposeful efforts to incorporate health as a foreign policy tool and has been defined as any "political change activity that meets the dual goals of improving global health and maintaining and improving international relations, particularly in conflict areas and resource-poor environments" (Novotny & Adams, 2007, p. 1). South Africa's health diplomacy efforts are focused in Africa and are generally guided by the 1999 SADC Health Protocol.[8] The protocol's most important objectives are "to facilitate the establishment of a mechanism for the referral of patients for tertiary care" and "to coordinate regional efforts on epidemic preparedness, mapping, prevention, control and where possible the eradication of communicable and non-communicable diseases" (Department of International Relations and Cooperation, 2011).

CONCLUSION

South Africa has become a significant medical tourism destination since the collapse of apartheid in 2004. Medical tourism is often associated with elective cosmetic surgery and South Africa markets itself as an ideal destination for combining such surgery with tourist activities such as game safaris. The majority of these medical tourists come from the UK, Germany and the US. The evidence shows that they are attracted by the 'total tourist experience' offered by the industry. Even the names of prominent cosmetic surgery facilitators – such as Surgeon and Safari, Surgical Bliss and Nulook Surgery – convey this message. Important as this form of elective medical travel is, this chapter has attempted to demonstrate that medical tourism is much more complex and varied than these images suggest.

The term 'medical tourism' seems inappropriate to describe the other form of medical travel outlined in this chapter: the rapid growth in travel from other African countries to South Africa to seek medical diagnosis and treatment. South Africa is increasingly looked to by the continent's elite and middle-class as a country where high quality private care is available for treatments such as surgery after accidents, heart surgery and cancer treatment. However, the greatest growth in medical travel to South Africa in recent years is from neighbouring countries

whose public healthcare systems are in a state of crisis. South Africa's own public healthcare system is itself overburdened and under-resourced but it can still deliver a quality of treatment that is often unavailable at home.

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[1]Netcare is the largest hospital group in South Africa consisting of 56 hospitals with 9,546 registered beds, and more than 1 million admissions per year. It operates 86 pharmacies and the largest private emergency service, Netcare 911, with 7.5 million members and a fleet of 264 vehicles, three helicopters and two fixed-wing air ambulances transporting 175,600 patients per year. Through the primary care networks, Medicross and Primecure, a combined 3.5 million patients are treated per year. Netcare employs nearly 20,000 people in South Africa and yearly South African revenue reached R 8,869 million in 2007 (Mortensen, 2008).

[2]Immigration Act No. 13 of 2002, Section 17 at http://www.info.gov.za/view/DownloadFileAction?id=68047.

[3]The fall in 2010 reflects a change in the methodology used for collecting data on foreign tourist arrivals. This changed in 2010 to bring South Africa in line with the guidelines of the Word Tourism Organization. Prior to 2010, the reported figures for tourist arrivals were synonymous with the total number of foreign arrivals which included day visitors and people who engage in remunerated activities in South Africa (SAT, 2011, p. 2).

[4]The Africa air market in Table 3.2 refers to countries where more than 60 percent of arrivals come by air. It also includes Middle East countries, namely Bahrain, Iran, Iraq, Israel, Jordan, Kuwait, Lebanon, Oman, Qatar, Saudi Arabia, Syria, UAE, and Yemen (SAT, 2010b, p. 6).

[5] Various surgeons provide an industry price range on their websites. These prices represent the mean of the high and low estimate.

[6]The women were from Botswana (152), Malawi (36), Ethiopia (32), Zambia (28), Mozambique (16), Zimbabwe (12), Angola (8), Namibia (8), Ghana (4), Mauritius (4), Nigeria (4), Senegal (4), Swaziland (4), Tanzania (4) and Uganda (4) (Ahwireng-Obeng & Van Loggerenberg, 2010, p. 12).

[7] Such intergovernmental arrangements for cross-border treatment in public facilities are not, by conventional definition, medical tourism, but represent another aspect of the globalization of health care.

[8] South Africa ratified the SADC Health Protocol in 2000 and it came into effect in August 2004 (South African Development Community, 2004, p. 14).

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4 Medical Value Travel in India: Prospects and Challenges

Rupa Chanda

INTRODUCTION

In recent years, several medical tourism hubs have emerged in different parts of the world. This is because familiarity with countries which share similar languages, social customs, and cultural mores makes it easier for foreign patients to access treatment in another country.[1] Some of these countries have become leading providers in specific health services such as cardiac, cosmetic, or dental surgery. The Asian region constitutes an important medical tourism market. It was estimated that medical tourism in Asia generated US$1.3 billion a few years ago and is projected to reach US$4.4 billion by 2012 (United Nations Economic and Social Commission for Asia and the Pacific, 2009, p. 9). India, along with Thailand, has established itself as a recognized hub for medical value travellers in the Asian region. Although reliable country specific estimates are not available to gauge the size of the medical value travel industry in different countries, it is estimated that India in 2004 had 150,000 medical tourists and US$333 million in medical tourism revenues, and has the potential to realize US$2.3 billion from medical tourism by 2012 (Confederation of Indian Industry (CII) and McKinsey and Company, 2002; Federation of Indian Chambers of Commerce (FICCI) & Industry and Ernst and Young, 2007; Tourism Research And Marketing, 2006; Chinai & Goswami, 2007).

This chapter discusses India's prospects for and challenges to medical tourism. Section 2 briefly highlights the salient characteristics of India's healthcare sector (for medical value travel) and then outlines recent trends in India's exports of medical tourism, how it compares with other countries with respect to arrivals and expenditures by foreign patients, and some of its key markets. Sections 3 and 4, respectively, discuss the facilitators and constraints to India's medical tourism exports. Section 5 presents the benefits and concerns that have been voiced in India regarding medical value travel exports and situates this discussion within the wider debate on the pros and cons of trade in health services. Section 6 concludes by outlining positive steps

for India domestically, as well as internationally, in order to facilitate its medical tourism exports.

OVERVIEW OF INDIA'S MEDICAL VALUE TRAVEL EXPORTS[2]

India's healthcare sector is estimated at US$50 billion and is expected to reach US$75 billion in 2012, with an annual growth rate of 18 percent. The sector's contribution to gross domestic product (GDP) has remained virtually stagnant throughout the past decade and stood at 4.2 percent in 2009. It is expected to increase to 8.5 percent by 2017 (Cygnus Business Consulting and Research, 2010).

Key features of India's healthcare sector

There are several noteworthy features of India's healthcare sector, many of which are pertinent to a discussion on the prospects for medical tourism exports from India and the associated issues and concerns. The most striking feature of India's healthcare sector is the dominance of the private healthcare segment, which accounted for around two-thirds of total expenditure and for around 80 percent of the 16,386 hospitals in the country in 2009 (Cygnus Business Consulting and Research, 2010). The share of public spending in India is much lower than in comparable developing countries such as Brazil, China, and South Africa, where the public sector accounts for around 40 to 50 percent of total healthcare expenditures. Moreover, tertiary care constitutes a significant 15 to 20 percent share of India's healthcare spending and is expected to grow steadily due to the growth in specialized hospital care, which is noteworthy given the country's poor basic health indicators. There is a stark urban-rural and rich-poor divide in availability of healthcare, with private hospitals mostly catering to the urban and affluent sections of society, and rural and poor sections depending mainly on the public healthcare system. Such features not only indicate the growing importance of private players in healthcare delivery but also the low priority and inadequate resources devoted to the public sector by the Government of India.

Table 4.1 Status of Human Resources in Healthcare in South Asia and Other Regions

	Health Workforce										Hospital beds (per 10,000 persons)
	Physicians		Nursing and midwifery personnel		Dentistry personnel		Community health workers		Other health service providers		
	No.	Density	No.	Density	No.	Density	No.	Density	No.	Density	
	2000-07		**2000-07**		**2000-07**		**2000-07**		**2000-07**		**2000-07**
Global Avg	8404351	13	17651585	28	1854512	3	…	…	14631863	24	25
Global median	5201	11	12746	29	900	2	548	2	2767	5	25
Southeast Asia Avg	849324	5	1955203	12	92759	1	132612	1	2002575	12	9
India	645825	6	1372059	13	61424	1	50393	1	1752027	16	7
Brazil	198153	12	659111	38	190448	11	…	…	499592	29	24
China	1862630	14	1259240	10	136520	1	…	…	1724620	13	22
Malaysia	17020	7	43380	18	2160	1	…	…	2880	1	18
Singapore	6380	15	18710	44	1190	3	…	…	1280	3	32
South Africa	34829	8	184459	41	5995	1	…	…	71850	16	28
Thailand	22435	4	172477	28	10459	2	…	…	71528	12	22

Source: Based on data from WHO Statistical Information System (WHOSIS) http://www.who.int/whosis/indicators/en/ (accessed May 25, 2012)

Although there has been growing demand for both physical and human infrastructure, availability has not kept pace. As per the WHO guidelines, there is a gap of around 1.4 million doctors and 2.8 million nurses worldwide.[3] According to a Confederation of Indian Industries (CII) and McKinsey and Company study, between 2002 and 2012, there was a projected requirement of 750,000 additional hospital beds to meet the growing demand for in-patient services and to reach a hospital bed to population ratio of 1.9:1000 by 2012, with an estimated investment requirement of US$24 to US$34 billion to set up the required infrastructure (CII & McKinsey and Company, 2002). Table 4.1 highlights the status of human resources and physical infrastructure in India's healthcare sector compared to other developing countries. It shows that India compares poorly on these indicators not only relative to these other countries but also relative to the global average.

Table 4.2 captures the predominance of the private sector in healthcare expenditures in India and also shows that the bulk of private spending on healthcare is out-of-pocket, indicating the very low levels of public and private insurance penetration in this region. Access to healthcare is thus largely a function of ability to pay, i.e., income level and economic background, with implications for equity and human development outcomes.

Table 4.2 Characteristics of Healthcare Expenditures in India and Other Countries

	Public-Private Composition of Health Care Expenditure (percent)						**Out of pocket in private health expenditure (percent)**		**Share of external resources in health expenditure (percent)**	
Country/ Region	**2000**		**2003**		**2006**		**2000**	**2006**	**2000**	**2006**
	Public	**Private**	**Public**	**Private**	**Public**	**Private**				
India	22.2	77.8	18.5	81.5	19.6	80.4	92.1	94	0.6	0.7
Brazil	40	60	41.3	58.7	47.9	52.1	62.7	64	0.5	0.1
China	38.3	61.7	36.2	63.8	42	58	95.6	92.9	0.1	0.1
Malaysia	52.4	47.6	56.4	43.6	45.2	54.8	75.4	73.3	0.6	0
Singapore	36.8	63.2	34	66	33.6	66.4	97	94	0	0
South Africa	42.4	57.6	40.1	59.9	41.9	58.1	18.9	17.5	0.3	0.8
Thailand	56.1	43.9	66.6	33.4	64.4	35.6	76.9	76.6	0	0.3

Source: Based on data from WHO Statistical Information System (WHOSIS) http://www.who.int/whosis/indicators/en/ (accessed May 25, 2012)

This dependence on private out-of-pocket spending when placed against the poor performance on social and physical infrastructure parameters such as availability of healthcare personnel or number of hospital beds (as highlighted in Table 4.1), is also indicative of this inequitable distribution of healthcare availability and quality of services.

India's medical tourism segment in the global context

Against this backdrop of private sector-led healthcare, with imbalances in availability and quality of healthcare delivery, India's medical tourism segment has been growing rapidly, in line with global trends. International arrivals and associated revenues have increased considerably in recent years. According to CII and McKinsey and Company (2002), India's medical tourism revenues were estimated at US$300 million in 2002 and were projected to reach US$2.2 billion by 2012, with an estimated year on year increase of 25 percent in foreign patient arrivals between 2002 and 2012. More recent data from Euromonitor International[4] on international arrivals and medical value travel expenditures for selected countries suggest that the CII estimates may be optimistic, although there has been an increase in the number of foreign patients seeking treatment in India and in the value of medical tourism exports from India (Euromonitor International, 2011).

India faces competition from several countries, mainly within Asia but also globally as a destination for medical value travel. The main competing destination is Thailand, in terms of price and quality, owing to its image as a tourism destination and its efforts in accrediting hospitals. Other notable competitors include Singapore due to the latter's modern healthcare infrastructure, Malaysia for its price competitiveness and government efforts to attract foreign patients from the region, and the Philippines given recent government initiatives in that country to boost its medical tourism industry. Globally, countries such as Mexico, Costa Rica, and Panama in Central America and Jordan and the UAE in the Middle East are competing destinations for foreign patients from the US, Canada, and Europe.

Table 4.3 highlights India's comparative performance in medical tourism by showing the trends in international arrivals for medical treatments and in medical tourism expenditures for India and other selected Asian countries for the 2007-10 period.

Table 4.3 International Arrivals for Medical Treatments and Medical Tourism Spending for Thailand, India, Singapore and Malaysia, 2007-2010

Country	No. of foreign patients ('000s) and Expenditure (US $mn)							
	2007		2008		2009		2010	
	Patients	Expenditure	Patients	Expenditure	Patients	Expenditure	Patients	Expenditure
Thailand	1325	294.2	1360	390.2	1260	487.2	1580	635
India	450	186.9	530	200.7	609	202	731	253.4
Singapore	571	238.6	646	274.5	665	275	725	206.4
Malaysia	341	83.8	370	102.8	425	116.8	489	157.3

Source: Adapted from Euromonitor International Reports by author

The data indicate that India compares favourably with other leading destinations for medical value travellers in Asia, such as Thailand and Singapore. The number of foreign patients has increased around one and a half times between 2007 and 2010 although per head expenditure remains at about US$40,000, and total earnings from medical tourism remain at less than US$300 million (Euromonitor International, 2011). Thailand is clearly the leader in this region, with more than twice the number of medical tourists than India in 2010. The data also indicate that India has caught up with Singapore as the second most preferred destination for medical value travellers within Southeast and South Asia.

India's medical tourism exports in the regional context

India attracts medical tourists from various geographies and for various reasons. Foreign patients receiving treatment in India include the Indian diaspora who prefer to come to their home country for personal and social reasons, patients from countries with rationed healthcare where waiting periods can be long, such as the UK and Canada, patients from uninsured in markets such as the US who prefer low cost and high quality treatment in India, and patients

from developing countries in Africa and South Asia where healthcare facilities are lacking or are of poor quality (Oberholzer-Gee, Khanna and Knoop, 2007).

There is a strong regional dimension to India's medical tourism exports. Within South Asia, India is a medical tourism hub. It is an attractive destination for patients from neighbouring countries such as Nepal, Bangladesh, Bhutan, and the Maldives given the latter's relatively underdeveloped facilities and the lack of specialized treatments in these markets. Patients from other South Asian countries find medical care in India attractive due to cost, quality, and cultural and geographic considerations.

Discussions with several leading corporate hospitals indicate the importance of the regional market as a source for foreign patients (Chanda, 2011a).[5] For instance, the Manipal Hospital in Bangalore receives patients from Sri Lanka, Bangladesh, Nepal, and Pakistan. The Apollo Gleneagles Hospital in Kolkata receives patients from Nepal and Bangladesh and the Apollo Chennai Hospital receives patients from Sri Lanka. Pakistan is seen as a potential source market for patients seeking high-end treatments at a reasonable cost. There have been several high profile cases of Pakistani children seeking specialized cardiac treatment at Indian hospitals (Chanda, 2011a). The Bhutanese government sends patients to Kolkata and Delhi and pays for their treatment. In view of the promising regional market for medical tourism, the Bangalore-based Narayana Hrudayalaya Hospital targets patients from South Asia and other regional markets. Some of the Narayana Group's hospitals have already established referral arrangements with hospitals and agents in source countries and joined up with travel operators to provide an integrated set of services to medical tourists.

Medical tourism opportunities have also led to investment initiatives by leading Indian hospitals in other South Asian countries, through joint ventures, wholly owned subsidiaries, and management contracts, in order to cater to patients in the regional market. For example, Apollo Hospitals has taken on an operations management contract for a 330-bed tertiary care hospital in Dhaka. It has entered into a joint venture with its Bangladeshi partner, STS Holdings, Dhaka. The objective of this project is to cater to the large number of patients coming to India and other neighbouring countries for treatment. According to newspaper reports, Indian hospitals are increasingly looking at entering Bangladesh through joint ventures and standalone

entities, given that country's growing market and affluent population, and economic stability and the large number of Bangladeshi medical tourists who are at present seeking treatment in other countries such as Thailand (Oberholzer-Gee, Khanna & Knoop, 2007, p.6).[6] Likewise, Kolkata's BM Birla Heart Research Centre is interested in establishing its presence in Chittagong and Dhaka. It is setting up a hospital in Dhaka and will be undertaking the management of another hospital in Chittagong. AMRI Hospitals (a private hospital chain) is similarly considering setting up a branch in Bangladesh. These hospitals are interested in tapping the patient base in Bangladesh travelling to Kolkata and other cities in India for treatment. Cultural and linguistic similarities and geographic proximity make Bangladesh an attractive market for overseas ventures for Indian hospitals in the Eastern part of the country. The BM Birla Group is considering setting up a hospital in Bhutan given the country's need for state-of-the-art facilities in healthcare. Thus, opportunities for medical tourism have given rise to other commercial opportunities and private sector players in India are leveraging the linkages that exist between medical tourism and other modes of trade in health services, such as commercial presence and telemedicine in the regional context.

FACILITATING FACTORS

There are several factors that have contributed to India's competitiveness as a medical tourism destination. As highlighted in the following discussion, these factors relate to intrinsic advantages such as the presence of a low cost, skilled health workforce and a large diaspora population. Pro-active efforts and initiatives that promote growth in private healthcare are also factors.

Cost advantage

One of the most important drivers has been India's cost advantage. Data on relative costs for different medical procedures shows India's cost competitiveness in a wide range of treatments, such as transplants, cardiac surgeries, and orthopaedic treatments. India compares favourably with developing country destinations and is one-fourth to as much as one-tenth cheaper than developed countries such as the US for common procedures such as organ

transplants, orthopaedic surgeries, and heart bypass surgery (excluding travel and accommodation related costs). Table 2.1 in Chapter 2 of this volume demonstrates these cost advantages.

With respect to both physician and clinical expenditures, for a variety of medical procedures, India has a significant cost advantage over the US. However, it is also worth noting that if one were to add costs of travel and stay to the cost of medical procedures, India's cost advantage may be considerably eroded when compared with cost competitive destinations such as Mexico or Costa Rica which can cater to patients travelling from the US.

Role of the private sector

The emergence of a vibrant, rapidly growing private corporate sector hospital with state-of-the-art facilities, upgraded technologies, super-specialty care, and standards comparable to those of developed country hospitals, has played a very important role in shaping India's medical tourism exports. Privately owned corporate hospitals such as Apollo, Fortis, Max Healthcare, and Columbia Asia are the main destinations for foreign patients seeking treatment in India. Several of these hospitals have established a reputation in specific areas such as cardiac surgery and joint replacement (Arellano, 2007). Many have partnered with international insurance and tourism companies as well as with hospitals and practitioners abroad to facilitate the medical tourism business. Health cities have also emerged where major corporate hospitals provide an integrated set of services, including hotels, residential, recreational, and transport facilities. The private sector hospitals have also entered into agreements with wellness and holistic centres in their efforts to provide a comprehensive approach to healthcare.[7]

An important driver behind the growing presence of private hospitals in India's medical tourism exports has been international accreditation. Over 10 Indian hospitals, such as Apollo Hospitals (Bangalore, Chennai, Hyderabad, Chennai), Apollo Gleneagles Hospital Kolkata, Indraprastha Apollo Hospital Delhi, Asian Heart Institute, and Fortis, among others have received JCI accreditation. International accreditation has helped raise the standards of healthcare delivery in India and improved India's visibility as a medical tourism destination.

The private sector has also played an important role through associations such as the CII and the Federation of Indian Chambers of Commerce and Industries (FICCI). These

associations have helped in raising awareness about issues of standards and accreditation in the country and have actively lobbied the government on issues such as taxes, infrastructure, financing, medical technologies, and insurance. All have a bearing on the industry's overall cost competitiveness and quality assurance, with implications for India's prospects in medical tourism. Industry associations have also helped in marketing efforts, such as by organizing an annual health conference, with a section on medical tourism and by organizing visits by delegations from the Indian hospital industry and from overseas bodies such as the NHS in the UK to promote the medical tourism industry and highlight barriers affecting such exports from India.

Government policies

Around the world, many countries have promoted the medical tourism segment through aggressive marketing efforts, pro-active policies such as special facilities and incentives for medical tourists, facilitation of investments in multi-specialty corporate hospitals, expedited visa procedures, and integration of healthcare and tourist facilities. For instance, Singapore has a multi-agency initiative through trade exhibitions, investments, and focus on niche treatment areas to promote itself as a medical tourism destination. Thai consuls provide price guidelines for selected treatments available at Thai hospitals (Wibulpolprasert et al, 2004). Many countries have also undertaken targeted initiatives, including efforts to promote themselves as regional hubs.

Although the Indian government has not had a similar pro-active and targeted drive to promote medical tourism, it has indirectly promoted it by considering medical tourism to be a "deemed export" in its National Health Policy of 2002, and thus granting the sector fiscal incentives in the form of lower import duties, providing prime land at subsidized rates, and tax concessions (Burkett, 2007; Garud, 2005; de Arellano, 2007; Sengupta, 2008). However, discussions with government health officials reveal a general reluctance to actively promote medical tourism, mainly due to the many shortcomings in public healthcare delivery and the possible adverse effects on equity that are associated with the commercialization of healthcare through medical tourism.[8] This concern is also reflected in criticisms that have been levelled against the government regarding the provision of fiscal and other incentives to help private

sector players, given the shortage of healthcare facilities and the geographic and economic inequities characterizing healthcare delivery in India.

Other factors

A variety of other factors have helped India's prospects in medical tourism. These include the widespread use of the English language which puts India at an advantage over neighbouring competitors such as Thailand which need translators, its widespread diaspora which provides a market for attracting patients from overseas, and the Indian doctors and nurses who have practiced overseas and are recognized for their skills and competence. Geography, culture and language have also played a role in terms of India's position as a hub for medical tourism within South Asia given the cultural and linguistic affinities between India and other countries in the region.

Another contributing factor is the availability of alternative and traditional systems of medicine, such as ayurvedic, unani, panchkarma, and homeopathy as well as spiritual and rehabilitative forms of treatment such as yoga or siddha, which have been important contributors to India's attractiveness as a medical tourism destination. The latter treatments and therapies, in particular, ayurveda, are distinguishing features of the Indian medical system and are particularly popular among foreigners from Western countries. The Ayur Vaidya Sala at Kottakal in Kerala is popular among German, British, and American tourists, some of whom come to India specifically to avail of these services and for treatment of chronic disorders where allopathic (Western) medicine may fail to deliver (Gupta, Goldar, Mitra, 1998). According to a 2007 report regarding the distribution of Indian doctors by type of medicine, over 50 percent of doctors were practicing alternative medicines, including 36 percent in ayurveda and 16 percent in homeopathy, alongside 43 percent in allopathy (FICCI & Ernst and Young, 2007; CRISIL Research, 2007). Hence, India's niche in alternative therapies is also supported by a sizeable body of practitioners in these other fields of medicine.

CONSTRAINING FACTORS

There are a host of regulatory, infrastructural, quality, and perception related factors which constrain India's prospects for medical tourism exports. These are both domestic and external, some of which may be more difficult to tackle than others. Some of these factors are specific to India while others are constraints inherent to the very nature of the medical tourism industry and healthcare in general (Chanda, 2011a, 2011b).

One major constraint is the lack of insurance portability between important source countries for medical tourists and India. State insurance trusts and private insurance companies do not reimburse for treatment carried out in India. This limits the potential pool of foreign patients mostly to those paying out-of- pocket or to those insured by select companies which have reimbursement or Third Party Arrangements (TPAs) with hospitals catering to foreign patients in India. The absence of reimbursement arrangements with public sector health providers, such as the UK NHS, also limits the scope for attracting patients from countries where the public sector dominates the provision of healthcare and there are generous public health insurance schemes, and where the share of non-insured, out-of-pocket paying patients is low[9]. The dominance of the public sector in healthcare provision and insurance also creates problems of political acceptability for allowing medical value travel to India or for claiming reimbursement from national health insurance trusts in the patient's source country. In the case of some countries, there are restrictions on the reimbursement of patients by national insurance trusts if time spent travelling exceeds a certain amount, which effectively negates the possibility of India as a medical tourism destination. For instance, there is a flight time restriction of 3 hours for patients from the UK for reimbursement from the NHS, which would thus accommodate most European countries where patients can access care, but not countries outside of Europe[10]. There are also restrictions on the reimbursement of alternative medicines and therapies for lack of scientific evidence, registration, and regulation.

There are related domestic regulatory issues pertaining to health insurance in India, which are an impediment to insurance portability from source countries to India. Foreign insurance companies face problems with underwriting and premium setting in the absence of a

regulated environment and control over healthcare providers in India and thus bear most of the risk of non-recovery, fraudulent claims, and collusion between clients and providers. Lack of standardization of guidelines and classification of procedures also acts as a deterrent to the growth of the health insurance industry. Absence of a transparent regulatory framework in the Indian insurance sector makes it difficult for Indian healthcare providers to negotiate with foreign insurance companies for insurance portability from the source countries of foreign patients seeking treatment in India.

As healthcare requires a close interface between the doctor and the patient, perceptions play an important role. Concerns regarding India's ability to provide quality healthcare, hygienic conditions, and standards of healthcare are a constraining factor, particularly with regard to patients from developed countries. The latter is not specific to India as concerns about the quality of care received abroad relative to that offered in the home country affects developing country medical tourism destinations more generally. While leading corporate hospitals in India have obtained international accreditation to overcome such perception barriers, the general view of India as a country characterized by poor hygienic conditions and poor infrastructure continues. There are also concerns about lack of follow-up care, possible complications post-surgery which may require treatment back in the home country, and lack of information flow between doctors in the two countries. Again, these are not specific to India and are inherent to most instances of medical value tourism.

Foreign patients and private insurance companies are also concerned about issues such as medical liability and legal settlement (dispute resolution, geographic jurisdiction, and compensation) given the limited malpractice laws in countries like India and Thailand. Absence of mutual recognition agreements between India and key source countries for medical tourists, the still small number of internationally accredited healthcare establishments, and lack of standardized medical and nursing training in the country contribute to this perception barrier and also adversely affect the prospects for insurance portability.

Discussions with leading corporate hospitals also indicate that the rapidly growing domestic healthcare market and the increasingly affluent domestic population within India tend to limit the private sector's focus on medical tourism.[11] Expanding hospital chains and setting up

integrated health cities within India may be a more attractive proposition than catering to medical tourists and undertaking costly initiatives to promote health tourism.

This lack of pro-active and targeted marketing also characterizes the Indian government's approach to medical tourism, particularly in comparison with other competing destinations such as Thailand. Apart from medical tourism being seen as an extension to general tourism campaigns where major hospitals have been linked with tourism, there are no targeted efforts to promote medical tourism or efforts to provide the support infrastructure and facilities in an integrated manner. Even within South Asia, where there are considerable medical tourism opportunities, policies have been lacking. Delays in getting visas and absence of processes for granting expedited medical visas, delays in obtaining approvals for getting overseas treatment, poor airline connectivity, inadequate and poor local support infrastructure constrain the scope for medical tourism within the region (Chanda, 2011a). There are also financing issues, including the lack of insurance portability and absence of regional insurance products, which result in the use of informal channels for payment and constrain medical tourism exports to the region.

POTENTIAL BENEFITS AND CHALLENGES

The debate in India regarding the potential positive and negative fallout of medical tourism echoes the equity-efficiency concerns that have characterized the wider debate on trade in health services (Smith et al, 2009; Chanda, 2002). Proponents of India's medical tourism exports cite resulting benefits in the form of increased foreign exchange earnings, enhanced resources for investment in the sector, increased job creation, and improved standards and accountability in private sector hospitals with spill-over benefits to the wider Indian healthcare system. Proponents also point to the potential for leveraging medical tourism to attract health workers back to India given the growth in job opportunities and more competitive salaries in private hospitals that would result from medical tourism, with additional beneficial effects on quality and perceptions regarding the sector.

On the other hand, numerous concerns have also been voiced about India's engagement in medical tourism exports. Many of these concerns are not specific to India and have been highlighted in earlier studies on health services trade. For instance, there are concerns about the possible creation or worsening of an already existing two-tiered health system where foreign medical patients would have access to state-of-the-art private hospitals while domestic patients are squeezed out from quality care. Should a country that is unable to meet the healthcare needs of its local population devote resources to the treatment of foreign patients? There are concerns about possible internal brain drain, with healthcare professionals leaving the public sector to work in private corporate hospitals where wages and working conditions would improve on account of medical tourism but leave the public system weaker in terms of quality and availability of manpower. It is also feared that medical tourism could divert resources towards investment in urban tertiary care and specialized facilities that cater to foreign patients to the neglect of the needs of the local population. The possible upward pressure on the cost of treatment and medical procedures has also been noted, though there is no hard evidence to suggest that this has indeed happened or any evidence of discriminatory pricing behaviour of healthcare providers who cater to medical tourists.

While the above concerns are part of the general debate on commercialization of health services, there are also issues specific to India given the country's prevailing regulatory environment in this sector. For instance, there are ethical concerns surrounding transplant tourism and possible exploitation of local donors in the absence of regulatory mechanisms to check ethical violations. There is also a wider concern that commercialization of health services through medical tourism and other forms could indirectly encourage more unregulated growth of private healthcare providers and also lead to more pressure from this segment for subsidies and other fiscal incentives in the context a lack of a strong regulatory framework to enforce standards and monitor the operations of private healthcare providers.

These concerns are to some extent valid in the Indian context, given the stark inequities in healthcare delivery between the urban and rural population, between the rich and the poor, and between the public and the private segments in terms of availability of physical, human, and financial resources and the quality of these. Medical tourism could aggravate these existing

inequities and imbalances. For example, fiscal incentives offered to private players in the form of subsidized land or reductions in import duties on medical equipment could further encourage the creation of subsidized specialty hospitals which cater to foreign and affluent domestic patients, aggravating the rich-poor divide in this sector. With an estimated shortage of 600,000 doctors and one million nurses, particularly in the public health segment, medical tourism could worsen the resource gap between private and public healthcare by widening existing disparities in wages, facilities, and working conditions (Planning Commission, 2008, p. 111-112).[12] Hence, the potential benefits in the form of resource inflows and upgrading of standards need to be weighed against such negative fallouts, although, as mentioned, it is difficult to ascertain this cost-benefit balance without actual evidence.

POLICY DIRECTIONS

The Indian medical tourism industry has been growing in recent years and has potential for further growth given its comparative cost advantage, competent medical workforce, mix of traditional and alternative systems of medicine, and world class private sector healthcare providers. In light of the shortage of medical manpower and rising healthcare costs plaguing many countries, India's medical tourism prospects are promising. However, there are associated challenges and concerns, particularly given various structural and regulatory shortcomings in India's healthcare sector. The objective therefore has to be to facilitate the growth of medical tourism but with a view to helping the overall healthcare sector and ensuring that the negative consequences are minimized and conditions contributing to these adverse effects are addressed.

The starting point for any policy measures concerning medical tourism is to recognize that the debate surrounding medical tourism needs to be more nuanced than it is been so far and that the root cause of many of the aforementioned challenges lies elsewhere. The Indian healthcare sector is already plagued by a two-tiered system and many imbalances. These problems are not due to medical tourism but are a result of domestic factors such as insufficient funding of public healthcare, inefficiencies in public healthcare establishments, poor

human resource management systems, issues of access and affordability more generally, and inadequacies in the regulatory framework, among others. Therefore, the challenges posed by medical tourism have to be tackled through domestic regulatory and systemic measures, which can reduce these existing imbalances and also enable leveraging of the positives that medical tourism can bring, for the benefit of the wider healthcare system.

Three broad directions for policy action are required. The first involves addressing the structural issues in the healthcare sector. The second pertains to undertaking specific measures to facilitate medical tourism. The third involves looking at ways to derive benefits from medical tourism for the overall healthcare system, with an integrated health sector perspective. A few measures are proposed in the context of each of these areas.

STRUCTURAL ISSUES

Perhaps the most important issue to address in this regard is that of standards and accreditation. The JCI has accredited a number of hospitals in India but all of these are in the private sector. The decline in public sector standards has resulted in declining utilization of government resources in both rural and urban areas. If this gap is to be addressed, then concrete steps have to be taken to improve the standards of public healthcare establishments, improve infrastructure, and to establish a national accreditation body with international recognition in order to ensure a standardized healthcare system. (The latter has been done recently with the introduction of the National Accreditation Board for Hospitals (NABH) and efforts to promote adoption of NABH standards by domestic hospitals.) Improvements in the regulatory framework for both public and private healthcare establishments would ensure greater transparency and accountability. Such efforts would also help India project a positive image to foreign patients as quality of care is among the main concerns for medical tourists.

Facilitating Medical Value Travel

Specific steps can be taken to promote medical tourism. For instance, the government and the private healthcare providers could negotiate to remove the flight time restrictions on reimbursement of overseas treatment, as in the case of the NHS. (Efforts in this regard have

proved futile to date, however.) Discussions could also be undertaken with national health insurance trusts to highlight benefits such as reduced costs and waiting time that would accrue to the latter from recognizing and reimbursing treatments received in India. A pilot approach could be taken, such as by selecting certain Indian healthcare establishments for reimbursement, for selected procedures such as cardiac surgeries, joint replacement, or cosmetic surgeries where overseas treatment can be justified easily on grounds of costs or waiting time. Selection could be on the basis of international accreditation coupled with additional audits by the authorities of the concerned governments or insurance companies and third party administrators. There could be an understanding on costs, procedures, and payment arrangements.

There is also scope to negotiate insurance portability with private insurance companies with premiums or co-payments being linked to the place of treatment to account for additional risks along with caps on the maximum reimbursable amount. Trade and industry delegations could negotiate with and incentivize these insurance companies to accept establishments that have international accreditation, coupled with additional audits of facilities (an approach which has worked for Bumrungrad Hospital in Thailand). Thus, sensitization to and promotion of India's potential as a medical tourism destination is required, with information dissemination on India's medical system, procedures, establishments, and advantages, in order to gain visibility.

In the regional context, possible steps to promote medical tourism would include the introduction of a regional insurance product and cross-border payment arrangements through bank-to-bank guarantees in the region. Pilot schemes could be introduced for specialized elective treatments and procedures, which may not be available in the home country of the patient. Some potential segments would be transplant surgery, infertility medicine, joint replacements, and treatments for cardiac, eye, dental, urological, and gastrointestinal problems. The experience of other regional blocs such as in Mercosur, which have entered into regional payment arrangements to promote medical tourism, could be instructive in this regard. In addition, other issues such as visas, transport, supporting logistics in the destination country, and follow-up services would also need to be discussed to promote medical tourism in the region. There is for instance, a need to streamline medical tourism related visas. Follow-up

facilities through bilateral agreements between establishments in the host and home countries and telemedicine could also be explored.

Ensuring Synergies

It is also important to put in place policies that take into account the possible synergies between medical tourism and the rest of the healthcare system. For instance, benefits in the form of improved standards and technologies, increased efficiency, or return migration of health professionals, which are likely to accrue to the private sector could potentially be leveraged for the benefit of the public sector. This can be done through tie-ups and public-private partnerships between public and private healthcare providers in terms of management of healthcare facilities, pooling and exchange of skills and technologies, more inclusive forms of healthcare delivery in the private sector, and requirements such as cross-subsidization of poor patients in corporate sector hospitals against any fiscal concessions and incentives they receive for medical tourism or more generally. Thus measures are required which take an integrated view of the health sector and which link the medical tourism segment and its ensuing benefits to the rest of the healthcare system.

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[1] Most of the patients going to Singapore and Malaysia are from within ASEAN, those going to Jordan are mainly from neighbouring countries in the Middle East and North Africa, and those going to Cuba are mainly from the Caribbean and Central America.

[2] Medical value travel or medical tourism exports is how revenues earned by international patients seeking care in India are described in economic terms.

[3] The minimalist WHO guidelines specify a requirement of 2.28 doctors, nurses, and midwives per thousand population. (See, Milbank Memorial Fund (2011): 1)

[4] Euromonitor publishes reports on industries, consumers and demographics in India and many other countries.

[5] Discussions were carried out by the author with management and practitioners of leading corporate hospitals in India during 2008 and 2009 in the course of her research on prospects for regional integration in services in South Asia.

[6] This business model of expanding facilities to other countries, which in turn may also enhance medical travel to destination country facilities, is also being pursued by South African private hospital and health insurance companies (see the chapter by Crush et al, this volume).

[7] Hospitals have emerged with the inclusion of hotels within hospital facilities, where patients are provided holistic services.

[8] Discussions carried out by the author with health ministry officials in the course of conducting a research study. (See, Chanda 2011b).

[9] Although as other chapters in this book have argued, long wait times in such countries, or non-availability of a desired intervention, still plays an important role in people seeking OOCC.
[10] That this is the case is not surprising either, given recent European court rulings granting patients (with some restrictions) the right to seek reimbursed medical care in any EU member state.
[11] Discussions were held by the author with health industry practitioners and management in 2008 and 2009 in the course of her research work on prospects for regional integration in South Asia. (See Chanda 2011a)
[12] These estimates are based on the benchmark ratios of 1:1000 for doctors, 1:500 for nurses.

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5 Exploring Medical Tourism in Latin America: Two Case Examples

Mariella Ferreyra Galliani

INTRODUCTION

Working as a physician a few years back in Lima, Peru, I had my own perceptions of a 'medical tourist;' an affluent patient or patient with special health insurance plans who opted to travel abroad for a particular procedure due to state-of- the-art equipment or for cutting-edge technology not yet available in Peru. Others were in search of physicians highly trained in a certain subspecialty only found abroad. As a result, I was left believing that our healthcare professionals and services were not up to par. Besides, the only tourists hospitalized in the large private healthcare facility where I worked were those unfortunate travellers who fell ill or suffered an accident during their trip.

Five years later, the picture looks quite different. Several private hospitals around the whole country have embraced the 'hotel-spa' approach. Boasting large LCD TV screens in many of their suites, as well as high speed internet, en-suite office work stations, manicure services, and chef-inspired meal options, successfully contradicting the long established hospital-food stereotype, patients are now meant to feel that they are anywhere but in a hospital. These luxurious surroundings are coupled with outstanding medical care and access to modern medical infrastructure, for a fraction of the cost of a similar service in medical tourists' home countries. Many of the staff physicians have completed training abroad, acquiring highly specialized skills, once again broadening the scope of health services offered in these private hospitals.

During these same five years, overall tourism in Peru has grown by 46 percent (MINCETUR, 2011) and, not surprisingly, so has medical tourism. Not only are independent private clinics tailoring their websites and services to include international patients' needs, but the Peruvian government has also created the Disfruta Salud Perú® (Enjoy Health) initiative offering services in the areas of plastic surgery, dentistry, ophthalmology, and fertility.[1]

Peru is not alone in this growing trend among Latin American countries, but it is far from being the leader in this field. According to the World Travel & Tourism Council, Latin America's direct contribution of travel and tourism to GDP was US$133.8 billion in 2011 (3.2 percent of regional GDP) and is expected to increase to 4.7 percent of GDP by 2021 (World Travel & Tourism Council, 2012). In addition, visitor exports, also known as foreign visitor spending, generated US$35.6 billion in 2011, and is expected to reach US$70.8 billion by 2021, which would place Latin America in first for visitor exports among 12 other regions (World Travel & Tourism Council, 2012). In addition to steadily increasing tourism, factors such as geography, language, politics and healthcare systems are also playing a key role in the development and competitive marketing of medical tourism in Latin American countries. While most agencies do not specify the reason for picking a certain destination, cultural aspects may also be a contributing factor. There are reports of people residing abroad who consider returning to their home countries in search of physicians who speak their language, or with whom they have a more comfortable physician-patient relationship (Bolis, 2001). This is particularly important in the Canadian context where there are currently over a quarter of a million Canadians with Latin American origins, with the Latin American community being one of the fastest growing cultural groups in Canada (Lindsay, 2001). Patients in search of more culturally competent services may choose to return to their countries where they feel comfortable navigating the healthcare system or to seek care from providers whom they are already familiar with and trust.

Despite the recent growth of this industry in the region, several Latin American countries still struggle with the challenge of convincing potential medical tourists that the quality of medical care they receive will be similar to the standard of care available at home (Connell, 2006). Specifically targeting these concerns, hospitals in this region are increasingly seeking formal accreditation. JCI, a US-based organization, which provides accreditation and certification services to healthcare organizations worldwide, regulates hospital standards while maintaining the "highest international benchmarks for accreditation entities" (JCI, n.d.a). The JCI, which has been accrediting hospitals for over ten years, also forms part of a joint partnership with the World Health Organization (WHO) in the first World Health

Organization Collaborating Centre on Patient Safety Solutions (JCI, n.d.b). To date, the JCI has accredited 44 healthcare organizations in Brazil, Chile, Colombia, Costa Rica, Ecuador, Mexico and Nicaragua. By receiving the JCI accreditation, many countries can now provide certain reassurance that patient outcomes, safety, and quality of care will meet international standards. Despite the purported benefits of JCI accreditation, some argue that attempting to meet American standards may override local values and established ways of providing healthcare (Jenner, 2008; Johnston, Crooks, Snyder, & Kingsbury, 2010).

Regardless of the reasons medical tourists may have for deciding to seek care in a Latin American country, most of these countries are considered developing nations and as such, questions arise regarding the effect of the industry on exacerbating health inequities. With a few exceptions, the majority of Latin American countries have two-tiered healthcare systems. This is of particular concern where public and private healthcare organizations rely on the same resources such as equipment and personnel. With this in mind, what follows are two country case examples (Mexico and Cuba) selected because they represent fundamentally different models of medical tourism, as well as differing in terms of geography, culture and politics. An overview of each country will be provided, along with a discussion of the medical services offered, and the effects medical tourism appears to be having on the overall healthcare system of each country.

MEXICO'S EXPERIENCE

Mexico, covering almost two million square kilometres with an estimated population of over 113 million (World Factbook, 2011), is the third largest Latin American country in size, after Brazil and Argentina. It is a democratic republic consisting of 31 states and a Federal District. While Mexico's GDP is over US$1.5 trillion (World Factbook, 2011), income is distributed unequally contributing to inequities in access to services and opportunities (World Health Organization, 2011).

Mexico's Human Development Index (HDI) rose annually by 0.9 percent from 0.581 to 0.750 (1980-2010), obtaining a ranking of 56 out of 169 countries. Mexico's rate of

improvement was slightly greater than the average of the Latin American and Caribbean region, where HDI rose from 0.578 to 0.706 (1980-2010); yet it still falls below average when compared to North America, Europe, and certain regions in Asia (United Nations Development Programme (UNDP, 2010).

Mexico's total expenditure on health is 6.5 percent of its GDP (World Health Organization, 2011). Similar to most other Latin American countries, Mexico's healthcare system is not universal and quite complex involving three principal providers: 1) Social Security, which includes the Mexican Social Security Institute (IMSS) and the Social Security Institute for State Workers (ISSSTE); 2) The Secretariat of Health (SSA); and, 3) the private sector. By 2006, it was estimated that five million families would be covered (World Health Organization, 2011). A 2007 review in *The Lancet* argues that despite the institution of a popular health insurance (PHI) program in 2003, that the PHI will not solve Mexico's public healthcare problem, claiming that both families and states will have difficulty paying the insurance premiums, that there is insufficient infrastructure and staff to guarantee adequate healthcare delivery, and that private service contracting will interfere with service supply (Laurell, 2007). It is perhaps this last argument which most closely relates to medical tourism in Mexico as it is private healthcare organizations which are advertising their services to medical tourists. On the other hand, proponents of medical tourism claim that trade in health services could improve access to healthcare for all people in developing countries by properly allocating revenues earned through such trade, or by creating a specific tax for medical tourism with revenues hypothecated to the public health system. However, to date there is no evidence that either mechanism exists in Mexico (Laurell, 2007).

Focusing on tourism alone, Mexico is the second most common travel destination for Canadians, after the US (Statistics Canada, 2011). Specific information focusing on medical tourism, however, is still lacking. Because of proximity and rising domestic healthcare costs, the majority of international patients seeking care in Mexico are from the US. A survey conducted by the University of California in 2001 stated that every year over one million California residents travel to Mexico for medical services, dental services, and medications, though some of these numbers may overlap in cases where patients access more than one service. However,

the number may be an under-estimate given that the definition of medical tourist used in the survey (travel for a period of more than 24 hours yet less than one year primarily to receive medical treatment) would forcibly exclude medical tourists who cross the border for dental treatment or same-day surgical procedures (Ramirez, 2007). Likewise, the exact number of healthcare organizations providing services to international patients in Mexico is unclear.

Popular destinations, especially for California residents, include the border town of Tijuana and, to a lesser degree, Rosarito, both located in the state of Baja California, Mexico (Ramirez, 2007). Although Tijuana continues to recover from a plunge in tourism arising from the H1N1 flu travel warnings in 2009, the recession, and drug-related violence, some hospitals have managed to continue attracting patients and have increased the services they offer. One example is Hospital Angeles Tijuana, a US$60 million, 122-bed private hospital belonging to a larger network known as Hospital Angeles. This is the largest private network of hospitals in Mexico, with 22 locations all equipped with state-of-the-art technology, a total of 1,700 beds and over 11,000 specialists. This network also has the designated medical travel division, Angeles Health International, based in the US, claiming to "treat more North American medical tourism patients- Americans and Canadians traveling abroad for medical care- than any other hospital network in the world" (Angeles Health International, 2011a). Reporting over 6,000 American and Canadian patients treated over the past three years, this Network offers services in bariatric, spinal and orthopedic surgery, interventional cardiology, dental care and organ transplant, among others. According to the President of the College of General Practitioners, patients traveling to Tijuana may save from 30 to 50 percent on consults, laboratory testing and medication, and from 30 to 80 percent on surgical procedures (Sanchez, 2006). Weight loss surgical procedures in particular, have an important saving potential. The LAP-BAND® Adjustable Gastric Banding System for example, is a popular weight loss procedure which at the time of writing was not covered by provincial medical insurance in Canada, but offered through the private sector with a price range varying from CAN$16,000 to CAN$18,000 (Admin, 2008). In contrast, the Angeles Hospital offers a US$5000 LAP-BAND® Program which includes all surgeon and doctor fees, a two-night hospital stay, one-night hotel stay, standard pre-op lab testing, complimentary travel concierge services for the patient and their travel companion,

shuttle transportation to and from the airport, and a twelve-month follow-up program (Angeles Health International, 2011b).

Contributing to the growing Mexican medical tourism industry is the development of plans covering medical treatment abroad by some major US insurance companies. This gives certain groups of Americans the option of accessing healthcare in Mexico, typically with lower premiums and co-payments. Blue Shield of California, for example, has created the *Access Baja*® insurance plan, which is available to employees living or working in the municipalities of Tijuana or Mexicali, or in California within a 50-mile radius from the US-Mexico border (Blue Shield of California, n.d.a). While this plan is quite comprehensive, Blue Shield is keen to add the following caveat:

> Legal requirements and generally accepted practice standards of medical care in Mexico are different than those of California and elsewhere in the United States. Care received through the providers in Mexico in the Access Baja® plans will be consistent with generally accepted medical standards of Mexico, not California (Blue Shield of California, n.d.b).

This statement may not pose an impediment for the majority of potential clients who tend to be Mexican residents (or of Mexican nationality) and therefore familiar with the Mexican healthcare system, yet it may deter other North American citizens. Nevertheless, the potential savings and virtually non-existent wait times make this an irresistible option for many.

Although Tijuana is a popular destination, less than 20 miles from downtown San Diego, California, patients may be hesitant to trust a hospital without international accreditation. Currently, Mexico has nine healthcare organizations accredited by the JCI, (eight are large hospitals and one a clinic), located mainly in Mexico City and Monterrey. Three of these are of particular interest: CHRISTUS MUGUERZA® Alta Especialidad Hospital, The American British Cowdray (ABC) Medical Center, and CIMA Monterrey Hospital.

Hospital Alta Especialidad, a CHRISTUS Muguerza® Hospital, located in Monterrey, Nuevo Leon, Mexico was the first healthcare organization to receive JCI accreditation in 2007 and was recently re-accredited in 2010. This hospital is affiliated with Christus Health in Dallas, Texas, a Catholic non-profit health organization. The hospital's strength lies in their cardiovascular

service department, which they describe as "the leading cardiac care center in all of South America," (CHRISTUS® Muguerza, n.d.a) while highlighting that all of the physicians on their Medical TravelSM team are internationally trained (CHRISTUS® Muguerza, n.d.a). CHRISTUS Muguerza® Hospital has also obtained flattering reviews from media such as Men's Health magazine,[2] Newsweek,[3] and the Los Angeles Times.[4] Maintaining a firm commitment to the local community, the CHRISTUS® Muguerza group operates five social assistance clinics in five communities improving access to high quality care, through their Adelaida Lafón Foundation (Sisters of Charity of the Incarnate World, 2007). These clinics provide services in primary and emergency care, nutrition and education programs, mental and dental health, physical rehabilitation and speech therapy, among others. They also organize medical and surgical brigades, which include services in surgery, paediatrics, gynaecology and ophthalmology. In 2005, a comprehensive telemedicine program was developed to provide remote populations with immediate access to specialized care (Sisters of Charity of the Incarnate World, 2007). This is an example of how private, for-profit institutions can facilitate access to healthcare for disadvantaged and vulnerable populations using revenues generated by private healthcare and medical tourism. However, despite the interesting model of care that the Foundation presents, we were unable to find additional information about the numbers of patients treated, if any costs are attached to the services and payable by patients, and if there are any advantages that accrue to the philanthropic status of the foundation.

The ABC Medical Center, whose aim is to be recognized as the leading health system in Mexico and Latin America, is a not for-profit organization with two JCI-accredited campuses, one in Mexico City, and one in Santa Fe, New Mexico (MHL USA, n.d.). In addition, the Center is affiliated with Methodist International, the international division of the Methodist Hospital in Houston, Texas. Emphasizing their intention to participate at multiple levels, they state on their website:

> *Through its affiliation with Methodist International, ABC Medical Center will be integrated into a global network of hospitals-the first in Latin America. This network will become model and benchmark for hospitals at the local, national and international level (*Centro Médico ABC, 2009).

Through a user-friendly website, available in both Spanish and English,[5] the ABC Medical Center readily conveys a strong sense of security, professionalism and trust. Contrary to many medical tourism websites, the centre does not provide a single quote or price comparison for their services offered. Potential patients are asked to contact the centre directly to speak with a representative. While to some this may initially appear to be a barrier, it is common practice particularly among the larger hospitals and does not seem to create a disadvantage. Similar to CHRISTUS® Muguerza, the ABC Medical Center has two private clinics exclusively devoted to providing private medical assistance to nearby underserved communities whose population lacks insurance through social security. Both of these clinics combined, provide approximately 27,000 medical consults per year, as well as assistance during natural disasters.

Finally, the CIMA Monterrey Hospital is owned by the US-based, private, for-profit International Hospital Corporation (IHC) and is affiliated with the Mayo Clinic, the University of Texas Southwestern Medical Program, and the Children's Hospital Boston. The IHC is a Texan company and owns several healthcare facilities throughout Latin America, including in three other Mexican cities, and in Costa Rica and Brazil. International patients are drawn to this hospital not only because of its international affiliations but also, as with the CHRISTUS® MUGUERZA hospitals, because it is located in Monterrey, Mexico's wealthiest city. Unlike the previous two examples (both of which are non-profit organizations), there is no indication that this hospital has any social commitment with the local community. In November 2011, the parent US company (renamed DTF Corporation) filed for bankruptcy reorganization under Chapter 11 with reported liabilities exceeding assets. Some of these liabilities include a lawsuit filed by the family of its deceased former CEO (Hethcock, 2011).

The number of accredited hospitals and services directed towards medical tourists has grown over the past years and is projected to continue increasing rapidly. In August 2011, during the first Forum for Medical Tourism, held in Monterrey, Mexico, both the Minister of Health and the Minister of Tourism affirmed that Mexico possesses the necessary conditions to be a leader in this field. The Minister of Tourism further announced that tourism has a central role in the national agenda, as it represents nine percent of Mexico's GDP and generates 7.5

million jobs (SECTUR Secretaria de Turismo, 2011). Targeting specifically North American citizens, the Minister of Health recognized that

> …despite geographic proximity to the US and Canada, a large proportion of these citizens travel all the way to Asia for health services, while [in Mexico], these issues could be resolved perfectly or even better (Garcia, Mendoza, 2011).

A new national agreement will begin by promoting the certification of hospitals particularly along the US-Mexico border (SECTUR Secretaria de Turismo, 2011).

CUBA

Cuba is an archipelago located in the Caribbean Sea with a total land area of 110,860 km^2. It is made up of 14 provinces, divided into 169 municipalities and has a separate Special Municipality known as the Isla de la Juventud (World Health Organization, 2009). With a population of 11,241,161, approximately 75 percent of Cubans live in urban areas (Oficina Nacional de Estadisticas - Republica de Cuba, 2010). In terms of health indicators, Cuba's public expenditure on health is 9.9 percent of GDP and its total expenditure on health is 11.8 percent of GDP (World Health Organization, 2009). Cuba's HDI only became available in 2010, reporting a value of 0.760[6], and ranking 53rd among all other countries. Although there are no values from prior years, it ranks above the rest of Latin America and the Caribbean, notably three spots above Mexico.

As a socialist, collectivist state, Cuban social policy expects the State to be accountable for the health of its citizens. As such, all policies are geared towards promoting and maintaining human development in all areas, such as health, education, culture, safety, employment, and social welfare (World Health Organization, 2009). Indeed, over 60 percent of Cuba's budgetary expenditures have been destined to assist in the areas of health, education, safety, and social welfare throughout the period of 2000-2005, after recovering from the economic downturn in the early 90's (Pan American Health Organization, 2007).

Like many other Latin American countries, Mexico included, Cuba is experiencing an epidemiological transition where chronic diseases are becoming more prevalent as

communicable diseases gradually decline. In 2009 infectious diseases account for only 0.1 percent of deaths as opposed to non-communicable diseases accounting for 90 percent of deaths (World Health Organization, 2009). This has been accompanied by a demographic transition, resulting from a rapidly aging population and low fertility rates. Cuba now shares the common challenge of providing complex healthcare delivery services to a rapidly changing population.

Cuba is well recognized for placing health as a priority, assuring equitable healthcare delivery through universal coverage and access. Recent changes have included the creation of programs geared towards bringing highly specialized services to the primary level of care, which had previously only been offered at the secondary and tertiary levels. This has required careful allocation and investment of resources, along with proper personnel training. Relying heavily on the delivery of primary care, the National Health System has 70,594 physicians, of which 33,769 are family physicians providing care to 99.4 percent of the entire population (Pan American Health Organization, 2007). In addition, Cuba is also recognized for the provision of medical personnel abroad. According to some reports, in March 2006, there were 25,000 Cuban medical professionals working in 68 nations, "representing more than the World Health Organization can deploy" (Calvo Hospina, 2006). Cuban medical staff has been deployed to provide aid during several recent catastrophic events such as the 2005 earthquake in Kashmir and the 2010 earthquake in Haiti, as well as assisting Venezuela in providing primary care in rural and poorer urban areas. This has enabled Cuba to use healthcare as a diplomatic tool, allowing it to strengthen political ties with many other nations (Ramirez de Arellano, 2011).[7]

Despite the historic political tensions between the US and Cuba, and the longstanding US trade embargo, Cuba manages to attract a large number of tourists. Each year, nearly two and a half million people travel to Cuba, and of these, almost a million are from Canada, the leading visiting country. Following in frequency but to a much lesser degree are England, Spain, Italy, Germany, France and Mexico (Oficina Nacional de Estadisticas- Republica de Cuba, 2010). Approximately 52,000 US citizens visit Cuba every year as well, but usually do so by traveling through Toronto, Montreal or Mexico.

As previously discussed, information is lacking regarding the exact number of people traveling to Latin America for health tourism, and this holds true for Cuba as well. One report indicates that between 1995 and1996, over 25,000 international patients sought medical services in Cuba, generating approximately US$25 million in revenues (Chanda, 2001). Other, more recent, reports state that Cuban medical tourism generates an estimated US$40 million per year (Fawthrop, 2003).

As several Latin American and Caribbean countries have come to realize, competitiveness in this field is better achieved by specializing in certain services that others cannot (or will not) offer. While some countries focus on weight loss surgeries, such as Mexico, or plastic surgery in Brazil, Cuba has found its niche as well. One of the most solicited medical services in Cuba is treatment for retinitis pigmentosa, an eye disease causing difficulty seeing at night and in many cases, leading to permanent blindness. For many years, Cuban physicians have been conducting research in this field. In the world of ophthalmology, the 'Cuban Treatment' for this condition is well known yet highly controversial, with many North American physicians remaining skeptical about the results of this procedure, and refraining from practicing it or suggesting it as treatment for their patients. Developed by Cuban physician, Dr. Orfilio Pelaz Molina, data for this procedure suggests 75 percent of patients remain stable post surgery, meaning the progression of the disease is halted, 16 percent show improvement, and 9 percent continue with the natural progression of the disease (Garcia Layana, 2003). Although long-term results properly documented in peer-reviewed journals have yet to back this claim, many patients faced with the possibility of permanently losing their sight are willing to take the risk of surgery, especially in the absence of alternative treatment (Garcia Layana, 2003). Sample 'packages' for this procedure tend to go as follows: 1) Basic Retinitis Package which includes an evaluation only, for US$1,441; 2) Standard Retinitis Package offering both evaluation and surgery for a total of US$7,070; and, 3) Premium Retinitis Package which includes evaluation, surgery, follow-ups and transfers totalling US$10,140 (Cuba for Health®, September 2011).

Other areas of specialization in Cuba include the treatment of several dermatologic diseases such as vitiligo and psoriasis, treatment for neurologic conditions, and drug rehabilitation programs. While there are individual hospitals and clinics offering these medical

services, the most recognized hotel operator group in Cuba, Cubanacan S.A., does this through its subsidiary tourism and health company operating under the trademark of Servimed. Most of the medical tourism agencies have chosen to deal directly with Cubanacan, such as the Canadian agency, Go Cuba[8], based in Toronto, Ontario. Other Canadian agencies, such as Choice® Medical Services[9] based in Winnipeg, Manitoba, do not specify the exact medical organizations tourists will be dealing with in Cuba, but do provide a clear breakdown of what is included in the medical package. In addition, patients are assigned a 'Personal Patient Consultant' (PPC) who assesses the client's medical situation and gathers documentation, acts as a liaison with the medical team in Cuba, and makes all necessary travel arrangements and payments. Upon arrival, patients are greeted by a secondary PPC in Cuba to assure a smooth transition and quality of service delivery (Choice® Medical Services, 2007a). According to Choice® Medical Services, medical tourists are expected to save anywhere from 20 to 80 percent when accessing medical services in Cuba (Choice® Medical Services, 2007b). Perhaps due to their high quality medical care and outstanding health indicators, Cuba has managed to place itself as a growing leader in this field, even without international accreditation of its hospitals by the JCI or others.

When considering the impact of medical tourism on the Cuban health system and health equity, it might be assumed that because of its social responsibility to its citizens, revenues from medical tourism are reinvested in public healthcare. Certain medical tourism agencies address this issue directly on their websites. The agency Cuba for Health® for example, clearly expresses:

> The Cuban Health Care system is organized in such a way that the funds obtained through foreign health tourism helps to cover the costs of the services that are offered to the nationals. In this way the health care for the Cuban nationals is entirely for free. Reserving the treatments with our agency not only gives you access to the best medical care but also you are guaranteeing the health care of others (Cuba for Health®, 2008 August).

As with the case of Mexico, it is difficult to ascertain the veracity of these statements. In fact, in 1994 Dr. Hilda Molina, an internationally renowned Cuban neurosurgeon and founder of

the country's Centre for Neurological Restoration, stepped down from her position after hearing the government's plan of turning the Centre into a foreigner-exclusive institution (de Albornoz, 2006). She has been quoted as saying:

> I am not a politician. I am a doctor. Cubans should be treated the same as foreigners. Cubans have less [sic] rights in their own country than foreigners who visit here (Vincent, 2004).

Her concerns have been shared by others, and have made it to the Canadian press (Vincent, 2004). Other Cuban analysts suggest that the problems the country is now encountering are a result of the many 'tourist-only' hospitals, which have reoriented the public health system (Vincent, 2004).

CONCLUSION

While most Latin American countries have been receiving medical travellers for many years, medical tourism has only recently been gaining momentum and, for some countries, is being seen as a key platform for economic development. The impact that this growing industry is having on Latin American countries varies, and depends greatly on socio-political and cultural factors. Countries that have long relied on tourism for economic growth, such as Mexico and Cuba, are now actively investing in the medical tourism sector to encourage exports as a source of foreign investment.

Certain aspects of medical tourism have been identified as potential solutions for health systems problems. Improvement of existing medical infrastructure, for example, is one of them. Keeping in mind that international accreditation bodies require health institutions to maintain a certain standard, many hospitals have invested in improving and maintaining their hospital's infrastructure. This can lead to positive benefits for the local population in countries where foreign patients and local patients make use of the same hospitals. The same does not hold true, however, for countries with designated 'foreign-only' hospitals, or for services offered at a cost that the local population can rarely afford. In addition, this may lead to the improvement of only the hospitals that care for foreign patients. Acknowledging that this may lead to important

health inequities, certain hospitals, such as CHRISTUS® Muguerza or the ABC Medical Center in Mexico, have developed several programs specifically targeting underserved populations with no access to social insurance benefits. In the case of Cuba, where access to healthcare is universal and is the responsibility of the government, revenues generated through medical tourism are reinvested in the public health system, yet the exact percentage is unclear or unknown.

As waiting times and insurance non-coverage of 'medically unnecessary procedures' remain pressing issues in the Canadian healthcare system, and as US healthcare costs continue to rise, North American patients may increasingly turn to cross-border care to address their needs. Latin American countries have recognized this market opportunity and are actively courting medical tourists. The Latin American region has historically struggled and experienced challenges around healthcare system reforms. As such, it is important to consider the implications that medical tourism is having on current healthcare delivery of the local population. While it is clear this industry presents an important economic opportunity, countries should proceed with caution to ensure that the health of their nation is not compromised in the process.

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[1] This is an initiative of the Commission for the Promotion of Peru Export and Tourism (promperu). It is through the program for Promotion of Export of Services. For more information see http://www.peruhealth.org/Main.asp?T=20120. This initiative is designed to identify the best Peruvian clinics through an extensive evaluation, and provide a complete portfolio for medical tourists. For more information see http://www.peruhealth.org/Main.asp?T=20281.

[2] See, for example, the October 2008 Issue of Men's Health Magazine, pp. 150-57.

[3] See, for example, the 2008 article of The Daily Beast, "Ultimate Outsourcing," found at http://www.thedailybeast.com/newsweek/2008/11/18/ultimate-outsourcing.html.

[4] See, for example, the 2008 article of The Los Angeles Times, "Ticket to treatment," found at http://articles.latimes.com/2008/nov/02/business/fi-cover2.

[5] See English version of website at http://www.abchospital.com/en/home.

[6] The 2010 HDI value and ranking reflect the inclusion of one or more HDI indicators that were not available at the time of the preparation of the 2010 Human Development Report.

[7] A similar use of cross-border public health care as a form of 'health diplomacy' has been used by South Africa (see the chapter by Crush, Chikanda and Maswikwa, this volume); and it is

interesting that South Africa also employs a large number of Cuban-trained physicians to help meet human resource shortfalls, particularly in its rural areas.

[8] For more information on *Go Cuba*, see http://www.gocuba.ca/client/home/index.php.

[9] For more information on Choice® Medical Services, see http://www.choicemedicalservices.com/index.html.

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6 Exceptional Aspects of the Experiences of Canadian Medical Tourists from Patient Narratives

Rory Johnston, Valorie A. Crooks and Jeremy Snyder

INTRODUCTION

For the past several years we have been researching Canadians' involvement in medical tourism, defining medical tourism as the practice of intentionally traveling outside of one's country to access privately paid for and arranged care (Bookman & Bookman, 2007). Our work to date has involved conducting interviews and focus groups with several key stakeholders, including Canadian medical tourists, medical tourism facilitators, family doctors, and patient health and safety officials. While Canadians have typically been thought to participate in medical tourism out of frustration with wait times for care within Canada (Snyder, Crooks, Johnston & Kingsbury, 2011), our research has confirmed that access to treatments not performed in Canada and cost-savings for elective treatments not covered by public Medicare are also powerful motivators. Our studies have also shown that, while Canadians do rely on the Internet to research and arrange for care abroad, the idea of medical tourism is often sparked by conversations with other Canadians who previously went abroad. This word-of-mouth knowledge is also a powerful source of the confidence they have for the skills of particular surgeons abroad.

We have looked to the scholarly and popular literature to assist us in interpreting the findings of our focus groups and interviews and in doing so have found that certain types of 'patient narratives' dominate. These narratives often emphasize patient empowerment and choice, access to improved quality and/or affordability of care, and the novelty of travelling to exotic foreign locales as common features or trends among the patient experience (e.g. Choat, 2003; Ehrbeck, Guevara, Mango, Cordina & Singhal, 2008; Law, 2008; Prashad, 2008). While our research has, for the most part, confirmed the relevance and centrality of these common features to Canadian medical tourists' experiences, we have also learned about experiences that are very unique and fall completely outside the scope of current knowledge. In this chapter

we present five vignettes that bring forth uncommon or exceptional aspects of particular Canadian medical tourists' experiences, wherein they deviate in unexpected and important ways from the commonly-reported features of medical tourists' experiences. Recognizing the value of giving voice to experiences that do not fit with the typical trajectory, these exceptions highlight a range of issues that raise questions and offer caveats to the many generalizations and conspicuous absences that are found in current popular and academic discussions of how a medical tour unfolds.

The five vignettes we share below are drawn from semi-structured phone interviews with a larger sample of 32 Canadians who underwent surgical care abroad.[1] These 90 minute, digitally recorded interviews explored participants' decision-making processes regarding access to care abroad and their experiences in both the Canadian and non-Canadian health systems. All medical care was obtained outside of Canada and had been privately purchased and arranged, and interviewees were 18 years or older at the time they spoke with us. Following data collection, all interviews were transcribed verbatim and coded thematically using a scheme that included both inductive and deductive codes and that was created through an iterative process of transcript review and team discussion and feedback. The vignettes shared in this chapter were initially noted by the interviewer and data coder, who is the lead author, as being exceptional in deviating from the more standard narratives. This interpretation was confirmed by the other team members.

While the experiences recounted amongst our 32 participants varied widely, most of their narratives had similar decision-making trajectories, comparable outcomes, lasting impressions and common decision making supports such as doctors abroad and other medical tourists. The majority were spurred to consider going abroad for medical care in the face of needing treatment that was not available to them locally or being assigned to a wait list. Only two participants were compelled to go abroad solely by cost. All participants but one researched and arranged their care abroad prior to departure, and all but one were seeking elective care that was typically viewed as needed but not immediately urgent. Research by patients was primarily mediated by the websites of destination hospitals and forums of former patients. Most participants did not use medical tourism facilitators (i.e., agents who make

bookings for international patients) to arrange for their care abroad. Of those that did, only one had a negative experience. By and large, the participants perceived their journeys to be driven by medical necessity, and only included tourist activities as an afterthought or minor add-on, if at all. A slim majority of participants were accompanied by a partner, family-member, or friend as a caregiver-companion. These companions were seen as indispensable supports by those they were accompanying, and often played the role of the tourist while their partner was recovering. Finally, all but one participant were very pleased with the quality of their procedures abroad, even amongst those that experienced complications.

In the following sections each vignette will be presented, followed by a discussion highlighting its significance. The vignettes included here describe the experiences in our dataset that sharply depart from the norm at some point in their recounting. In doing so, their exceptional elements help to illustrate points at which some standard narratives that surround medical tourism break down, revealing important lessons that may go undetected if not highlighted. While none of the vignettes are composites, the names and some non-essential details of participants have been altered to protect their anonymity. Following the vignettes, a short concluding discussion will be offered that draws together the implications of what we convey in the five unique cases for future medical tourism research.

JOLENE'S VIGNETTE

Jolene is a retiree in her late fifties. She is in poor health and managing a number of chronic illnesses, including diabetes, depression, and arthritis. Jolene was faced with a lengthy surgical wait list of over two years for an orthopaedic intervention in Canada that could help address her increasingly painful arthritis. Wracked with chronic pain so severe she lay awake many nights, and urged on by her husband, Chris, Jolene was eventually compelled to look into accessing surgery outside of Canada so that she could receive treatment sooner. She began looking at her options in spite of her own inclination to both save money and remain in solidarity with other Canadians by waiting to receive care within Canada.[2]

Chris' idea for Jolene to access care abroad originated with him seeing an advertisement for a medical tourism facilitation company that was posted in *Maclean's,* a popular Canadian news magazine. Jolene initially contacted the facilitator and made basic inquiries about where orthopaedic surgery was available and how much it would cost. She then waited to hear back if she was a candidate for surgery, after having shared with the facilitator the details of her health status. The facilitator got back to her within the week to let her know she was a candidate for surgery, and that they could arrange for the care either in India or Costa Rica. Fancying herself a bit of a traveler, she chose to go to Costa Rica because she believed it had greater tourism opportunities suited to her interests. She booked her surgery the following month, planning a three-week stay. At this point, the facilitator made a proposition to Jolene. If she were to help him promote his company's services and medical tourism on a broader scale by agreeing to be interviewed by Canadian media outlets, he would secure her and her husband an upgrade for the recovery portion of their trip by booking them a stay at a 5-star hotel, up from a 3-star, at no extra charge. However, this upgrade was contingent on Jolene agreeing to 'blame' the Canadian healthcare system for her decision to go elsewhere, insisting she must offer herself and her story up as a symptom of a failing system.

The facilitator's proposal posed a serious ethical conflict to Jolene. On the one hand, she already felt that she was forsaking the ethic of solidarity that underpins the Canadian healthcare system by privately seeking care abroad, and the idea of disingenuously pillorying the Canadian system for the facilitator's benefit was unappealing to her. On the other hand, she did feel mistreated by the lengthy wait list in her home province that negatively impacted her quality of life by prolonging her exposure to severe pain, and hoped to let others know of the option of care abroad. She ultimately agreed to use the facilitator's prefabricated rhetoric in the testimonial she provided for news reporters in interviews that were arranged by the facilitator.

Jolene found her experience of accessing surgery in Costa Rica to be excellent, and was especially pleased by the patient-centric care and the quality of services available at the hospital she visited. Regardless, Jolene and her husband found themselves exhausted and homesick by the end of two weeks in the hospital. They chose to forgo a third week recuperating in a resort as was initially planned, instead returning to Canada as soon as she left the hospital.

Interestingly, although Jolene provided her story to Canadian reporters before leaving, the deal offered by the facilitator to upgrade their accommodations was never mentioned again, let alone fulfilled. Neither Jolene nor her husband felt it was appropriate to confront the facilitator and push for the upgrade they were promised, especially given her reticence to provide the 'groomed' testimonial in the first place, so they quietly let the promise go unfulfilled.

Significance

Jolene was one of the few people we spoke to who used the services of a facilitator to access a non-experimental surgery abroad. Her story is unique because of the offer made to her by the facilitator, and the ethical dilemma she faced in deciding whether to take part in it. We have not shared Jolene's account to suggest widespread misconduct among medical tourism facilitators. Rather, we raise it to provide a potent illustration of how the lack of any professional regulatory body that enforces common standards or codes of conduct for those working in the industry (Penney, Snyder, Crooks & Johnston, 2011; Snyder et al., 2011) are implicated in allowing the unprofessional behaviour demonstrated by Jolene's facilitator.

TIM'S VIGNETTE

Tim is a middle-aged man employed full-time in a moderately physically-demanding job. He experienced a gradual and prolonged decline in his health over many years, a process that began in his mid-twenties. His energy levels fluctuated regularly in this period, culminating in a feeling of chronic exhaustion and low blood oxygen levels for a number of years. During this time, Tim had access to many rounds of diagnostic testing in his home province to try and locate the source of the problem, but the specialists assigned to his case could not come up with a diagnosis or an effective course of treatment.

While Tim was frustrated with the lack of progress in treating his symptoms, his partner Cynthia was even more so. She was aware of the option of care abroad from working in the health field and hearing about alternatives from her co-workers. Cynthia suggested getting a second opinion from a private hospital in the US, but Tim was comfortable leaving his case in

the hands of his regular doctors as he was still managing to meet the demands of work and home life. Tim's health nonetheless continued to slowly worsen.

Tim's condition continued to deteriorate and ultimately resulted in him waking at night breathless and struggling to walk around his house and workplace without becoming short of breath. Despite this, he did not aggressively pursue a diagnosis or treatment. Cynthia continued to suggest going abroad for care for almost two years, and Tim continued to refuse. His attitude shifted abruptly when he fainted while at work. With both Tim and Cynthia believing he was on the verge of reaching a point of irreparable damage or death, Cynthia immediately arranged for a trip to the US to hear a second opinion in hopes that Tim would finally be diagnosed and treated. Tim gladly went along with her plans. After the arrangements were made, the two departed within two days for what ended up being a three week stay at a widely known and regarded private hospital. The speed of their exit was aided by Tim's family physician, who supplied the files of his case history immediately upon request.

The care Tim received at the private hospital was prompt, and within two days the root cause of the problem that his specialists at home had been unable to locate for years was found and the course of treatment was determined. Tim underwent surgery to resolve a spot of slow, constant internal bleeding. He spent a little over a week recovering there, with Cynthia joining him. The CAN$20,000 cost of the surgery was considerable but the couple did not hesitate in selling a piece of property they owned to pay the medical bills, nor did they regret their decision to seek private care afterwards. Tim credits his 'life being saved' to the efforts of his partner, without whom he would not have thought about going abroad, made the arrangements, nor been able to bear the emotional distress.

Significance

Tim's story differed from the other medical tourists we interviewed because of the perceived immediate severity of his condition. While the rest of our participants were clearly seeking elective treatments, Tim and his partner Cynthia perceived his condition to be an emergency and had lost faith in their healthcare system's ability to diagnose the problem and deliver the necessary care. The speed at which they arranged and travelled for care in the US reflects this, as does Tim's lasting belief that he would have died had he remained within his

provincial system. We have chosen to highlight Tim's account to demonstrate the variety of motivations and conditions that compel people to seek care abroad. While medical tourism is often characterized in a nonchalant fashion by media headlines like "Sun, Sand and Surgery," those identified as medical tourists also include patients who see their care abroad not only as medically necessary, but sometimes also as an emergency.

EMMA'S VIGNETTE

Emma is a middle-aged woman who engages in part-time volunteer work. She has had MS for many years and leaped at the opportunity to access chronic cerebro-spinal venous insufficiency (CCSVI) treatment, or 'Liberation Therapy' as soon as she heard about its availability. As the treatment is experimental and currently unavailable in Canada, Emma and her husband, Matthew, looked at their options abroad through conducting their own research online. Matthew and Emma did not have means to pay for the $20,000 treatment, but were willing to mortgage their home to receive care they saw as integral to slowing the course of Emma's MS.

Neither Emma nor her husband had ever traveled outside of Canada or the US before, and quickly found the prospect of arranging for travel, visas, accommodation, and medical care overwhelming. The perceived complexity compelled them to seek assistance from a Canadian medical tourism facilitator. Once in touch with the facilitator, Emma and Matthew agreed to all the planning decisions the facilitator made for them and relied exclusively on the information provided to them by the facilitator about the hospital, surgeon, and treatment. As Emma remarked, they traveled to India because "that's where [the facilitator] sent us." Upon deciding to go, Emma informed her neurologist of her decision to go abroad to India for the CCSVI procedure. While the neurologist was wholly unsupportive of her decision, he did agree to provide a statement of Emma's condition to give to her Indian surgeons.

Upon arriving in India, Emma and Matthew went directly to the hospital. Having never left North America before, they felt overwhelmed by the long-haul travel and the striking cultural and material differences between India and Canada. While they had initially intended to

incorporate tourist excursions and a resort recovery following the surgery, Emma and Matthew spent the entirety of their three week trip at the hospital. Matthew had accompanied Emma with the understanding that he would be providing supportive care throughout the trip. However, soon after Emma's surgery, Matthew experienced a flare-up of an existing chronic condition and required surgery himself. In this same period, Emma experienced a heart attack and required prolonged hospitalization. Due to these unexpected health problems, especially given their severity, Emma and Matthew's plans to tour and recover in relative luxury were dashed.

In spite of the unexpected twists in her trip, Emma remains adamant that seeking care abroad was the best course of action, given the unavailability of CCSVI treatment in Canada. She bears her care providers in India no ill will, does not hold them liable for her complications, and feels she received excellent care throughout her stay.

Significance

Most of the Canadian medical tourists we spoke with reported having had no complications related to their surgery, either at the time of their trip or after returning to Canada. Of those that did report experiencing complications, Emma's story was unique. The severity of the complications that both she and her partner experienced were striking, and serves to underscore the very real risks faced by medical tourists and their caregiver-companions. While the flare up of Matthew's chronic condition cannot be directly linked to the physical stress of unfamiliar travel and surgery, the added layer of complexity posed by the distance and isolation where the couple experienced the complications poses a unique risk in itself. The unexpected surgery Matthew underwent brings the role of the caregiver-companion to the forefront. Caregiver-companions are relatively invisible figures in current discussions of medical tourism, despite their often considerable roles in helping to arrange for care and in assisting medical tourists while abroad. Matthew's own experience is a reminder that the kinds of risks faced by caregiver-companions are shaped, and also may be complicated, by their novel environments. This case raises important questions regarding the types of stressors to physical and mental health caregiver-companions may be exposed to when assuring the care recipient's wellbeing in a foreign environment.

MOLLY'S VIGNETTE

Molly considers herself to be an adventurous person, and takes international vacations regularly. While on an extended trip to Malaysia with her boyfriend Terence, she met Samantha, a friend of a friend who had recently undergone breast augmentation from a local surgeon. Molly had been considering having her breasts augmented, and was familiar with what the surgery entailed and its typical cost in Canada from casual research she had done online in the past. She took the opportunity to ask Samantha detailed questions about her experience with the surgeon and the surgery in Malaysia. Excited at the prospect of saving thousands of dollars and the purported skill of the surgeon, Molly contacted the clinic within a day of talking with Samantha and arranged for a consultation.

At the consultation, Molly was set at ease and was impressed by the surgeon's confident attitude and the orderly, sterile appearance of the clinic. Most concerned with the symmetry and natural appearance of her breasts following surgery, Molly was thrilled by the photo album of previous patients' post-surgical bodies, all of which showed outcomes she thought desirable. Motivated by the combination of cost savings, perceived surgical expertise, and recovery time that her remaining two weeks of vacation offered, Molly booked the surgery for later that week.

As the breast augmentation was offered as a day surgery, Molly went back to her hotel room with Terence after it was complete. She went to bed as soon as they returned, as she was groggy from the anaesthesia and found that her breasts were very sore. Later that night, Molly awoke in extreme pain. Alarmed by the severity of her discomfort, she woke her boyfriend. They quickly discovered that one of her breasts was swelling alarmingly. Both Molly and Terence grew very worried, and he called the surgeon on his personal cell phone to alert him of the situation. The surgeon told Molly to come back to the clinic right away, so her boyfriend drove her there in the middle of the night. On the way to the clinic, their car hit a bump and caused a suture in the swollen breast to tear, spilling blood all over Molly. At this dramatic sight, Terence grew panicked at the thought that Molly might die. Meanwhile, Molly

tried her best to keep pressure applied to the haemorrhaging breast for the remainder of the drive. Molly's complications were dealt with at the clinic that night with no further issues arising, although she extended her vacation a week to allow herself more time to recover from the surgery.

Despite experiencing a dramatic complication, Molly remains pleased with her decision to access cosmetic surgery abroad. She advises that others who choose to have surgery while already on vacation should be aware of the exhaustion that can accompany recovery, and to not anticipate a high energy trip after surgery.

Significance

Molly was the only medical tourist we spoke to who decided to have her surgery done while she was already abroad as opposed to planning it prior to departure. Other medical tourists or their caregiver-companions did report having additional treatments or diagnostic tests unrelated to their planned surgeries done while they were abroad, but Molly was unique in seeking an impromptu surgery while she was on vacation. Seeking care in this manner clearly excludes any pre-operative input from a patient's domestic physicians, and raises concerns around both continuity of care and adequate preparation for surgery. Additionally, Molly's account of her complications from what was, in her understanding, a minimal risk surgery, highlights the danger inherent in a popular conception of medical tourism that perceives elective, and in particular cosmetic, surgery as a mundane experience (see, for example, Jesitus, 2006 and Alsever, 2006). The role Terence played in providing important supportive care during her post-operative emergency also provides further justification to more seriously and conscientiously consider the role of the caregiver-companion as a key support for medical tourists during their care abroad.

JESSICA'S VIGNETTE

Jessica is a woman in her early fifties and is in very good health. Well-travelled from numerous overseas trips with her husband for his work, she has visited many low-, middle- and high-income countries in the course of her life. In recent years Jessica was experiencing chronic

pain in her hips and a specialist recommended she receive a hip replacement. The wait list for this procedure in her home jurisdiction was three years. She agreed to be placed on the wait list. Her quality of life was rapidly declining as she waited for a surgical date, and by the second year of waiting she was largely bedridden. With no surgical date in sight in her third year, Jessica switched to a different surgeon's wait list in another city, having been told this would cut her wait time. Soon after this switch, Jessica's husband, Tom, saw a segment on hip resurfacing on the popular newsweekly *60 Minutes* television program, and together they began researching the procedure online. They found hip resurfacing an attractive alternative to a total hip replacement. In hip resurfacing, artificial surfaces are fixed to the degrading hip joint. This conserves more of the original bone and permits greater post-operative flexibility and mobility when compared to hip replacement, although the long term success of the approach remains uncertain (Ollivere, Darrah, Barker, Nolan & Porteous, 2009).

Jessica and Tom quickly found that hip resurfacing was largely unavailable in Canada, and that the most experienced surgeons were in other countries. Excited by the perceived technical superiority of the procedure and the potential of obtaining an immediate solution to her debilitating pain, Jessica decided she was going to undergo a hip resurfacing abroad and take herself off the local wait list for hip replacement. Weighing the surgical expertise, long recovery time, and relatively low cost of the procedure in India against her long held discomfort with the extreme material poverty found there, Jessica ultimately decided to pursue surgery at an Indian hospital rather than the European centres that also offered the procedure.

Jessica's surgery in India went well with no complications. She chose to recover in a beachside resort outside the city she and Tom had travelled to, which regularly received foreign patients from the hospital. The resort was more commonly used by vacationers, and was a focal point for local craftspeople and other vendors hoping to benefit from tourist dollars. While staying at the resort, Jessica and Tom struck up a friendship with Mohinder, a beach trinket seller, and proceeded to meet his entire family. The Canadian couple was struck by the degree to which the region had been affected by a devastating tsunami in 2006, and was especially moved by what they saw as the resilience of Mohinder's family in the face of the poverty in the

region. Inspired by this resilience, Jessica and Tom asked Mohinder and his wife if they would be willing to let them finance their three daughters' educations, to which they eventually agreed.

The relationship between the two families has continued for many years since Jessica and Tom's trip to India. They exchange emails weekly, and the charitable financial relationship has not only allowed Mohinder's daughters go to school, but also enabled Mohinder's wife to access life-saving medical care. Jessica's perception of India has greatly changed following her surgery there, and she and Tom have returned twice since her first surgery - once to have her other hip resurfaced and a second time as a leisure vacation to visit Mohinder and his family.

Significance

Jessica's account of charitable involvement was not totally unique amongst the Canadian medical tourists we spoke with, as others also talked of personally giving back to the economic and social well-being of the low-income communities in which they had received care. For example, an interview participant spoke of paying for orthopaedic surgery for an athletic youth in India, and another sent care packages with hard-to-get consumer goods and medical supplies to the physicians and nurses who had treated her in Cuba. However, the degree of Jessica and Tom's initial and continuing involvement with the destination country was unique, and spoke to a powerful affinity to India that Jessica established after first going as a medical tourist.

Jessica's vignette highlights two points of interest. Firstly, unprompted personal charitable acts may suggest a nascent willingness amongst medical tourists to offset their use of medical resources elsewhere with more structured cross-subsidization schemes for local users by foreign patients. Doing so could provide one mechanism for addressing some of the health equity concerns that have been raised regarding medical tourism for destination nations, although cross-subsidization schemes may serve as a distraction from the larger, systemic inequities that medical tourism represents and arguably exacerbates in healthcare systems (Johnston, Crooks, Snyder & Kingsbury, 2010). Secondly, Jessica's experience underscores the need for the affective dimensions of medical tourism to be readily acknowledged and explored; both visiting foreign environments and undergoing surgery can be deeply emotional experiences (Knudsen & Waade, 2010; Panagopoulou, Maes, Rime & Montgomery, 2006; Reisinger & Mavondo, 2005). While the structural and system-level accounts of medical tourism that

dominate much of the scholarly literature are clearly important, they cannot capture the potential shifts in personal perspective that medical tourists undergo. These patients enter contexts they would otherwise never visit, and do so in a vulnerable a position. A full understanding of the experience of medical tourism requires consideration of the lived experience, including its emotional dimensions.

CONCLUSION

The vignettes shared above bring forth a number of important lessons for medical tourism researchers. We see three such lessons to be most important. First, these vignettes highlight the value of gathering and analyzing patient narratives in order to understand all facets of medical tourism. As we said at the outset, published narratives characterizing the experiences of medical tourists tend to emphasize commonalities. While this is not problematic as there is much use in identifying common trends and experiences, our vignettes show the value in bringing forth uncommon or unique aspects of the patient experience highlighted in narratives in order to advance our knowledge about medical tourism. As research in this field is at an early stage, there is great potential for these unexpected or unanticipated insights to meaningfully inform future studies.

Second, all five of the vignettes demonstrate the very important role that caregiver-companions can play in medical tourists' experiences. In some instances caregiver-companions prompted medical tourists to consider going abroad for surgery, often assisting in the research process, while in others they provided valuable emotional support during the recovery period abroad. In effect, the vignettes position caregiver-companions as an important stakeholder group in the global health services practice of medical tourism. The lesson here is that it is important that research on medical tourism be designed in such a way to allow unplanned or unanticipated perspectives to be brought forth on issues that we know little or nothing about. In the case of our research, we did not initially set out to learn about caregiver-companions, nor did we even ask about them at the outset, but many valuable insights about this stakeholder group emerged throughout the process of data collection.

Third, the heterogeneity captured by the vignettes in relation to the experiential accounts of medical tourists demonstrates the importance of approaching research in this field with a non-homogeneous understanding of who medical tourists are. If research is limited to or overly-focused on a narrow definition of who engages in medical tourism and what their experiences are, then this will have an influence not only on study design but also on research findings and ultimately on the messages that get disseminated about who medical tourists are.

Many research questions emerge from the vignettes and our articulation of their significance. These questions include: how common or uncommon are the 'unexpected' experiences we have showcased here among medical tourists, including those departing from other countries or traveling abroad for non-surgical procedures; what interventions, if any, should be implemented in order to address health and safety-related issues; and, what else do we need to know about caregiver-companions in order to have a more complete understanding of the roles they play in the care and decision-making of medical tourists and the types of unique health and safety risks they might experience? Addressing these questions in future research could positively influence the operation and regulation of the medical tourism industry as it develops over the coming years. While some of these questions have been posed by other medical tourism researchers, some aspects of the vignettes presented herein may warrant reinterpreting their scope, meaning, and/or intent. We believe that these and other questions emerging from the vignettes offer important directions for future medical tourism research.

The accounts shared in this chapter describe five exceptional experiences pulled from our interviews with 32 Canadian medical tourists. While elements of these five participants' decision making and care-seeking trajectories fit larger trends seen within the entire group, the anecdotes shared above illustrate unique instances that we had yet to share. The vignettes aim to highlight exceptions that demonstrate the variability of Canadian medical tourists' experiences. Our hope is that they serve as springboards for future qualitative research that can further document the varied practices of facilitators, supportive roles of caregiver-companions, motivations for traveling for care, risks faced while in destination countries, and the affective shifts in perspective that might accompany these journeys abroad for medical care.

[1] Details about the study design and methods can be found in Crooks, Snyder, Johnston and Kingsbury (2011). A listing of study publications can be found at www.sfu.ca/medicaltourism.
[2] Canadians are largely unable to privately purchase medical services that are offered through the public Medicare system, including orthopaedic surgeries, due to provisions in the Canada Health Act that discourage private financing of care.

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7 Out of Canada: A Personal Experience of Bariatric Surgery

Lorraine Hopkins

My introduction to bariatric surgery occurred in 2001 during a discussion with a physician who had supervised me through a hospital-based weight loss program. I had successfully lost a significant amount of weight on the program but two years later I had regained it all. This was one more in a long line of unsuccessful attempts to achieve sustained weight loss through a variety of programs. This pattern of weight loss and regain is typical for patients in the morbidly obese category[1], frequently starting each attempt at a higher weight than the previous one. This was the start of my journey to obtain weight loss surgery that would eventually lead me to seek medical care outside of my country.

The physician's suggestion to me at that time was that I should consider this option as current research showed that this was the only solution for sustainable weight loss for morbidly obese patients; studies revealed a less than one percent chance of keeping weight off through diet and lifestyle changes alone. I had relatively few co-morbidities for someone at my weight but my quickly elevating glucose level indicated that Type II diabetes was not far off in my future. I already had partial sleep apnea and needed to use a Continuous Positive Airway Pressure machine. My knowledge of weight loss surgery at that point was from news reports of a woman in Québec dying after intestinal bypass surgery and from anecdotal accounts of patients gaining back all their weight after undergoing stomach stapling in the 80's. It didn't sound like something I wanted to consider but a little research assured me that a gastric bypass was a completely different procedure with impressive long-term statistics.

In the ten years I have been researching surgical options for weight loss in Ontario, the availability and the rules governing accessibility have been in a constant state of flux. The basic criteria for qualifying stayed consistent: a body mass index (BMI) of 40 or greater, or a BMI over 35 with two of the following severe co-morbidities: coronary heart disease, Type II diabetes, significant obstructive sleep apnea, and/or hypertension. At the time I started my research, there were two surgical options available in Ontario, gastric bypass (Roux-en-Y – RNY, for short) and gastric banding. There were very few surgeons in Ontario performing

either of these procedures, with most of them centered in the Toronto area with wait lists of two to three years. I was referred to one of these surgeons and after an initial consultation was put on his waiting list. The adjustable gastric band was coming into use at this point and while my province's health insurance plan – the Ontario Health Insurance Plan (OHIP) – would cover the cost of the surgery, it would not cover the cost of the band itself, approximately $5,000 at that time.

Shortly thereafter, OHIP cut funding for operating room access for all bariatric surgeries across the province except for a limited number performed by a small group of surgeons operating out of the Humber River Hospital in Toronto. Several bariatric surgeons in the Toronto area began operating out of private clinics performing adjustable gastric banding but these were now completely self-paid by the patients at a cost of $15,000. The gastric band was not an option I could consider because of the prohibitive costs.

With Ontario no longer an option for OHIP funded gastric bypass, my weight loss specialist then referred me to a surgeon in Montreal. OHIP would cover the cost of the surgery itself, but in order for this physician to get operating room time, he was performing his surgeries during the night when the rooms were not in use. Patients choosing this option would have to pay $5,000 out-of-pocket to cover the operating room costs. At that point, I was motivated enough to agree to pay but I never heard back from this surgeon.

As the possibility of obtaining weight loss surgery dwindled, I started on yet another diet, and although my weight would fluctuate up and down over the next few years, I managed to sustain a permanent 50-pound loss. My success at sustaining that loss gave me hope that I would be able to further lose weight on my own without resorting to surgery. Comments from family and friends about weight loss surgery ranged from "it's a little extreme don't you think" to "it's the easy way out." I made another visit back to the weight management clinic for another attempt at losing weight using their liquid meal replacement program but with similar results to the previous one; I lost and regained. Throughout those years, I attempted to make exercise a regular part of my daily routine as it had the same degree of sustainable success as dieting. My regular job involved sitting at a computer all day so I took on part-time employment that involved physical activity, as a means of making it a regular part of my life – and getting paid

at the same time was a bonus. I had also been doing therapy to deal with the emotional eating side of the equation.

While to many people, the solution to losing weight is simple – don't eat as much and exercise regularly – the reality is that eating disorders are complex and multi-layered. Unraveling the root cause involves examining everything from genes to environment to emotional issues. Eating is so intricately woven into the fabric of our daily lives that extricating that which is emotional unhealthy eating from that which fuels our bodies is a difficult task.

The battle to sustaining weight loss continued over the next few years but in the fall of 2008, when my weight began to crawl up again, I threw up my hands in surrender and decided that it was time to once again to pursue weight loss surgery as a more permanent solution. I was 53 years old at that point and was fully aware that the longer I waited to have surgery, the greater my risk of developing serious health issues due to obesity and my age became. This put me at a higher risk of surgical complications. It was now or never.

While waiting for my appointment to once again meet with the physician at the weight loss clinic to discuss the options, I began researching the process. In the intervening years since I had first been referred, OHIP began funding patients to go out-of-country for bariatric surgery, mostly to upper Michigan and the State of New York. The capacity for bariatric surgery within Ontario had become so limited and existing wait times long enough that the situation had become life-threatening for many morbidly obese patients. Initially, only patients whose co-morbidities were so severe that they had lost their mobility or were considered at risk of imminent death were approved. On the referral form that doctors were required to fill out and send in to OHIP, there were two statements with boxes that had to be ticked off before approval was granted: one stated that a delay in surgery could result in the death of the patient and the second one stated that the patient was at risk of medically significant irreversible tissue damage. Over time, OHIP took a more liberal approach to these prerequisites and would require only one to be ticked off, therefore allowing more patients to qualify. Most doctors could argue that a patient in the super morbid/morbidly obese category was assuredly experiencing irreversible tissue damage in the joints as the result of carrying that amount of weight and in the case of Type II diabetes, organ damage as well.

A good part of my research was completely non-scientific in nature. I spent a great deal of time perusing a weight loss surgery forum for Ontario patients. The participants were at various stages of the process and depending on where they lived and were referred for surgery, each had a different story to tell. It was through reading the stories of the forum members that I gained an understanding of the various surgical options available, complication rates, the experience of going out of the country for surgery, and the hoops that were necessary to jump through to obtain approval. Many of these patients were more knowledgeable about the surgery options as well as the process to get it approved than their family doctors. Reading the various posts also provided valuable insight into what post-surgical life was like.

Although the RNY gastric bypass was considered the gold standard procedure for bariatric surgery with 20 years of statistics to back it up, I soon learned from my research that there were other surgical options. The Duodenal Switch (DS) was another combined mal-absorption/restriction procedure similar to but more extensive than the gastric bypass, and a lesser-known procedure, the Vertical Sleeve Gastrectomy (VSG), involved restriction only. In December 2008, OHIP had been approving requests for all three procedures. In the span of the next few months before getting my own referral submitted, the rules would change again.

An increasing number of serious complications were occurring for Ontario patients who traveled to Michigan for the DS. These patients were often the more seriously morbidly obese with significant co-morbidities, which meant a higher risk of surgical complications or mortality for any surgery. Patients in this category were shown to have a far greater chance of success with this procedure. In Ontario, the issue was further complicated by the fact that OHIP would only approve this surgery to be performed as open surgery, as opposed to the less invasive laparoscopic surgery, which they considered to be experimental at that time. This, coupled with the distance patients had to travel for the surgery, family doctors' and emergency room staff's lack of knowledge about the changed anatomy and surgery and care of these patients upon their return to Ontario, meant an increase in the rate of infection and lack of appropriate follow-up care. Because a longer segment of the bowel is bypassed in DS surgery, patients have a higher potential for serious nutritional deficiencies if not monitored closely. One patient

developed permanent vision damage, the result of a Vitamin B1 deficiency that was not identified by the hospital.

In February 2009, OHIP would no longer approve this procedure for all but a few patients with BMIs over 60 and sent letters out to family physicians recommending against this option. Although initially this procedure looked very appealing to me as it had the highest success rate with the additional 'bonus' of being able to eat up to 3000 calories a day because of the significant mal-absorption, the complication rate and need for significant lifelong supplementation had discouraged me.

Many patients with lower BMIs who had requested the DS were now denied this option, but subsequently approved for their second choice, the VSG. The VSG was becoming increasingly popular in the US. This involved the laparoscopic vertical stapling and removal of 85 percent of the stomach. The stomach is left anatomically intact but shaped like a long banana. This surgery had several advantages, fewer complications, was less invasive, left an intact pyloric valve, presented less risk of nutritional deficiency, and had the additional benefit that the appetite stimulating hormone ghrelin, which is manufactured in the part of the stomach that is removed, would no longer be produced. Although gastrectomies had been performed for 30 years as a treatment for stomach cancer or for serious damage caused by chronic ulcers, it had only been performed as a bariatric surgical option in the last decade. Initially, the gastrectomy was performed on super morbidly obese patients (BMI >60) as the first stage of the DS. The idea was to perform this less invasive procedure on high risk patients, which would lead to a 100 to 200 pound weight loss, and would therefore put them in better shape for the more complicated second stage, the intestinal bypass. However, surgeons were increasingly finding that patients were not coming back for the second stage of the surgery as they were satisfied with the weight loss they achieved with the gastrectomy alone.

Because of the high failure rate in the 1980's of a previous restriction-only procedure, the Vertical Banded Gastrectomy (VBG), there was a lot of skepticism about the long-term success of the VSG. The major issue with the VBG procedure is that it creates a pouch in the part of the stomach that stretches such that, with no mal-absorption and a stomach capacity back to where it started, most of these patients eventually regain their weight. The VSG,

however, creates a long tube from the thickest and least 'stretchy' part of the stomach and, several years down the road, would retain its restrictive capacity. At this point in time, there were 5-year statistics available, which did not have as promising long term numbers as the RNY. This was partially due to the fact that earlier procedures only removed 65 percent of the stomach thereby allowing more food intake than the more current version, which removes 85 percent. The statistics on this version were looking more promising.

In February 2009, the Ontario Ministry of Health and Long Term Care (MOHLTC) announced that it would be investing $475 million into the creation of four centres of excellence for bariatric surgery in Ontario. The centres would be located in Ottawa, Toronto, Guelph and Hamilton, with an additional assessment centre in Windsor. This change in policy direction was made after examining both the cost to the healthcare system of treatment for Type II diabetes and the statistics for the successful resolution of this condition after weight loss surgery. The cost of performing the surgery in Ontario was $10,000 cheaper than sending patients out of country (Government of Ontario, 2011).

With the upcoming development of in-province bariatric surgical centres, I knew that the option for out-of-country surgery would soon be phased out. My research of surgical practices in the US showed that the American Society for Metabolic and Bariatric Surgery (ASMBS) strongly recommended that bariatric surgery be performed in centres of excellence by surgeons who exclusively performed bariatric surgery. The complication rate dropped significantly when the surgeon had performed at least 100 procedures. One of the major differences with this bariatric surgical practice is that it needs to include a comprehensive program where the surgeon and other team members work closely with the patient over the course of a year of follow-ups providing supervision, continuing education and support. Patients are routinely seen post-operatively, at two and six weeks, three and six months, and one year.

After much research and discussion with friends, family members and healthcare professionals, I decided that surgical experience was an important criterion for me in choosing where I wanted to have my surgery done. Although I could wait to have a gastric bypass in one of Ontario's new surgical centres, I did not want to be a guinea pig in their first years of operation, while the surgeons were still gaining experience. My own history with surgeons and

hospitals in Ontario, along with reading stories about the experiences of some bariatric patients operated on in Ontario, left me feeling doubtful that I would receive the same degree of care in Ontario as in the US. Travelling to the US for surgery would be complicated; I would need to have a current passport, make travel arrangements, book hotel rooms, take time off work for appointments, and arrange for someone to accompany me for the surgery. Any travel costs incurred would not be covered by OHIP. I would be able to claim them as a medical expense on my income tax but that would only recover a small portion. Despite the logistical complications, I was determined to travel to the US for the surgery.

After studying the different procedures at length, I chose the VSG as the option with which I was the most comfortable. I liked the idea of being left with a fully functioning stomach, not having to worry about the risk of nutritional deficiencies from mal-absorption or the possibility of strictures or bowel obstructions. I wanted to develop a normal relationship with food that could include indulging in a small piece of birthday cake once a year. For many RNY patients, eating sugar or high fat foods triggers 'dumping syndrome,' with very unpleasant symptoms such as dizziness, nausea, and weakness. For patients with Type II Diabetes, the RNY provides the quickest resolution of this disease but as I didn't have it yet, that didn't need to be a consideration for me. Now all that was left was to choose a surgeon and, most importantly, seek approval from OHIP if I was to expect the cost of the surgery to be covered by Ontario's Ministry of Health.

In the few months prior to my referral being submitted, patients who requested the VSG were granted approval without question. By the time my request was sent to OHIP in May, the rules had changed once again. With the development of the Ontario surgical centres, the decision was made that the RNY was the only procedure that would be approved going forward unless there was a valid medical reason why the VSG was necessary. In an era where shared decision- making and informed consent were being encouraged in many areas of healthcare treatment, this rigid approach of not allowing patients input into their treatment options was frustrating. If the percentage of excess weight loss - the barometer of success - was 68 percent for the VSG versus 72 percent for the RNY, and I was prepared to accept that

lower percentage as a compromise for all the other advantages, I felt that it should be my choice.

The notion that an OHIP medical consultant, with whom I had never met or discussed my preferences, was in a better position to make a decision about what was in my best interest, as opposed to my family physician who was familiar with my history, lifestyle and health issues, seemed bureaucratic and paternalistic. After seven weeks and some back and forth discussion between the consultant and my physician, they finally accepted that the RNY would not be the best option for me because of multiple previous abdominal surgeries and my need to take anti-inflammatory medication, which are prohibited with the RNY, as part of my pain management regime. I finally received approval to have the VSG at the Barix Clinics® in Michigan, which was the only OHIP-approved facility providing this procedure at the time.

Two weeks later, I was getting into my car to start the nine hour drive to Ypsilanti, Michigan to meet with the surgeon. Driving into the parking lot of the Barix Clinics®, I was struck by the number of Ontario plates on the cars. The clinic was as described - pleasant, efficient and geared to larger patients. This first visit would consist of filling out a multitude of forms, a brief physical examination, a meeting with the clinic coordinator, a group information seminar with Dr. Stephen Poplawski, an experienced bariatric surgeon, as well as a one-on-one session where he reviewed my file, took notes on my history and discussed my surgery choice with me. Because I was over 50, he requested that I have a stress test and an ECG prior to approving me for surgery. He would have preferred a cardiac consultation but being aware of wait times in Canada, would settle for these two. Having finally got the ball rolling to get the surgery, I feared that it would take months to see my doctor for the referrals and to get the stress test done. However, one area in which my hometown of Ottawa is very good is providing timely healthcare services in the field of cardiology. A month later, my cardiac clean bill of health, including a letter from the cardiologist I had seen, was faxed to the US surgeon and two weeks later, I had my surgery date, November 12, 2009. Start to finish, from submission of OHIP referral to date of surgery, six months.

Patients are requested to lose 10 to 15 pounds prior to surgery by following a high protein, low carbohydrate diet. This helps to shrink the liver to give the surgeon better

visibility. I made the decision that I was going to do my part to assist the surgeon by not only losing weight, but also by getting my body in better shape. I started walking regularly. I decided to use the same meal replacement shakes as the hospital program as my diet for the two months before surgery because of the sheer simplicity. Dealing with physical withdrawal symptoms from caffeinated diet cola and simple carbs is difficult enough at the best of times without trying to do it while recovering from surgery, so I immediately eliminated these from my diet. I managed to lose 33 pounds by the time I returned to Barix on November 9th.

The regular surgical process at the clinic involved a visit for pre-admission testing two weeks prior to surgery, then a return for a two-day hospital stay for the surgery itself followed by a two-week post-op follow-up visit. In deference to the distance I had to travel from Canada, I was allowed by the Clinic to compress these processes into one trip where I would stay in the vicinity of the hospital for eight days with the pre-admission tests done three days prior to surgery and a follow-up visit two days after release. I was also expected to return for the standard follow-ups at six weeks, three months, six months and a year.

I was comfortable driving long distances and fortunately my daughter was at university in London, Ontario, three hours from Ypsilanti. She would be able to accompany me for the surgery and I could use her apartment as a base. I didn't have any concerns about the follow-up care when I returned to Ontario: the VSG rarely has any complications and because there is no mal-absorption, nutritional deficiencies are uncommon and do not require close monitoring like the RNY. The only thing that my physician would likely have to take care of was to order the list of blood tests that the surgeon requested to have done four times over the next twelve months, and then fax the results to the clinic. I did have some concerns about making an additional four trips to Michigan over the first twelve months. I wasn't sure that, if I was progressing well with my weight loss and had no health issues, there was enough to gain from these visits that would be worth the lengthy trip. I could always reach the clinic by phone to speak to the surgeon or the nutritionist at any time. My plan was to return for follow-ups at six weeks, six months and one year.

The pre-admission testing day at Barix was a demonstration of a well-designed program and a well-run clinic. Step one was fasting blood work followed by a chest x-ray, physical

examination by an internist and a group nutritional class. By the time I met with the surgeon in the early afternoon, he had the results of all the tests I had done that day. He explained that the surgery would take approximately 50 minutes and there would be a total of five laparoscopic ports. He determined that everything was in order and I would return three days later for surgery.

Throughout the journey to reach this point, I had felt a great deal of anxiety about successfully getting approval and frustration at the length of time it took, but I was never fearful of the surgery itself. Despite the fact that every surgery has risks, I knew that I was in good health, had easily recovered from surgery in the past and was in the hands of a very experienced surgeon. Other than the surgery taking a little longer than expected due to adhesions, it was uneventful. My daughter accompanied me to the hospital and was there to greet me when I came out of recovery. I was up walking the halls a couple of hours later. Throughout my 48 hour hospital stay, every staff member I dealt with was competent, pleasant and very responsive to my needs.

After spending a relaxing weekend with my daughter in a hotel close to the clinic, I returned for a quick check-up to ensure there were no issues and that I was in shape for the trip home. With my daughter behind the wheel this time, we headed back across the border to Toronto. In order to prevent blood clots, we made several stops along the way so that I could get out of the car for a little exercise. For the second leg of the journey, I took the train from Toronto to Ottawa where I was free to get up and walk around as needed. Arriving home later that day tired, but in relatively good shape, my other daughter was waiting at the train station to drive me home, and I had supportive family members ready to lend a hand as needed over the next few weeks. I even received a call from the clinic a week after my return asking how I was doing and if I had any questions.

The remainder of my recovery went smoothly and after a steep learning curve, I slowly adapted to eating and drinking to suit my new anatomy. My mantra became "food is fuel, food is not your friend." With the extensive therapy I had done leading up to the surgery, in addition to the researching and information gathering with other weight loss surgery patients, I was as prepared as possible for my new life.

I have had no issues that required any medical intervention since the surgery. I made my first follow-up visit to Barix seven weeks post-op where I was told that I was on track and doing as expected. I did not get to the six month check-up as planned due to some logistical complications but regularly had my blood work done, and I had had no issues that required any medical intervention since the surgery. Throughout the next year, because my blood work and my health in general reflected that there were no complications from the surgery, and my weight loss was progressing well, I did not make any further trips to Michigan for follow-up. One year to the day since my surgery, I reached my goal weight of 167 pounds, having lost exactly that same amount from my heaviest weight.

POST-SURGICAL REFLECTIONS

Although I might have been provided with a few frills during my hospital stay in the US that I wouldn't expect a public system to provide – like a free toiletry kit – what I appreciated most about my treatment was the respectful way in which I was dealt with and the consideration that was shown for my time. In a profit-making operation, it is in their best interest to work efficiently to maximize their profits. They also need to attract 'customers' by providing good service. In my opinion, these two things go hand in hand; working efficiently by providing a well-organized program of services leads to good customer service – both sides benefit. I see no reason why a public healthcare system cannot provide these as well. Sadly, the reality in Ontario from my observation and personal experience is that problems for people seeking bariatric surgery persist. As the new Ontario bariatric surgery program struggles to get organized, and with out-of-country surgery no longer an option, wait times have grown to two years in some centres. No communication process has been put in place; getting through to speak to someone at one of the centres can be almost impossible. In some of the surgical centres in the Toronto area, new surgeons who have spent time working in the US are more open to allowing the patient to decide which surgical procedure is best suited for them and will perform the VSG if the patient requests it. However, in eastern Ontario the gastric bypass remains the only option available unless there is a medical reason, based on very strict criteria,

for a VSG. Should geographical location determine whether a patient has a say in their treatment or not?

A prominent Ottawa bariatric expert recently blogged that he felt it was only a matter of time before a patient sues the Ontario health care system for denying timely access to bariatric surgery under the new system (Freedhoff, 2010). In a later interview on CBC Radio, he argued that in fact, with the current wait times, there is no cost savings to having surgery in-province rather than out of country, because the cost to sustain the patient in the system for an additional 18 months exceeds the savings, in addition to putting their life at risk. There are presently 1,200 patients on a waiting list for bariatric surgery in Ottawa alone. Out-of-country surgery should have continued to be made available until the new system was prepared to handle the load. (CBC News, 2010).

Morbidly obese patients start the journey down the road to weight loss surgery with a poor self-image, hating the bodies they have been living in. The boost to their self-esteem as their thinner selves emerge sustains them for a period of time, but by the time the last few pounds come off, the poor self-image returns to a degree because of the large amount of excess skin they are left with. I have learned through chat rooms of people undergoing bariatric surgery that a number of patients are now opting to go to Mexico for plastic surgery to have it removed. Surgical costs are about a third of what they would be in Canada. If you have the energy to jump through another set of OHIP hoops, you may get the cost covered for the removal of excess skin in the lower abdomen or for a breast reduction, but it only applies under limited circumstances and is, not surprisingly, a complicated process. Veterans of the surgery often counsel new patients to start saving for 'plastics' as soon as possible. Despite being left with a large amount of excess skin, even for those that cannot afford plastic surgery, you will be hard pressed to find a patient who regrets having bariatric surgery. The benefits far outweigh the costs.

The personal toll of jumping over the many hurdles to obtain bariatric surgery in Ontario is enormous. Should I be in a financial position to do so in the future, I would certainly consider the option of once again being a medical tourist, perhaps to a warmer climate next time.

[1] "Obesity traditionally has been defined as a weight at least 20% above the weight corresponding to the lowest death rate for individuals of a specific height, gender, and age (ideal weight). Twenty to forty percent over ideal weight is considered mildly obese; 40-100% over ideal weight is considered moderately obese; and 100% over ideal weight is considered severely, or morbidly, obese." More information can be found at http://medical-dictionary.thefreedictionary.com/Morbidly+obese.

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8 Travelling for Healthcare from Canada: An Overview of Out-of-Country Care Funded by Provincial/Territorial Health Insurance Plans

Vivien Runnels and Corinne Packer

INTRODUCTION

Many countries have seen fit to make healthcare arrangements for their citizens when, for a variety of reasons, domestic healthcare is unable to provide the medical treatments or interventions required. In some cases, these arrangements are made within country, but outside the patient's province or territory. Many cross-border patients are treated in hospitals located close to provincial borders. For example, residents of the Mamawetan Churchill River region in the province of Saskatchewan receive services at Flin Flon Hospital in the neighbouring province of Manitoba (CIHI, 2010). In other cases, patients are sent out of country for the medical care they need. Sometimes patients explore medical care out of country and afterwards seek reimbursement of costs (Xuereb, 2011). In Canada, which is a federation of provinces and territories where the majority of healthcare is publicly insured, all provinces and territories currently have provisions in their health insurance plans to facilitate and cover the cost of both out-of-province/territory and out-of-country care (OOCC). These provisions offer the possibility of alternative or additional healthcare options outside the home province.

As Canadians look to have their health needs met in a timely fashion, we have seen evidence of increasing pressure from physicians, patients and healthcare advocates to provide funding for cross-border care, whether it is for out-of-province care, or for OOCC.[1] The media is increasingly dotted with reports of patients seeking medical treatment abroad on their own initiative and at their own cost (i.e., as medical tourists). But so, too, are there increasing reports of individuals hoping for facilitation and payment of their health services abroad through public health insurance plans. Evidence of this growing trend can be found in the number of requests and appeals made directly to ministries of health that organize OOCC, to the quasi-judicial appeal boards which hear the appeals of patients whose cases have not been approved or resolved to their satisfaction, and in the number of cases that have been investigated by

provincial ombudsmen or reviewed by the courts.[2] In the case of cross-provincial border care, there is some publicly available documentation and a compilation of data by the Canadian Institute of Health Information recording the transfers of funds and the costs of services (CIHI, 2010). However, data with regards to funded OOCC are not currently available publicly.

In this chapter, we examine OOCC funded by Canadian provincial/territorial health insurance plans. For the purpose of this review, we have defined OOCC as care funded by provincial/territorial health insurance plans where patients physically travel or are transported to a location in another country for the purpose of medical treatment. We consider some challenges to the current system of OOCC which include: increasing knowledge of, and demand for, OOCC; associated increases in costs to meet demand; challenges associated with the application of legislation and guidelines; and, the role of the media, particularly the Internet. We also suggest some potential research questions on OOCC and provide reasons for taking a broader look at the health equity and economies of scale trade. We suggest some general implications of cross-border and OOCC for a country which has a publicly-funded healthcare system.

TRAVELLING FOR HEALTHCARE

Travelling for care deviates from 'close to home' care one would traditionally expect from healthcare systems. For urban populations in particular, 'close to home' care means ready access, time savings, and minimal disruption to personal lives. In rural and northern areas of Canada, healthcare (such as for childbirth), is not always close to home, and travel can be onerous as well as socially and personally disruptive (PHAC, 2009). However, the value of 'close to home' whilst becoming increasingly realizable in rural and remote areas (NorthWest LHIN, 2009), differs from well-entrenched images of patients accessing care in doctors' offices, clinics, and hospitals. Telemedicine, where care 'travels' to the patients through information technologies, has become a preferred option in some cases to expensive, long distance travel. In Canada, telemedicine has improved access to healthcare, reduced patient waiting times, and allowed patients to save money (NorthWest LHIN, 2009).[3] However, despite these changes,

and in contrast to 'close to home' care, cross-border care requires (often long distance) travel away from home, the travelling always being done by the patient.

Not all patients are able, or keen, to travel for healthcare. Additionally, travelling with a medical condition has disadvantages that include increased patient stress, and, for some countries, reductions in hospital revenues. It also raises a number of associated legal and ethical concerns (Boyd, McGrath, & Maa, 2011). Some evidence infers that for some treatments the further residents live from healthcare facilities, the less likely they are to access post-operative care. In fact, doctors' selections of certain types of healthcare may even be impacted by their assessment of distance to facilities or care for patients (Athas, Adams-Cameron, Hunt, Amir-Fazli, & Key, 2000). If medical care can be matched domestically, people and their governments would prefer to receive and deliver treatments close to home (Boyd, McGrath, & Maa, 2011; Atwater, 2008). However, costs of treatment and timeliness of care also come into play.

CANADA'S PUBLICLY FUNDED CROSS-BORDER CARE

Legislative context

Canada is a federated country with ten provinces and three territories. The Canadian healthcare system is guided by the Canada Health Act of 1984. This Act sets out the principles of the Canadian health care system, and outlines the terms of agreement of the federal government with the provincial and territorial governments with regard to transfers of funding for the payment of healthcare. Healthcare is delivered and administered for the most part by the provinces. The federal government has certain responsibilities with regard to the provision of healthcare, but these are largely limited. The provinces are not required to provide services that are not listed in the Canada Health Act. An important feature of the Canadian healthcare system as a whole is that it is publicly-funded, and has a single payer (a province or territory). In 2011, of the approximately CAN$200.5 billion estimated to be spent on healthcare, around 70% of this is expected to come from the public sector: 65.3% was expected to come from provincial/territorial governments (this figure includes federal transfer payments[4]), 3.5% for federal government direct health care services, 0.4% from municipal governments[5] and 1.3%

from social security funds (CIHI, 2011).[6] The Canada Health Act builds on five main principles: public administration; comprehensiveness; universality; portability; and, accessibility. The principle of accessibility (Section 12.1) is fundamental to publicly-funded cross-border care in that provincial healthcare insurance plans are obligated to provide for insured health services on uniform terms and conditions such that insured persons have reasonable access to healthcare, and provide payment for all insured health services.

Provisions and processes for OOCC

In keeping with the requirements of the Canada Health Act, all of Canada's provincial and territorial healthcare plans provide for reimbursement of costs for health services obtained by a patient out of country in emergency situations, but only at the rates that the provinces have established for in-province care, and on a time-limited basis. Plans typically provide coverage for emergency medical treatment of Canadians for up to three months if they find themselves outside of their province. A patient on vacation or on business outside of Canada who requires emergency treatment may therefore only receive what amounts to partial reimbursement of the total costs, depending on healthcare costs in the destination country. The provinces and territories therefore encourage all travelers to take out additional personal health insurance.[7] In these cases, travel by an individual is voluntary and not undertaken for health purposes, but healthcare plans acknowledge that Canadians may become sick or injured whilst outside the country and that the potential patient is not abandoned on leaving the country, nor denied ongoing care on return. But, this form of insurance coverage, which is limited to money transfers (usually directly to the patient), contrasts with another form of coverage, which is the focus of this chapter. In this different form of OOCC, patients are *sent* abroad by provincial/territorial healthcare plans for specialized healthcare services or treatments which are pre-approved, pre-arranged and paid for by provincial (or territorial) ministries of health.

Depending on the patient's specific situation and the province/territory, some or all of the costs of OOCC will be covered under provincial/territorial health insurance plans, determined by a process designed to ascertain that the patient meets the conditions for OOCC. These criteria for eligibility are generally similar in all provinces and territories, and are as follows:

- the treatment or care must be medically required;
- the medical or hospital service must be demonstrated to be unavailable in the province/territory and/or elsewhere in Canada; that is, "if all Canadian medical resources have been exhausted"(Manitoba Health, 2011a);
- the delay in the provision of medical care available in the province/territory or elsewhere in Canada must be considered to be immediately life threatening or may result in medically significant irreversible tissue damage;
- the treatment must fall under insured medical, oral surgeries and/or hospital services; and,
- the applicant must be a resident of the province/territory (BCMSC, 2011).

The interpretation of these eligibility criteria is somewhat problematic. For example, what is meant by 'medically required?' What is understood by 'delay?' Flood, for example, has identified "the determination of what constitutes a sufficiently serious delay to merit seeking out-of-country healthcare services" as a major quandary for out-of-country health services. (Flood, 2004:3)

Some variations or additions to these general conditions occur. For example, Prince Edward Island (PEI) which is a small province, permits patients to apply for care if only one specialist practices in the province, although prior approval to go out-of-country must still be obtained from the Medical Director (Health PEI, 2011). Understandably, small provinces may find it hard to justify certain investments in health human resources or laboratories because of their small population base, whilst the same investments are deemed financially reasonable in the more populated provinces. Additionally, some provinces will cover some costs that are not covered by others. For example, Manitoba makes it known that it is "only one of a few provinces in Canada that offers assistance to help cover transportation costs" that are related to receiving medical care outside the province (Manitoba Health, 2011b). Transportation and accommodation costs (outside of a hospital) are typically not covered by provincial/territorial health insurance plans.

In order to receive medical care out of country through provincial/territorial insurance plans, specific procedures need to be followed in order to determine eligibility. In the case of

the Ontario OOCC Prior Approval Program, a family physician (general practitioner) must take the first steps towards determining need with the patient. The family physician initiates the request for approval, and is required to refer a patient to a specialist physician or an assessment centre within Ontario for assessment. Only after the specialist physician has seen the patient and judged that the care needed cannot be obtained within the province does the specialist write an application for funding for out-of-country health services to the provincial health authority. The referring physician and a specialist must both complete and sign the application form, along with the patient or his/her representative who has power of attorney. The form must be accompanied by relevant documentation, such as clinical reports and lab test results (Ontario Ministry of Health and Long Term Care, 2011a; Ontario Ministry of Health and Long Term Care, 2011b).

Information must be provided on the case and explanations given as to why OOCC is needed. The Ministry of Health reviews the application, and must approve it before treatment is obtained abroad, otherwise costs will not be reimbursed. In other words, not only must eligibility be established, but a patient must be pre-approved for OOCC by the provincial ministry of health if the costs of the healthcare are to be borne by the province. This process adds to the waiting time as the patient waits to be seen by a specialist who may refer the patient to yet another specialist within the province who is either able to offer the treatment or surgery or will recommend OOCC.

Health services and treatments which have been approved by out-of-country prior approval programs in different provinces and territories have included cancer treatment, diagnostic testing, high-risk bariatric surgery, residential treatment (such as for psychiatric disorders, eating disorders or substance abuse), neurosurgery, spinal surgery, and pregnancy complications.

APPEALING THE DECISIONS OF HEALTH MINISTRIES

Many applications for OOCC are not approved because they do not meet the requirements of the legislation as interpreted by the provincial/territorial ministries of health.

Patients have options to appeal their ministry's non-approval decisions. In Ontario, patients may appeal directly to the Ministry as well as to the province's Health Services Appeal and Review Board (HSARB), which is an independent quasi-judicial tribunal. Board members of this tribunal who serve on a part-time basis are appointed by the Lieutenant Governor-in-Council and include healthcare providers, lawyers, social workers, and business people. Appeal proceedings are public, and members of the public can have access to information on these unless the Board orders otherwise. The decisions of the Board are posted to the Canadian Legal Information Institute (CanLII).[8]

Undergoing an appeal can be difficult and painful for patients seeking treatment (Priest, 2009). The urgent nature of some cases may mean that any delay in subsequent approval of treatments can adversely impact patients' opportunities for treatment; for example, they may no longer be eligible for clinical trials, or infections may prevent them from travelling or being accepted for care in some locations. For example, Valerie Niles, who successfully appealed for funding, was subsequently rendered ineligible for OOCC because of a complication that developed after the appeal was granted. Susan Caiger-Watson was also denied care and successfully appealed the decision but, like Valerie Niles, was also affected by a complication (Priest, 2009).

Outside of appeals to ministries of health and associated review boards and the courts, a number of provinces have independent officers (ombudsmen) who investigate the public's complaints about government services.[9] The role of the ombudsman extends in part to determining fairness and equity, with regards to access to healthcare. In Ontario, for instance, the Ombudsman investigated a case where a patient (Suzanne Aucoin) complained about not being approved for treatment. The Ombudsman found in favour of Ms. Aucoin, stating that she had been wrongfully denied approval for OOCC (Marin, 2007). This case prompted an external review of the program by the MOHLTC and Ms. Aucoin was able to receive OOCC coverage (Lindberg & Risk, 2007). In 2009, a number of complaints received by the Ombudsman in Alberta prompted him to embark on an investigation into out of country health services. The Ombudsman found that appeals to the Out-of-country Health Services Appeal Panel of Alberta were administratively unfair, prompting a number of recommendations (Button, 2009).

OOCC AND WAITING LISTS

Some appeals for reimbursement for OOCC have been brought on the basis of lengthy waiting lists leaving patients with no choice but to personally take steps and acquire healthcare outside of Canada. However, OOCC was not designed specifically as a response to relieve a healthcare system's waiting lists, but to be responsive to an individual's healthcare needs in keeping with the legislation. According to most provincial and territorial health insurance plans, eligibility for OOCC is determined on the basis of a high level of urgency, particularly when a person is affected by a condition identified as 'immediately life threatening or [that] may result in medically significant irreversible tissue damage.' However, in certain cases, OOCC has been used as a technique to manage waiting lists. In 1991, for example, the Ministry of Health in British Columbia authorized coronary artery bypass surgeries in Seattle, Washington hospitals to relieve waiting lists (Katz, Migala, Welch, 1991; Katz, Cardiff et al, 2010). Other examples of groups of patients being sent out of Canada because of waiting lists have included breast cancer patients (Dayes et al, 2006).

Provincial ministries of health and other parts of the healthcare system, including hospital departments, have taken steps in many cases to reduce patient time spent on waiting lists and to reduce the size of waiting lists by prioritizing urgent and non-urgent issues, increasing infrastructure and generally introducing efficiencies such as centralized booking.[10] However, the questions remain as to how long must a patient wait, and how long is too long (Fogarty, 2008)?

Further, the issue of wait times has become a matter for judicial review, in which plaintiffs seek accountability for healthcare, including timely access to care, through the Canadian Charter of Rights and Freedoms (with the exception of Quebec which applies its own Charter of Rights and Freedoms).[1112] The 2005 Supreme Court of Canada's landmark Chaoulli decision[13] has opened the door for lawsuits on the basis that a "lack of timely care may nevertheless infringe a patient's right to life and security for the person" (Georgas & Shap, 2006, 14). While the reasons for bringing forth challenges at this level of the judiciary are

understandable, it is not ideal. As Jackman (citing Sheldrick) notes, "leveraging access through the courts is costly and time consuming" (Jackman, 2010). According to Jackman, "there is judicial reluctance to seriously engage with rationing of publicly funded health care services – the reasons why or the ways in which decisions are made – as a *Charter* issue"(Jackman, 2010 p.4).[14] [15] From the perspective of an ill individual who needs treatment without delay, pursuing access through the courts is not an attractive option to obtain care either. Regardless of court activity and Charter challenges, media reports continue to suggest that any wait times for treatment are a driver of patients' applications for OOCC, whether or not wait times meet benchmarks for medically acceptable wait times for treatment. Advertisements for medical centres or treatments may prey on this uncertainty and fear, and easy-to-access hospitals and clinics on the US/Canada border also prove attractive to anxious patients (Health Council of Canada, 2011).[16]

CROSS-BORDER CARE AS A LENS ON GAPS IN THE CURRENT HEALTH CARE SYSTEM

Demand for particular types of cross-border care can act as a lens on the current health care system. For example, in Ontario, bariatric surgery is a comparatively recent specialty that is becoming more widely available to patients. However, morbid obesity was becoming a significant health problem prior to 2009, when the Ontario MOHLTC made a commitment towards developing a Bariatric Registry and Bariatric Centres of Excellence. According to the Bariatric Registry project website[17] these Centres will reportedly increase capacity by over 750%, although no actual numbers are listed alongside these percentages. While waiting for the Centres to be created, bariatric surgery still remains listed as an out-of-country service, and preferred providers in the US are indicated.[18] But, Ontario's response to the high demand for bariatric surgery may be a demonstration that trends in requests for OOCC are used as an indicator of needed treatment or surgery in Canada, as well as a practical response to an increasing demand that could be justified through economies of scale. Analysis of the reasons why approval requests for OOCC are made may indeed provide useful information for system

planners and administrators of increasing trends in illness and/or growing demands to address health problems, keeping in mind that they may also be a reflection or result of policy decisions not to provide certain treatments in-country.

There are a number of issues with regards to ethics and the law that regulate access to new treatments in Canada (Somerville, 1999). However, the rapid availability of new information through the Internet and its associated technologies, have complicated these discussions. Groups of patients and their supporters who acquire knowledge of promising new technologies and surgeries that are being utilized outside of Canada may apply pressure to ministries of health and regulatory bodies such as Health Canada to offer these procedures in Canada or, at a minimum, to open up access to these technologies through OOCC programs. For example, in 2010, Dr. Paolo Zamboni's 'discovery' of CCSVI in patients with MS and its treatment through endovascular surgery, along with positive preliminary results of a study indicating a decrease in MS patients' symptoms, led to the procedure being encouragingly dubbed 'liberation therapy.' This led to a movement of Canadian MS patients to countries such as the US and India that offer the surgery, which has not been approved and thus remains unavailable in Canada (CTV.ca News Staff, 2009; Centre of Excellence for CCSVI Testing, 2011). In this example, knowledge of new treatments through the media and Internet has led patients and their families to form their own ideas of what they think they need to address their health issues. Public knowledge of enrollments in clinical trials, and participation in experimental treatments available outside the country, accompanied by anecdotal reports of improvements, has arguably influenced if not accelerated discussions of the science of such treatments, and has influenced decisions to fund research in these areas.[19]

From a different perspective, as a source of health care information the OOCC Prior Approval Program provides something other than filling a gap in health care services. According to the Ontario MOHLTC, physicians and patients often do not have information about services available in Ontario. Applications for Prior Approval Program are thus often resolved with information from the Ministry of the location within Ontario of the healthcare service sought.[20] The OOCC Program thus oddly fills a gap in critical information on healthcare

services available within the province, which preferably should be accessible by other, less time-consuming means.

As well as being described as a "generous program that serves a diversity of needs and provides a range of health care services to Ontarians seeking access to treatment outside the province" (Lindberg & Risk, 2007), implying that the Ontario MOHLTC may be doing more than is strictly required by the law, OOCC has also been described as a 'safety valve.'[21] Although 'safety valve' and its purposes are not defined by the MOHLTC, it suggests that OOCC can be used to address those gaps that surface for individual cases, but also for identifying and resolving health system problems more broadly. Indeed, this has been recognized outside of Canada by critics of Canada's single payer health system (Priest, 2009).[22] However, in providing a 'safety valve,' OOCC may divert attention from the provision of access to new treatments in Canada, and the building of new capacity to deliver these treatments, new treatments that may not be available neither in the patient's home province, nor in Canada as a whole.

QUESTIONS OF COST, HEALTH EQUITY AND A NEED FOR FURTHER RESEARCH

To this point, we have focused on the content and processes associated with OOCC, but additional questions regarding the costs of care need to be posed. Does the Canadian healthcare system provide the conditions for treating Canadians in the most cost-effective way? Or, conversely, does cross-border care lead to a distortion of the allocation of healthcare resources? Is out-of-country/cross border care a cost *driver* or a cost *saver* for the Canadian health system? The costs of administering and providing care in the US, which is the primary location for Canadian OOCC, is more expensive than in Canada (Woolhandler et al, 2011). However, OOCC is not currently viewed as a major cost driver for Canada's public healthcare system. According to the Canadian Institute for Health Information (CIHI), the "biggest cost increases in the system are spending on new drugs, medical technology, medical imaging, costly interventions and community services" (2010). None of these 'cost drivers' or 'cost escalators'

specifically includes spending on cross-border care, which is sufficiently small that it is included in the 'other' category of health expenditures (Conference Board of Canada, 2004). However, a report by the Canadian Health Services and Research Foundation (CHSRF) noted that "a substantial proportion of observed healthcare expenditure growth remains unmeasured" and information on cost drivers, referring to factors that drive healthcare expenditures, is limited (Constant et al, 2011). New technologies that are not available in Canada, for example, may lead to increased use of OOCC and increased costs. The CHSRF report, however, does not discuss any up- or down-sides of the use of hospital arrangements out of country.

Does medical travel, even when it is paid for by public plans, genuinely offer positive opportunities and overall benefits for health systems in either or both sending and receiving countries? We suggest there are ways to approach this question, but until the research is conducted, answers are merely speculative. One way relates to an economic evaluation of OOCC. When rare surgeries can be organized with skilled surgeons and the necessary equipment outside of Canada, does it make economic sense to develop rarely used capacity to perform the same surgeries at a high cost in Canada?[23] In a recent media report, the Ontario Minister of Health, Deb Matthews, addressed this point, noting that for rare cases and for cases in which Canadian doctors are 'not competent,' OOCC provides an answer for the treatment of rare and uncommon diseases or surgery. It can also facilitate diagnostic tests and rare or unusual pharmaceutical treatments that are not available in Canada (Light, Lexchin, 2005). [24] Canada's comparatively small provincial and territorial populations and subsequent limitations on provincially covered services and pharmaceuticals means it is more cost-effective to occasionally send citizens to New York State to obtain rare surgical care or the drug *Avastin* (Marin, 2009). Other routes for out-of-country treatment include enrolment in experimental surgeries or other forms of clinical trials.

BEYOND THE MOVEMENT OF PATIENTS: CONCLUSIONS

To understand the direct and indirect effects of publicly funded cross-border healthcare requires further research and understanding of the challenges to the current system of OOCC.

These include an increasing public knowledge and demand for new technologies and procedures, and the associated costs of meeting such a demand; the role of the media, appeal processes and legal challenges associated with the application of the legislation and guidelines, and other related laws and policies; and the familiarity of patients, their doctors and consultant specialists with cross-border provisions and agreements. Although travel by patients in the physical sense for some procedures may become a thing of the past, as long as the Canadian healthcare system plays catch-up with new technologies or procedures, or new technologies are so new that Canadians can only access them through clinical trials or experimental treatments elsewhere, and as long as waiting lists for certain procedures remain extensive, OOCC will likely still be needed as a 'safety valve'. Canadians, who have a publicly funded healthcare system, will continue to need certain types of care, and will likely demand and expect more of their healthcare system in the face of new technologies. They will also continue to test the extent of the state's responsibility for the public provision of healthcare. As a consequence, OOCC programs will likely be tested to their budgetary and conceptual limits.

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[1] See, for example, a public petition entitled "Patient battling OHIP over surgery" retrieved December 1, 2012 from http://humanrights4u.com/Hajinian.

[2] See, for example Ontario Superior Court of Justice. Divisional Court. Lederman, Swinton and Baltman JJ. Court File No.: 367/07, 599/06 and 620/07. Date 20090112. Retrieved December 1, 2012 from http://www.hsarb.on.ca/english/docs/legal/CCW_JFT.pdf.

[3] Bryan Meadows, for example, reports that "the use of telemedicine in the North West LHIN (a health authority in Northern Ontario) resulted in more than $9 million in avoided travel costs, and more than 23 million kilometres in avoided patient travel." This information can be found in the article, "Investments help keep health care close to home" from The Chronicle Journal, March 12, 2011. This article was retrieved December 1, 2012 from http://www.chroniclejournal.com/content/news/local/2011/03/12/investments-help-keep-health-care-close-home.

[4] It is noted that national health expenditures are reported based on which jurisdiction holds responsibility for payment, not on the source of the funds, with the exception of designated health transfers to municipal governments which are included in the provincial government sector. See Canadian Institute for Health Information, 2011.

[5] The municipal government sector expenditure includes healthcare spending by municipal governments for institutional services; public health; capital construction and equipment; and dental services provided by municipalities in the provinces of Nova Scotia, Manitoba and British Columbia (CIHI, 2011, p. 77 and p.95).

[6] Social security funds include the healthcare spending by workers' compensation boards, and other funds such as the premiums paid by the subscribers of the Quebec Drug Insurance Fund (CIHI, 2011, p. 77).
[7] It should be noted that the purchase of private insurance does not guarantee that the payment of costs are covered. See, for example the article, "Retired couple billed $50,000 despite travel insurance" from CBC news on November 16, 2011. This article can be found at http://ca.news.yahoo.com/retired-couple-billed-50-000-despite-travel-insurance-133857063.html.
[8] For example, see http://www.canlii.com/en/index.php.
[9] See for example, the Ontario Ombudsman at http://www.ombudsman.on.ca/Home.aspx. Accessed September 12, 2011.
[10] See for example, Kielar et al. 2010.
[11] See for example, Cilinger c. Quebec (P.G.) [2004] and R. v. Morgentaler (1988) Both cited in Jackman, M. (2010).
[12] Reference to the Canadian Charter of Rights and Freedoms Part I of the Constitution Act, 1982, being Schedule B to the Canada Act 1982 (U.K.), 1982, c.11 [Charter].
[13] Chaouilli v. Quebec (Attorney General) [2005] SCC 35 ["Chaouilli"].
[14] Jackman also noted that the Ontario Court of Appeal upheld the trial court's conclusion that lack of OHIP funding for all out-of-country medical treatments did not violate section 7 of the *Charter*.
[15] Outside of Canada, plaintiffs may pursue reimbursements through other laws, for example, in Europe, any resident (in Malta) is entitled to receive medical treatment in any EU member state at the expense of the Maltese Government (Xuereb, 2011).
[16] For example, through an organization called VIP Docs Inc., which has a Burlington, Ontario address, a Canadian patient can book an MRI or CAT scan at the Buffalo General Hospital, as well as advertising cross-border Canadian referrals to U.S. physicians for scans, assessments, surgery and treatments. The articles were accessed December 1, 2012 at http://www.buffalo-mri-cat-scans.com/ and http://www.vipdocs.com/request.htm.
[17] See website http://www.bariatricregistry.ca/.
[18] For the Ministry of Health and Long Term Care website, see here http://www.health.gov.on.ca/english/providers/program/ohip/outofcountry/us_preferred_providers/bariatric_services.html.
[19] See for example Health Canada (2011) Statement by Minister Aglukkaq on CCSVI and MS. June 29, 2011 Ottawa, Ontario Accessed from http://www.hc-sc.gc.ca/ahc-asc/media/nr-cp/_2011/2011_87-eng.php on December 1, 2012; Multiple Sclerosis Society of Canada (2010) stated that over $2.4 million committed to support seven operating grants to explore the relationship of CCSVI to MS. Information found at http://mssociety.ca/en/releases/nr_20100611.htm.
[20] Information obtained through personal communication.
[21] *Ibid*.

[22] See, for example, Goodman, J.C.; Herrick, Devon M. Twenty Myths about Single-Payer Health Insurance - International Evidence on the Effects of National Health Insurance in Countries around the World. Dallas: National Center for Policy Analysis. In this book, it is stated that "Canada uses the US as a safety valve for its overtaxed healthcare system, with provincial governments and patients spending a combined total of more than $1 billion a year on U.S. medical care." Information was accessed December 1, 2012 from http://www.debate-central.org/topics/2002/book2.pdf.

[23] This report was prompted by the case of 'Rose' from Markham, Ontario whose surgery to remove Tarlov cysts was performed in November 2010 by Frank Feigenbaum, a Kansas City US surgeon who had performed 'hundreds' of such surgeries. In addition, see March 21, 2011 article by Lisa Priest, "Ontario looks to change the rules for those with rare conditions" from the Globe and Mail. This article was accessed at http://m.theglobeandmail.com/news/national/ontario/ontario-looks-to-change-the-rules-for-those-with-rare-conditions/article1939555/?service=mobile.

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9 An Introduction to the Ethical Dimensions of Reproductive Medical Tourism

Raywat Deonandan

INTRODUCTION

Reproductive medical tourism is an emerging and ethically problematic phenomenon existing at the interface between commerce and clinical care. Defined by Ferraretti, Pennings, Gianaroli, Natali and Magli (2010) as "the traveling of citizens from their country of residence to another country in order to receive a specific treatment or to exercise personal reproductive choice," reproductive tourism occurs in many parts of the world and can involve the seeking of a variety of so-called assisted reproductive technologies (ARTs), including *in vitro* fertilization (IVF), intracytoplasmic sperm injection (ICSI), pre-implantation genetic diagnosis (PGD), gamete donation and surrogacy. For the present purposes, reproductive medical tourism is defined as an instance of a human being crossing an international border to seek an assisted reproductive technology service. According to this definition, the transport of gametes does not qualify, nor does travel for the purpose of gamete donation. Most commonly, travel for IVF, ICSI, sex-selection, PGD and maternal surrogacy are considered.

When the client seeking services is from a high-income country and the jurisdiction providing the service is a low-income country there is an added threat of potential exploitation, or at least of heightened ethical concern. This may be particularly true when maternal surrogacy is the service being sought, as it most blatantly abuts issues of female autonomy and reproductive rights, which are most immediate and prevalent in the global South.

MOTIVATIONS OF PARTICIPANTS

Matthias Helble of the World Trade Organization (WTO) points out that 'human body resources' are more available and affordable in low-income countries, where 'poor and vulnerable' populations are both available in large numbers and are perceived as being more willing than citizens of the global North to jeopardize their personal health for a small financial

reward (Helble, 2011). The provision of reproductive services is largely the domain of women, as ovum donation and surrogacy services are major components of the reproductive tourism industry: according to one source, 80 percent of Canadian IVF patients seeking care in the US were actually seeking donor ova (Whittaker, 2011). Further, an abundance of studies conclude that in vulnerable and economically disadvantaged populations, women tend to be the most vulnerable and powerless.

What is clear to observers is that residents of wealthy nations are travelling to less wealthy ones in increasing numbers for the purposes of seeking medical care of all types (Meghani, 2011). As Chapter 2 discusses, the exact size of the population crossing borders to seek care is unknown, but anecdotal evidence places it in the hundreds of thousands to several millions yearly (Helble, 2011). The complement seeking reproductive services specifically is unknown, but numbers in the tens of thousands in Europe alone (Whittaker, 2011) and, anecdotally, in the hundreds of thousands in Asia. While motivations vary from person to person, some generalizations can be made about the macro elements contributing to the movement of care seekers across borders: new developments in information technology that have facilitated knowledge of foreign care providers, globalization's effect on reducing travel costs, and trade liberalization policies at the state level (Helble, 2011).[1] Given that only 48 out of 191 member states of the World Health Organization (WHO) are known to have domestic IVF facilities (Inhorn, 2009), it stands to reason that an international reproductive tourism industry would arise.

The reasons for which individuals travel to another country for reproductive tourism are varied and include: the required services are not legal or available in their home country; they are not eligible for treatment in their home country; the efficacy of treatment is limited in their home country, or, the services in their home country have prohibitively long waiting lists or high costs (Ferraretti, 2010). The particular combination of reasons and the treatment sought will depend on the exact home country from which the person is travelling, along with the specific demographic characteristics and needs of the person desiring a child. Generally, the need to travel for ART is a combination of legal restrictions forcing people out of their home

countries and attractive services drawing patients to foreign countries to access reproductive services (Nygren, Adamson, Zegers-Hochschild & Mouzon, 2010).

Reproductive tourists seeking services relating to their own gametes share three major characteristics: the desire for a child who is genetically 'theirs'; the inability to produce this child through natural means; and, a willingness to expend significant resources to produce this child (Spar, 2005). On the other hand, the motivations for mothers in low-income countries to participate as surrogates have not been well studied. It is speculated that the primary motivation is financial, as Indian surrogates can make as much as US$6,000 (Johnston, 2008), which is substantially more than they would earn otherwise, though it is possible that feelings of altruism are also involved. There has been some anecdotal speculation that the participation of Indian surrogates is motivated or encouraged by a religious desire to help lift the 'curse' of infertility from their clients.

THE NEED FOR A DISCUSSION OF ETHICS

While this fast growing global industry has loci in the US, Eastern Europe, Latin America and Southeast Asia, India is one of the world's greatest providers, specifically of surrogate mothers. By some estimates, it is an industry worth US$500 million (Fontanella-Khan, 2010) to US$2.3 billion (Brenhouse, 2010). India's provision of surrogate mothers to high-income foreign clients is therefore ripe for ethical analysis, as it profoundly subtends an increasingly intimate relationship between medicine, business, finance, politics and an overall perception of the roles and rights of South Asian women.

Several attempts have been made to identify some of the factors informing an ethical analysis of this phenomenon, particularly as it applies to the case of surrogates arising from developing countries like India. The exploitation and objectification of women, the welfare of children produced through the procedure and the unregulated state of the industry have been identified as significant sources of concern (Bardale, 2009; Qadeer, 2009; Parks, 2010; Pennings, de Wert, Shenfield, Cohen, Tarlatzis, & Devroey, 2008; Humbyrd, 2009; Tieu, 2009). More

recent analyses have begun to consider the impacts on both the domestic and international public health systems (Whittaker, 2011).

Virtually all ethical analyses of medical tourism employ a Western liberal ethical framework, considering elements of autonomy and individual rights as suitable guideposts. The same approach is applied in this chapter, due mostly to the fact that informed consent, which can be considered to be a product mostly of the Western liberal framework, is a recurring theme surrounding surrogacy rights. There are, however, many limitations in employing this framework too narrowly for a global phenomenon because the Western liberal framework may be inadequate for application to all of medical tourism, "due to its over-individualistic nature" (Widdows, 2011a).

In some ways, reproductive tourism presents an excellent opportunity to both examine the conflict between Western and Eastern ethical frameworks, and to begin the process of developing a more global framework, which might be informed by the evolving constructs and concepts of universal human rights. A necessary first step is an acknowledgement of the existing ethical issues, presented from the well understood perspective of the Western liberal framework, which holds individual autonomy at its core. This chapter, as such, constitutes an initial presentation of these issues.

ETHICAL ISSUES

Misdirection of financial resources

Those who seek services abroad deny their resources (i.e., outgoing funds) to their home community, and instead offer them to clinics in destination countries (Turner, 2007). This aspect of the phenomenon applies, regardless of whether source and destination countries are of comparable wealth, and has rarely been discussed in the literature. When considered from the perspective of the 'tourist,' the issue becomes one of subtle libertarianism: one is free to spend one's money where one sees fit. However, from a policymaker's perspective, it is conceivable that a sufficiently robust global medical tourism industry may be seen as a financial negative for the society providing more tourists than it does service providers.

In one sense, reliance on another nation to provide healthcare for one's citizens frees the source nation from having to expend resources on its own domestic healthcare system. But medical tourists often spend their money more than just on medical services. The seeking of an invasive procedure, like a surgery or a pregnancy, likely requires a lengthy stay in the destination country, leading to further expenditures on that country's hotel and restaurant industry (Johnston, Crooks, Snyder & Kingsbury, 2010).

Thus, potentially, the departure of large numbers of citizens to seek care in another jurisdiction may be perceived as contributing to the budgetary deficit of the source country, by virtue of the tourists' failure to re-invest portions of their income into their home service industries; or otherwise contributing to trade imbalances that more recently have become a major concern with respect to global macroeconomic stability.

However, inasmuch as this transfer of wealth also applies equally to all types of tourism, whether medical or recreational, and given the present small scale of medical tourism, relative to other factors affecting most Western economies, this concern is likely trivial.

Misdirection of medical resources

While a clinician in a destination country is providing services to 'medical tourists,' they are, at that time, not providing services to their home community, even though citizens of the local community provided the investments and conditions that permitted the clinicians to assume their current status (de Arellano, 2007).

This aspect is well discussed in the literature. Oft cited is the Indian government's decision to use public resources to help develop that nation's robust medical tourism industry (Cortez, 2008). Those resources might have been more rightfully expended providing services to the Indian taxpayers. The obvious counter-argument is an economic one: that investment in developing services for medical tourists will eventually lead to greater economic wealth for a larger segment of the destination country, which will in turn lead to greater tax revenue and thus more resources for the betterment of the destination country's taxpayers. However, the author was unable to find empirical evidence of such trickle-down effects being demonstrated.

From a policymaker's perspective, the challenge is in distinguishing between the priorities of competing stakeholders. On the one hand, there is the need to encourage

independence in commerce and freedom to exercise one's skills set for the betterment of a wide clientele. On the other hand, there is the need to reserve resources for the citizens who, it can be argued, are part owners of the services their taxes helped to subsidize.

The issue is further complicated when it is considered that failure to provide medical services to foreigners may mean that those individuals may never receive services (depending upon their reasons for seeking cross-border care). When such services are medically necessary, then it can be argued that a practitioner has a moral obligation to provide them, regardless of the country of origin of the patient.

Clearly, how this issue is perceived depends upon the agenda and expectations of the agent whose perspective is under consideration. The priorities, responsibilities and ethical obligations of a policymaker are different from those of a clinician and those of the general citizen.

Implications of insufficiency

The act of 'tourists' seeking services abroad, implies that services are insufficient in quantity, type, timing or affordability, in the home country. When seating this observation as an ethical issue, the implicit assumption is that residents of the home country have a right to the services that they seek abroad. Failure to satisfy those rights, then, represents a moral failure on the part of the source nation's leadership.

Clearly, such an argument cannot apply to all forms of medical tourism. The "health as a human right" movement typically refers to basic healthcare only (Mpinga, 2011). When tourists are seeking exotic services deemed illegal in their home country, such as child sex-selection for Canadians (Department of Justice Canada, 2004), then their societies have explicitly stated, through an instrument of criminal law, that they in fact do not have a right to that service.

On the other hand, the seeking of life-saving interventions, such as surgeries or consultations with specialists, may be indicative of a deeper issue plaguing the source country; long waiting lists for life-saving therapies are a good example.

Implications of insufficiency are not so much an ethical issue as they are an indicator of a state's unmet responsibility. From a source country's policymaker's perspective, then, the very existence of medical tourism can be considered to be a sign of ineffectual policymaking. Failure

to act on such an indicator might subsequently be considered a moral failing or even a violation of legal obligations under international human rights treaties.

Criminality

If service seeking abroad is done to avoid prohibitions at home, then, in some circumstances, the provision of services to such a medical tourist might constitute the abetting of criminal behaviour. An argument can be made that if the activity is not illegal in the destination country, then no criminal activity has taken place. However, some societies have chosen to redefine the scope of criminality to include activities undertaken by a member of a society outside of that society's geographical limits.

The obvious analogy is to sex tourism. Many countries have enacted laws that enable their law enforcement to penalize citizens who go abroad and procure sex with minors. The United States' PROTECT Act of 2003 is an example of such a law (United States Government Printing Office, 2003). Clearly, it is possible to conceptualize the commission of a criminal act in a jurisdiction where that act is nonetheless legal.

The ethical transgression in the case of reproductive tourism can be examined from three perspectives. Firstly, given that the source country has deemed an act to be illegal (such as sex-selection, in the case of Canada) and therefore likely immoral, then, much like the case of child sex tourism, that nation may be ethically compelled to enforce its law upon all its citizens, regardless of their location.

Secondly, the tourists themselves, by virtue of seeking to avoid the technical criminality of their behaviour by changing jurisdictions, while nonetheless persisting in the moral transgression of the behaviour, may be considered to be acting in an unethical manner.

Lastly, the destination country is least complicit in this transgression, since its directives are internally defined according to the values of its citizenry and culture. Discussion of the potential complicity of the destination country leads to the unavoidable question of whether there exists a universal morality against which all local moralities may be judged. The framing of trans-border prosecution instruments, like the PROTECT Act, implicitly assumes universal morality, and thus denies a destination country the freedom to protect all within its borders from foreign prosecution.

This issue is most relevant when the source and destination countries are of unequal power, either in terms of wealth or international prestige. The inability to marshal a responsive judiciary or law enforcement, which is often a situation faced by less developed nations, presents an opportunity to establish a unidirectional flow of clientele from a more legally restrictive and wealthier jurisdiction to a less restrictive and poorer one. Again, the example of international sex tourism is most pertinent here, which the media tends to characterize as a flow of sex-seeking clients from rich nations to poorer ones.

However, gradients in legal restrictiveness can also exist between nations of comparable wealth and power. A good example is the phenomenon of abortion tourism. In 1998, more than 6,000 Irish women travelled to Britain to seek abortions, due to the latter's less restrictive policies (Payne, 1999). On a global scale, the wealth difference between Ireland and Great Britain is negligible.

From a strictly practical standpoint, the sidestepping of criminality is unlikely to be a strong issue with respect to medical tourism. The moral transgressions perceived to be implicit in the seeking of restricted medical procedures are likely not sufficiently inciting to warrant such extreme measures as trans-border prosecution. Even if they were, with the exception of specific surgical or organ transplant procedures, it would be extremely problematic to detect, prove and punish transgressions. For example, how does a prosecutor prove that a cross-border abortion took place, without first finding sufficient reason to conduct an invasive medical examination? And if an illegal reproductive service was sought, what does the prosecutor then do with the resulting child?

While criminality is theoretically problematic in the case of general medical tourism, it is a definitive ethical challenge for a case of reproductive tourism that transgresses a domestic law, and that results in the birth of a child. Policymakers would then be compelled to decide upon the disposition of the child, in the event that its creation was deemed to be illegal. It is an ethically, politically and legally chilling scenario.

Quality control

Inconsistencies in the quality of medical services will occur between jurisdictions. A tourist seeking a service in a foreign jurisdiction may not receive the same standard of care he

would have expected in the home country. A resident of Canada, for example, may feel compelled by the long waiting lists at home to seek surgery in India, and may experience a different standard of surgical skill and post-operative care. Patients seeking transplant tourism require a regimen of immunosuppressive post-operative care that might not be as robust in a developing world setting as it is in the home country (Schiano & Rhodes, 2010; Polcari et al., 2010). The agents acting in this moral framework are the governments of both the source and destination nations, and the emerging medical tourism brokerage and insurance companies that serve as intermediaries between domestic clients and foreign patients. In the case of reproductive tourism, often tourists are emotionally vulnerable and thus susceptible to inflated success rates marketed by less circumspect clinics. The extent to which source governments have a responsibility to protect their citizens who go abroad to seek such care is debatable, but may constitute the essence of the government's responsibility to its immediate stakeholders, its citizenry.

Similarly, the extent to which destination governments and clinics are responsible for moderating expectations, in terms of both success rates, pleasantness of the medical care environment and comprehensiveness of post-intervention care relative to the standards expected in source nations, constitutes the core of their ethical responsibility to the arriving patient, which is separate from their responsibilities to the clinicians who operate under their rubric and to the surrogates or gamete donors who are their immediate constituents. In cases in which the source country is wealthier than the destination country, client expectations with respect to hygiene, pollution, diversity of services and diet, and other luxuries taken for granted in the developed world must be managed by the clinician and indeed by the destination culture. The extent to which a poorer nation can meet the standards expected by the wealthier client can be considered the joint responsibility of both the clinician and the destination state.

On this topic, the literature has focused on the role of brokerage and insurance companies, as in Turner's paper on regulatory oversight of medical tourism companies (Turner, 2011). In brief, establishing high standards of oversight for such companies can reduce their role in skewing tourists' expectations and thus their risk.

It can be argued, however, that there is an overt responsibility on the part of destination policymakers to manage client expectations, inasmuch as failure to do so may constitute 'false advertising' and thus a kind of passive coercion. Similarly, there is a rational expectation by the citizenry of the source nation that its policymakers will take seriously the possibility that travelling citizens may be harmed by the poorer medical quality offered in foreign clinics.

Coercion

The seeking of trans-border care is an extreme response to particular medical duress. A seeker of care is therefore vulnerable to coercion and exploitation. For example, when one is seeking life-saving surgery abroad (perhaps due to lengthy waiting lists at home), one is more likely to accept the heightened risk of receiving that surgery at a less experienced or less well equipped clinic, in exchange for a shorter wait time. Clearly, this is related to informed consent; ideally, an element of that consent must include a true understanding of a procedure's risk, untainted by one's extreme emotional state. In the presence of a tourist's emotion, it is possible for a less circumspect clinic or broker to minimize or avoid discussion of the limitations or risks of their service provision.

Moreover, in the case of reproductive tourism, unlike other forms of medical tourism, care seeking is most often done by couples or families, and not by individuals. This introduces the problematic possibility of a spouse placing undue pressure on his partner to seek risky services. The extent to which providers or brokers manage this possibility is profoundly uncertain. In this context, a broker can be an insurance company that mediates between a tourist and the destination clinic, a third party that finds and negotiates for gamete donation or surrogacy service, or indeed the gamete donor or surrogate herself.

Within the Western liberal framework, coercion of any kind is an ethical violation (except, it can be argued, in some cases in which a degree of coercion or misdirection is employed to encourage someone to seek needed care that he or she would otherwise not receive). Overt coercion is easily identified. But it might also be argued that systemic factors can produce a coercive environment such that there is an illusion of choice, as in the case of an environment of poverty removing any real choice from a woman who must turn to prostitution to earn a living. Organ transplant tourism has been identified in the literature as a phenomenon

that is particularly vulnerable to coercion (Stephan, Barbari & Younan, 2007). The responsibilities of consanguinity or appeals to guilt can be used to coerce participation.

More immediately, coercion is oft masked by informed consent, as will be discussed in further depth later in this paper. In her critique of the Western framework's fit with current and emerging global trends, Widdows suggests that informed consent, as it is commonly practiced, "fails to take account of the context and commitments of individuals which may constitute inducement and coercion" (Widdows, 2011a, p. 83). She argues that focus on the individual makes the concerns of others invisible, an argument that has relevance in medical tourism scenarios involving the provision of services by members of non-Western communities. Organ donors and surrogate mothers are good examples of individuals whose decisions, while individualistically defensible, may have impacts on their non-consenting community members. In other words, to recognize coercion in all its forms, it is necessary to also recognize structural and context-related ethical injustices.

Violation of destination country's moral paradigm

Cultural change can arise from the introduction of new technologies. Reproductive technologies in particular have the potential to introduce secular and individualistic concepts and behaviours to societies unfamiliar or uncomfortable with such developments. Examples include ART's power to easily create single parent households and same-sex parented families.

India is a good example of a nation whose communities are experiencing rapid change, often as a result of external forces. While homosexual unions have recently been decriminalized under Indian law, there are reports that the Indian government is preparing a Bill that would prohibit same sex foreign couples from using surrogacy services in India, so long as same-sex marriages remain unlawful in India (Wade & Walters, 2010). This suggests that reproductive tourism is introducing social patterns that are unfamiliar, and in some circles undesirable, to the destination society. The economic gradient represented by the industry is perhaps accelerating the introduction of these issues to societies that otherwise would have discovered them at their own pace.

The extent to which this is indeed an ethical issue depends upon whether one considers prevailing or majority cultural norms to be sacrosanct. If so, then all agents involved in the

transaction are transgressing the destination country's moral paradigm, from the tourist to the service provider and both of their accommodating governments. On the other hand, if cultural relativism is not in play, or if one accepts that a culture is not defined by its most conservative or indeed its majority viewpoint, then the cultural change brought about by medical tourism is not an ethical concern, but rather a social catalyst that accelerates a change that likely would have occurred eventually anyway.

One cannot fully consider this issue without abutting the greater question of whether there exists a universal morality, or at least a shared set of values toward which all nations should tend. This is, in some ways, a neo-colonial manifestation of the Western liberal framework, inasmuch as the acceptance of a universal morality necessarily vitiates any sense of cultural relativism while simultaneously celebrating the rights of the individual. Universal same-sex rights are an example of this tension: if these rights are indeed universal, then reproductive tourism is a tool of liberation; if they are not universal, then the industry is a tool of imperialism, or at least of problematic social disruption.

Applicability of the adoption standard

In most nations, the state, as custodians of society's values, insists upon vetting parents for fitness when individuals seek to adopt. The criteria vary, but tend to involve measures of psychological fitness, economic health and stability of the home life. In the case of an individual or couple using ART to obtain a child, however, no such formal governmental vetting process is applied in most countries. In Western clinics, psychological screening is done at the discretion of the clinic.

The two scenarios differ in that one involves the welfare of a child who already exists, but whose care is managed *in loco parentis* by the state prior to adoption. In the other case, the point of the intervention is to biologically create a child. They are similar, though, in one key sense: in both scenarios, an external party is required to allow the suitor to achieve parenthood. In the first case, that party is the state and an adoption agency; in the second, it is the fertility clinic, in some ways acting as an agent of the state.

When assisting a client to create a child, there is the ethical question of how much responsibility the clinic or the state accepts in determining how qualified a patient is to be a

parent. A history of abusive behaviour is an obvious example as a potential disqualifier; but softer criteria, such as economic wherewithal, may also be applicable, as they are when considering an individual's fitness to be an adoptive parent.

In the case of reproductive tourism, it is possible that both the states of the source country and the destination country bear responsibility for assessing the suitability of a 'tourist' to essentially be given a child through the intervention of ART. This is a most profound ethical question that relates to the oft-heard cry for the welfare of the child to be more carefully considered when developing ART regulations (Bardale, 2009). Welfare concerns include the economic health of the household, the mental health history of the parent, and the extent of family support, emotional and otherwise, available to the child.

This issue is contextualized within the larger debate of whether parenthood is a right or a privilege. Proponents of the former also argue that aspects of ART, possibly even extending to support for reproductive tourism, should be paid for by the state, whose responsibility it is to ensure that all citizens' rights are upheld. But the correlate to this position is that acknowledging the state's responsibilities necessarily allows the state to apply "non-medical considerations into account in determining whether or not an applicant is entitled to this service, particularly in cases where the applicant seems to lack mothering ability" (Statman, 2003, p. 224).

Robustness of informed consent

Informed consent is in many ways the fundament that seats these analyses within the Western liberal, or individualistic, framework. Legal requirements and definitions will vary between jurisdictions, affecting the extent and nature of risk communication. The adequacy of such communication represents a challenge to the robustness of the informed consent of the reproductive tourist. Many documented instances abound of medical informed consent being variably applied across different nations and populations (Krosin, Klitzman, Levin, Cheng & Ranney, 2006). There is no certainty that a tourist will receive the same level of health communication that she would have expected in her home country, and therefore no certainty that her consent to receive therapies that may carry risk would indeed qualify as informed, by Western standards.

Informed consent, as it pertains to the surrogate, is quite separate from that pertaining to the 'tourist.' Traditionally, informed consent involves the communication of risks and benefits contextualized within the medical domain (American Medical Association, 1995). Challenges to informed consent have tended to focus on the quality and clarity of communication and the avoidance of coercion, subtle or overt (Krogstad et al., 2010); though, as discussed above, consent can be used to hide some kinds of coercion. These factors are certainly at play with respect to reproductive tourism, especially given surrogates' tendency to be economically vulnerable, illiterate, and susceptible to the neo-colonial motivator of an impressive medical authority figure.

Given the centrality of informed consent to almost any argument in favour of purchasing the reproductive services of poor, developing-world women, it is unavoidable that the industry will tend to be conceptualized within a Western liberal framework. Ultimately, the discourse concerns the tension between the individual rights of the surrogate and 'tourist' to negotiate a commercial relationship, and the responsibilities of policymakers, clinicians and civil society to ensure that the industry is not simply a new face of neo-colonial exploitation.

The legacy of colonialism is difficult to disentangle from the experience of reproductive tourism, especially when the destination country is a former European colony, such as India. Perspectives from Africa suggest that a combination of poor literacy and a colonial heritage combine to make informed consent problematic (Gong et al., 2008). The same forces apply in India, where an authority figure modelled on an image of Western power, such as a doctor, is afforded automatic deference.

An additional concern is the failure of the medical informed consent model to consider that downstream social risks and impacts must also be communicated; simply expressing the biological risks may not be sufficient to attain full, defensible consent. Surrogates are known to face the risk of social shunning (Lycett, 2009). Examples include the possibility that a surrogate's community, spouse or family may object to her carrying the child of a man other than that of her husband, or the child of a homosexual couple. Media reports suggest that rural surrogates are often accused of adultery and face being ostracized by their community (Hochschild, 2009).

Arguably, the risk of shunning or of other kinds of unpleasant experiences should be encapsulated within the process of acquiring the informed consent of the surrogate.

The obvious legal concern that arises if the informed consent process does indeed manage to include discussion of all possible dangers, including social and emotional risk, is that an individualistic legal system might conclude that an expression of autonomy includes the right to exercise one's autonomy to allow one's own exploitation. In other words, the legal expression of informed consent not only gives the surrogate a better sense of the real risks she will face, it also provides legal cover for the clinicians and 'tourist' who will then place her in a position of danger. Informed consent can be used to vitiate legal responsibility, which is often misunderstood as a vitiation of moral responsibility, as well.

In many ways, informed consent is the philosophical battlefield on which a new ethical framework for reproductive tourism must be won. Presently, the individualistic Western model prevails and holds that so long as a surrogate expresses understanding of her risks, and so long as the clinician, 'tourist,' state and brokers make a reasonable effort to fully convey those risks without a sense of overt coercion —and reasonably believe that their words were understood—then the procedure, however risky, is sufficiently ethical.

However, several factors confound that perspective: three are most pertinent. First, as mentioned, social risks and emotional risks can be as damaging as physical ones; communication of all kinds of risk, not just the biological, is indicated. Second, since many surrogates, especially those provided by Indian clinics, are poor and possibly illiterate, the economic and power differential between surrogate and clinician, or 'tourist,' is extreme. In such instances, the traditional threshold for accepting consent may not be high enough; additional and perhaps extensive measures are perhaps required to better ensure complete communication of risk, complete understanding of risk, and appropriate balance of real risk against the blinding lure of life-changing compensation.

And third, when dealing with a cross-cultural transaction, the Western perspective of individual autonomy may need to give way to the possibility of including the voices of other stakeholders in the provision of informed consent. The surrogate's existing children, husband, greater family and indeed her neighbours may have a stake in the decision she makes. In the

new bioethics that may emerge as reproduction tourism faces its legal and social challenges, the individualistic elements that presently characterize Medicine's legal and ethical practice may need to be enhanced by some context— and community-based elements — if informed consent is to have any real meaning on this new front.

Custody rights

Laws concerning the custody rights of a surrogate vary from country to country and sometimes between provinces or states within a single country. For example, the US State of Michigan's Surrogate Parenting Act (Michigan Legislature, 1988) does not allow for courts to recognize surrogate parentage contracts, meaning that the surrogate has strong rights with respect to potential custody. On the other hand, Indian law has been quite robust in recognizing the legality of the surrogate contract (Ramasubramanian, 2011), thus providing more assurance for the reproductive 'tourist.'

Arguably, a nation with laws disfavouring the surrogate and favouring the client is a more attractive destination for a reproductive 'tourist' seeking the smallest set of legal barriers to receiving a child. As reproductive tourism grows in economic importance, the extent to which a nation's custody and adoption laws become informed and influenced by the needs of the reproductive tourism industry need to be considered.

This is potentially an ethical concern because the responsiveness of the destination state to the needs of its citizenry may be co-opted by the needs of the industry. While the influence of big business on government policy is not unusual, it is nonetheless regrettable when the rights and needs of poor and vulnerable women are in play. Both source and destination societies should be on guard for the creep of commercial interest into the passing of laws meant to address societal values beyond mere financial wherewithal.

Quality of surrogate care

While it is likely that different clinics embrace different models of care, it remains uncertain to what extent a surrogate's health is maintained beyond her gestational role. It is reasonable to expect the client to fund the nutritional requirements of the surrogate, as her physical health relates directly to the health of the child she gestates. But her needs probably extend beyond the physical. What of her social and mental health? If her role as a surrogate

requires her to change her diet and perhaps alter her daily physical activities, it is possible that these changes impart an emotional impact. Moreover, her regular domestic familial duties may be affected by her role as a surrogate; the extent to which the stresses of these dual roles are dealt with by the client and clinician constitute an ethical question.

Unfortunately, it is difficult to find concrete examples of actual transgressions in this category. There are very few published studies of the care and home conditions of surrogates in the developing world. But even just theoretically, it is clearly foreseeable that a commercial model that employs a surrogate as a means for the creation of a child will have financial disincentives for expending resources on her beyond that which is necessary to produce a healthy child.

Limits of surrogate care

Related to the issue of quality of care is the point at which surrogate care ceases. While the surrogate's medical health is of prime importance during pregnancy, there is a moral argument for assuring that that care extends beyond the delivery. Given the likelihood of postpartum injury or depression, it remains uncertain who is ultimately responsible for assuring that a surrogate is given sufficient care to recover from such conditions. Obstetric anal injury (Marsh, Lynne, Christine & Alison, 2010) and postpartum haemorrhaging (Gei-Guardia, Soto-Herrera, Gei-Brealey & Chen-Ku, 2010) are examples of post-delivery health threats that would not be uncommon.

Postpartum injury is the direct result of a process begun by the tourist and clinician for the purposes of achieving a biological product for the tourist. It can be argued that, since such injury is a foreseeable consequence of the overall process, both avoiding and repairing such injury is the logical responsibility of all agents involved, and not just of the surrogate herself.

A corollary to this issue is the question of the economic incentives for maintaining a surrogate's health well past delivery. A woman with proven gestational ability is an asset to a clinic that employs surrogates; thus, it is rational for that clinic to ensure her continued health and gestational capacity. It is interesting that an economic argument would perhaps be more compelling than an altruistic one for ensuring proper extended care for a post-delivery surrogate.

Remuneration

One likely reason that a reproductive 'tourist' seeks service abroad is reduced cost, made possible in part by the lesser financial demands of surrogates who may live in economically distressed circumstances. The economic gradient that is at the heart of this commercial enterprise is ultimately subject to the forces of globalization. But while remuneration for the surrogate is likely above what she would otherwise earn, it is likely below the global average. The concept of "fair trade international surrogacy" (Humbyrd, 2009) addresses the choices that the client can make to improve the probability of an ethical transaction, but could be further enhanced by including an argument for either voluntary or compulsory standardization of global surrogacy fees, thus reducing the economic gradient.

Humbyrd's 'fair trade surrogacy' model seeks to apply the lessons of 'fair trade coffee' to the reproductive tourism industry. In short, pricing would be set to "a fair price in the regional or local context" (Humbyrd, 2009). The 'fair trade' label would presumably then be used to market the service to more equity-minded clients. It is unclear whether such a model would indeed alter the present pricing dynamic; and concerns exist over the potential for 'fair trade' labelling generally to be used as a marketing tool that, using coffee as the exemplar commodity, maximizes profits along the value chain but only minimally improves returns for the original producer (Bando & de los Rios, 2007).

Multiple Embryo Transfers and Abortion

Selective reduction is not an uncommon occurrence in ART (Min et al., 2010), especially in instances where multiple embryos are desired. The extent to which a surrogate is encouraged to accept multiple embryos, in order to maximize the probability of a successful implantation and thus reduce the costs to the client, is a factor influencing both the autonomy of the surrogate and the nature of her informed consent. Related is the possibility for a selective reduction abortion, done for several medically defensible reasons. It remains unknown whether surrogates from conservative cultures are either aware or culturally responsive to this likelihood.

This issue is an overlap between the earlier discussed issues of insufficient informed consent and potential coercion. Being informed of the risks of multiple embryo transfers and of

the likelihood of selective reduction is important, though whether an uneducated rural dweller with limited exposure to biotechnologies would truly grasp the risks being communicated is always an issue.

Coercion may manifest as pressure to accept multiple embryos. A multiple pregnancy is a dangerous medical condition that is avoided by fertility doctors in the West (Schieve et al., 2002). Yet it is attractive as a cost saving measure, since more transfers raises the chance of a pregnancy and reduces the number of attempts needed to become pregnant (Hurst, Shafir, & Lancaster, 1997). Thus there exists the possibility that tourists will view a poor foreign surrogate as an opportunity to confer risk upon someone else while simultaneously reducing the cost of the venture.

Medical advocacy

Perhaps the most blatantly problematic, and ironically the most easily addressed, of the likely ethical pitfalls of surrogacy tourism is the model for clinical supervision of the pregnancy: the clinic receives payment from one party (the 'tourist') and performs a procedure on a second party (the surrogate). In other words, the clinic as an entity represents both the paying client and the paid surrogate. But several stakeholders, with potentially competing interests, are at play: the primary client ('tourist'), his or her spouse, the surrogate and, of course, the child resulting from the process (Deonandan, Green, & van Beinum, in press).

The potential is great for conflicts of interest, especially when clinical decisions must be made that weigh monetary cost to the 'tourist' against the physical well-being of the surrogate. In such scenarios, the cynic would suspect that the interests of the paying 'tourist' will prevail, even to the detriment of the health of the surrogate. At the very least, the incentive for such favouritism is financial, whereas the sole disincentive is moral. (As a corollary, perhaps this conflict of interest, or the extent to which it represents a potential risk to the health of the surrogate, is one of the dangers that should enter into the informed consent process.)

In the absence of an independent advocate, the surrogate is essentially being treated as an independent contractor who must bring her own expertise and resources to the business relationship. The clinic, in this sense, acts as a negotiation arbitrator or an intermediary through which a commercial transaction takes place. Beyond the clinic's legal and professional

requirements of good care, conceptually the surrogate's interests are limited to those which she manages to negotiate a priori.

In this scenario, the ethics at play are business ethics, not medical ethics. In business ethics, so long as full disclosure and fair play are in effect, all actors must be content with the scenario negotiated before the actual act of business; and all actors are expected to consider only their own needs, not the needs of the other party. The arbitrator's role is to enforce fairness. But in medical ethics, a clinic's role is to provide continual good care throughout the duration of the patient's presence within that clinic's sphere, always acting in that patient's best interests. A clinic is not equipped legally or experientially to act in the role of broker or arbitrator, nor is it empowered to do so via the tradition of medical ethics that has evolved over the past decades and centuries.

Beyond the confusion relating to informed consent, herein lies the second major challenge faced by reproductive tourism: to find a comfortable space between medicine and commerce, utilizing a hybrid ethical framework that refuses to compromise the essential role of a clinician, which is to always act in the best interests of the person under care, with respect to her health.

One possible solution is to assure that each surrogate is given the support of a separate medical advocate to counterbalance the great power held by the 'tourist' to influence decisions made about the surrogate's health. The evolution of such an advocacy model has yet to begin.

Exploitation of the Poor

When one hears of travellers from the developed world paying very poor women in the developing world to carry their babies, it is difficult not to wonder if this is a case of exploitation. There is a tension here between the libertarian view of free choice versus the sense that choice may be economically coerced. Fundamentally, the question is, is it moral to leverage poverty to receive a service that might not otherwise be offered or be affordable?

Similar arguments have been put forward for condemning prostitution, especially amongst impoverished peoples. The assumption underlying this condemnation is that no one would choose to sell sex, or to rent their wombs, if there were any other economic options.

This is, of course, the core of the Western liberal ethical framework, to consider the individual's right of unhindered choice to be sacrosanct. In other words, so long as the provider of the service, whether it is a womb or sex for money, does so of her own free will, then the transaction is likely ethical. It is the nature of choice that is philosophically problematic: can there be genuine choice between two options if one of the options is profoundly unbearable, such as starvation? In the case of surrogacy tourism, it is the extent to which financial need plays a role in the surrogate's choice to participate that remains in question, as well as whether that extent really is a rational metric to employ when making an ethical determination.

There are most definitely instances of altruistic surrogacy, especially in nations like Canada in which paid surrogacy is illegal. So the temptation is to assess each instance of cross-border surrogacy on a case-to-case basis, which is both impractical and ultimately misleading, since there are indeed larger population observations that can shed light on the phenomenon. For instance, Indian surrogates are seemingly universally poor (Bardale, 2009), suggesting that the prime motivator is indeed economic, not altruistic.

Given that financial need is indeed the basis for surrogates' eagerness to participate, is it then ethical to use this need to encourage participation? Conversely, is it ethical to deny an impoverished prospective surrogate the opportunity to lift herself and her family out of poverty simply because one decides that financial need is an inappropriate lever? Is that, too, not a kind of neo-colonial arrogance, perhaps masquerading as 'liberal guilt?'

To use someone's poor state in life to leverage an outcome or behaviour that that person would not otherwise offer is indeed exploitation. Viewed from a business ethics standpoint, this is fair play, as the game of commerce is about negotiation from a position of power. However, as in the case of medical advocacy above, it is clear that reproductive tourism represents a grey frontier on which the ethical frameworks of business, medicine, human rights, and cultural collisions dance to an unsteady rhythm. Is it possible, then, to be simultaneously both exploitative and ethical?

In the spirit of that question, Humbyrd suggests that we need to distinguish between harmful exploitation and mutually beneficial exploitation, and feels that reproductive tourism is of the latter camp (Humbyrd, 2009). He concludes that the international surrogacy market

needs to be regulated to ensure that the exploitation continues to be a mutually advantageous one. While it remains uncertain whether the purchasing of the reproductive capacities of impoverished women is indeed ethical, it is abundantly clear that consideration of this issue is complicated by the competing frameworks and paradigms of different professions and traditions. Even if reproductive tourism, and notably the use of Indian surrogates, is found to be unethical for any of the reasons discussed in this chapter, the market for such surrogacy already exists, the poverty driving Indian women to act as surrogates is not going to disappear in the near term, and regulating the practice towards more mutually beneficial and less unethical ends may be the most ethical 'second-best' alternative.

CONCLUSION

While this analysis has been largely critical of the reproductive tourism industry, it is important to point out the benefits that the industry represents. In addition to providing possibly extraordinary income to poor surrogates who might otherwise be destitute, the industry provides an affordable opportunity for addressing the infertility of clients who would otherwise not have their needs fulfilled. In addition, destination communities receive foreign currency, create new job opportunities for locals through linkages with tourism, insurance, hotel and services business, and the retention of specialists who might otherwise emigrate for lack of wealth-generating opportunities (Whittaker, 2011).

Ethical questions around procreative tourism have heretofore focused on the tension between autonomy at one end of a spectrum of choice, and exploitation at the other end. In other words, the extent to which freedom of choice justifies the risks posed by these activities has been examined (Deech, 2003). The role of government is also oft discussed (Deech, 2003; Mulay & Gibson, 2006). Some effort has been made to explore the ethical dimensions related to restricting the industry (Pennings et al., 2008), and to describing the role of the client in examining her own role in ensuring an ethical reproductive transaction (Storrow, 2005).

The most pressing concerns are the limits and genuineness of informed consent for both the 'tourist' and the putative surrogate, and the uncertainty surrounding the extent of

independent advocacy enjoyed by the various stakeholders in the process, the surrogate prime among them. The latter is an issue that can be readily addressed by law or by voluntary policy changes at the clinic level; or indeed by choice of the client, who can insist that any engaged surrogate be given independent counsel, the price of whom would be included in the client's package.

As the global reproductive tourism industry expands, it becomes increasingly incumbent upon both government and civil society to take immediate steps to explore options for mitigating the many ethical challenges with which the phenomenon presents us.

The employment of a Western liberal ethical analytical framework is limiting to the extent that the cultures providing these services may not abide by the same value system. A useful subsequent analysis would be a comparison of ethical observations, within the reproductive tourism domain, from both Western liberal (individualistic) and community-focused (or non-Western approaches, the latter as defined by Widdows (Widdows, 2011b).

The reproductive tourism industry is new, but growing rapidly. Many have moral and ethical concerns, while others see opportunity and the potential to both treat infertility and to alleviate poverty. What is clear is that the phenomenon shows no signs of disappearing. Thus, the elucidation, acknowledgement and analysis of existing and potential ethical transgressions is a vital phase in the evolution of a global culture for the monitoring and control of the industry, as well as for the protection of all stakeholders.

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[1] However, as the chapter by Blouin in this volume discusses, most of the 'trade' in medical tourism is taking place outside of any formal trade liberalization agreements. The one exception to this may be the role played by bilateral investment treaties or Mode 3 commitments under the WTO's General Agreement on Trade in Services in facilitating foreign investment in commercial health facilities catering to international patients.

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10 The Impact of Trade Treaties on Health Tourism

Chantal Blouin

INTRODUCTION

In the last decade, there have been concerns about the impact of international trade agreements such as the General Agreement on Trade in Services (GATS) of the WTO on health systems: more precisely, analysts have highlighted the risk that committing to liberalisation of health-related services in a trade agreement may constrain the capacity of national governments to adopt public policies to protect public health and improve health systems (Blouin, Drager & Smith, 2006). Similarly, the rise of health tourism has led some scholars and policy experts to caution about the dangers of exporting health services: catering to foreign patients may drain human and financial resources away from domestic patients, without direct benefits for the domestic health system (Blouin, 2010).

This chapter examines the extent to which trade agreements can impact on health tourism. Given the nature of such trade, i.e. that the patient travels to the country where the services are delivered, it may seem that there are very few barriers to trade in this area, as patients are free to leave their country to purchase services abroad. A priori, it may appear that trade liberalisation, as undertaken in trade treaties, does not have a significant impact. However, there are two policy levers available to national governments which can create barriers to trade in medical tourism.

The first potential barriers to trade are constraints and limits on foreign investment in the health sector. Health tourism is often provided in clinics or hospitals that are wholly or partly owned by foreign investors. The first section of this chapter examines the levels, nature and the impact of trade commitments governments have undertaken in trade agreements, focusing on foreign investment in health-related sectors. The discussion focuses on the commitments at the WTO and whether countries that have been leaders in health tourism are also those with the strongest commitments in health-related sectors. It should be noted that some medical tourism does not involve foreign investors. For instance, many private hospitals in

India providing care to foreign patients are owned by Indian investors. Nevertheless, limiting the capacity of foreign investors to establish or buy healthcare facilities constitutes a significant barrier to health tourism.

The second potential barrier to health tourism is insurance portability. Foreign patients usually pay for healthcare services with their own resources, as public or private insurance programs in their country of residence usually do not cover non-emergency healthcare abroad. However, only a limited number of patients have the financial resources to afford travel expenses and the out-of-pocket payments for health services. Increasing the portability of private and public insurance would therefore greatly stimulate growth of medical tourism.

In a survey of medical travellers conducted by the consulting firm McKinsey, more than 70 percent of those seeking healthcare abroad were motivated by quality or access to advanced technology; they were typically travelling to the US to receive care (Ehrbeck, Guevara & Mango, 2008).[1] Faster access to healthcare and the lower-cost of the procedures were cited by only a small number of health tourists as the driver for seeking care abroad (respectively 15 percent and 9 percent of the respondents). Nevertheless, given the lower costs of medical services offered in developing countries, the report suggests that there is a great potential for growth in the number of patients travelling to reduce their healthcare costs or their wait times, if their private or public insurance scheme would cover elective care abroad. The chapter will examine to what extent insurance portability has been part of trade negotiations.

FOREIGN INVESTMENT

Creating a business environment favourable to foreign investment in health services can have a direct impact on the growth of health tourism. Even though public healthcare establishments and healthcare establishments owned by domestic investors offer services to foreign patients, foreign investors have played a key role in the growth of this type of trade. The linkages between health tourism and inflows of foreign investment in health services are well illustrated by the case of Thailand. Indeed, the Thai government promoted foreign investment in private health facilities in the late 1980s through taxation incentives. This policy,

coupled with the economic boom during the period 1989-96, resulted in an expansion of the number of urban private hospitals; between 1987 and 1997, 190 hospitals were established using this tax incentive (Buddhasri, Saithanu & Tangcharoensathien, 2003). After the 1997 economic crisis, some private hospitals started implementing new marketing strategies based on packaged services; foreign patients were the primary targets. Health tourism grew quickly and in 2007, more than 1.3 million foreign patients visited Thailand to receive care (Arunanondchai, Pachanee & Akaleephan, 2007).

When reflecting on the impact of trade treaties on health tourism, we should remind ourselves that the binding commitments national governments undertake in the context of a trade agreement do not automatically translate into a higher level of trade, or in this case, stronger exports of health tourism. A large amount of literature on economics examines and debates the impact of trade agreements on actual trade flows, especially as one of the first empirical tests was unable to find evidence that membership in the General Agreement on Tariffs and Trade (GATT)/WTO had an effect on international trade (Rose, 2002). Subsequently, more sophisticated tests have shown that in many cases, being party to trade agreements does lead to greater trade (Subramanian & Wei, 2007). However, very few empirical studies have focused on the impact of WTO commitments on investment and trade in services, including trade in health services (see for instance te Velde & Nair, 2006). Economists may have evidence that removing barriers to international trade in services will lead to greater inflows of capital and greater level of trade (Mattoo, Stern & Zanini, 2008), but the impact of the decision to list these liberalisations in a binding agreement has not been subjected to the same level of investigation. Nevertheless, the main view is that these commitments play the role of 'insurance policy' where foreign investors are guaranteed that the rules of entry will remain the same; the increased predictability associated to this market access commitment is expected to increase the foreign investment in the sector.

What is the state of commitments on investments in health services at the WTO? Reading a schedule of commitments requires several analytical steps. First, social and health-related social services make up the first of twelve categories of sectors within the GATS. Other categories include transport, communications, distribution, environmental, business, financial,

educational, construction, and recreational services. Relevant categories for health tourism also include health insurance services under financial services and retail of pharmaceutical drugs under distribution services.

For each sector, members of the WTO can fine-tune their commitments by sub-sectors, by modes of supply and by types of commitment.[2] For instance, a government can decide to make a market access commitment in hospital services for services provided through mode 3 (establishment of commercial presence) and not to make any commitments under the sub-category services provided by nurses and midwives under mode 4 (temporary movement of providers). Moreover, restrictions can also be added to the schedule of commitments. For instance, foreign investment can be capped to a specific amount or percentage of ownership or limited to establishments with a certain number of beds, professionals can be subject to language testing and entry can be conditional to a local or economic needs test. Finally, we additionally should note that WTO members can also take horizontal commitments; these are commitments that apply to all services sectors. Restrictions on foreign investment can be included in these horizontal commitments. For example, a limit to 49 percent of equity can be imposed on all services sectors if listed in the schedule of horizontal commitments.

When assessing GATS commitments overall, it appears that the health sector is one of the services sectors where members of the WTO have made the least commitments (Adlung, 2009). As of 2009, 66 countries had some commitments under medical services, 35 under services provided by nurses, midwives and other professionals, and 58 under hospital services. Most of these are 'partial commitments,' i.e. subjected to restrictions and limitations. Health insurance has often been the subject of commitment, with more than 100 countries registering it in their schedule of commitments, reflecting that financial services were a much more active file during the Uruguay round, i.e., the round of negotiations that led to the WTO agreements in 1994.

Table 10.1 Sectoral Commitments in Hospital Services (Mode 3)

Country	*Market access*	*National treatment*	*Notes*
Brazil	No commitment	No commitment	
Costa Rica	No commitment	No commitment	
Cuba	No commitment	No commitment	
India	Commitment with restriction: 51 per cent ceiling of foreign equity	Commitment with no restrictions	
Malaysia	Commitment with restrictions: Economic needs test, joint venture with Malaysian investor, 30% ceiling of foreign equity, hospital min., 100 beds	Commitment with restrictions: Establishment of feeder outpatient clinics is not permitted	Apply to private hospitals only
Mexico	Commitment with restriction: 49 percent ceiling of foreign equity	Commitment with no restrictions	Apply to private hospitals only
Jordan	Commitment with restriction: One of the owners must be a physician except in a public limited company.	Commitment with no restrictions	
Singapore	No commitment	No commitment	
Thailand	No commitment	No commitment	
United States	Commitment with restriction: Needs-based limits may be imposed (plus special rules for New York state)	Commitment with no restrictions	

Source: Author

The reasons for the low level of commitments in health-related services are multiple. "The most obvious reason is the existence of government monopolies, in fact or in law, offering their services for free or significantly below cost. There seems to be no point in assuming external policy binding at least under mode 3 (commercial presence), if private activities are either prohibited rendered or commercially unattractive." (Adlung & Carzaniga, 2006, p. 86).

Another reason resides in the lack of interest from commercial actors in the health sector during the GATS negotiations that led to the Uruguay Round agreements in 1994.

Indeed, when national governments make requests for commitments from other WTO members, they are usually driven by demand from the private sector based in their country seeking to enter other markets. Without such commercial interests, there are few incentives to make or request commitments. In this context, experts have described the GATS as a 'supporting actor; not a liberalizing force,' i.e., that the countries that have listed health-related services have not liberalised this sector more than it was before the signature of the treaty, but have increased the predictability of the existing of entry and operations for the potential investors (Adlung, 2009).

The question that remains is whether the lead countries in health tourism have used the GATS in that manner. We have verified the nature of the mode 3 commitment in hospital services for the top ten destinations for health tourism. Given the very low quality and reliability of the statistical information on the number and destinations of medical tourists, we do not have a definite list of what the destinations are. But, based on the review of the literature undertaken by the Organization for Economic Co-operation and Development (OECD) (Lunt et al, 2011), we established a list of the lead exporters of health tourism and verified the nature of their GATS commitments, as listed in the schedule of commitments of these countries, and made available on the WTO website. The results presented in Table 10.1 are surprising; several countries that are actively promoting health tourism as a key export industry, such as Singapore and Thailand, have not included hospital services in their schedule of commitments. In addition, Cuba, Costa Rica and Brazil have similarly not listed this sector, even though they are key players in the industry. Countries that have taken commitments (India, Jordan, Malaysia, Mexico, US) also included limitations such as a ceiling to the level of foreign investment, a minimum number of beds in the healthcare establishment, or that the commitments only apply to private hospitals. This would indicate that several exporter countries themselves do not consider that the lack of commitments in trade treaties will be an obstacle to health tourism, or at least to foreign investors moving into this sector of their economy.

We should conclude this section by highlighting that even if a country removes most barriers to foreign investment and has full mode 3 commitment in a particular services sector, it

does not guarantee that foreign investors will be interested in establishing a commercial presence in that country. Indeed, firms and investors consider many factors when deciding to invest abroad; these decisions are structured by several external and domestic constraints. In the health sector, India provides an example of a country that has adopted a liberal foreign investment regime and has included Mode 3 commitments in its GATS schedule of commitment on hospital services, but where there is only a weak presence of foreign investment in hospital services. (Cattaneo, 2009; Chanda, 2007) It has been suggested that several key domestic constraints explain these low levels of foreign investment:

> …high initial establishment costs (e.g. prohibitive cost of procuring land), low health insurance penetration in the country (i.e. smaller consumer base for corporate hospitals), restrictions on medical training and providers (i.e. supply bottlenecks and adverse effects on the quality of the personnel), high cost of importing medical devices (and a limited domestic manufacturing capacity in this area), other regulatory deficiencies (e.g. lack of standardization, proper governance, and quality assurance), and lack of policy clarity and priority to the healthcare sector (Cattaneo, 2009, p. 8).

INSURANCE PORTABILITY

One of the most significant barriers to health tourism exports[3] (Mode 2) is the lack of portability of health insurance overseas (Smith, Chanda & Tangcharoensathien, 2009). Most private and public insurance schemes do not cover healthcare abroad, except in the case of emergency while travelling in a foreign country. Within the EU, this general rule is changing, as courts now recognize the right of European citizens to receive reimbursement of the cost of care outside their country of residence, as long as it is provided by an establishment based in the EU. With these new rules of insurance portability, four percent of Europeans received healthcare abroad in 2007 (Glinos & Baeten, 2006) and 53 percent of Europeans said they would be willing to travel abroad for medical treatment (The Gallup Organisation, Hungary, 2007). In contrast, in the US, given the cost of care and the existence of a significant number of uninsured, those without health insurance are more likely to go abroad to receive care (1.4

percent of those *with insurance* in California went abroad for medical care compared to 7.1 percent of those *without insurance* (Laugesena & Vargas-Bustamante, 2010).

The lack of insurance portability is believed to "inhibit the consumption of health care abroad by consumers" and changes to the insurance rules could lead to significant cost savings (Mattoo & Rathindran, 2006). Based on a worldwide price comparison of 15 low-risk, highly tradable surgeries, they estimated the magnitude of the savings to be over $1.4 billion, even if only one in ten US patients chose to undergo treatment abroad rather than in the US. Of these annual savings, $690 million would accrue to the Medicare program alone (Mattoo & Rathindran, 2006).

An expert from the WTO secretariat has recently highlighted that countries that have undertaken full commitment under Mode 2 of the GATS for hospital services are de facto "guaranteeing insurance portability under public health schemes to nationals consuming like services abroad" (Adlung, 2009, p. 20). It is not clear that all members understood the health insurance implication of this commitment. According to this interpretation, WTO members with public insurance such as the European Community and Japan would have committed to insurance portability. In contrast, the US has explicitly excluded public health insurance portability from their GATS commitment and added a limitation stating that reimbursement of medical expenses is limited to licensed, certified facilities in the US. Poland, Latvia and Slovenia had also included similar provisions in their GATS commitments. In the recent trade negotiations between the EU and the Caribbean region, the EU has specified that its commitment relevant to hospital services only applies to privately-funded services.

The explicit integration of the health insurance portability in trade negotiations is an emerging issue. The best known example of this is the request from Thailand to Japan, during the negotiations of their bilateral free trade agreement (FTA), that medical treatment in Thailand be covered by the Japanese insurance system (Japan-Thailand Economic Partnership Working Group (JTEP Working Group), 2003). The Japanese government did not agree to this request, arguing that "the Japanese medical insurance laws clearly stipulates that the Overseas Medical Care Benefits are exceptional benefits to be provided to the insured person who can not be treated at designated medical care institutions in Japan" (JTEP Working Group, 2003).

The Japan-Thailand FTA, as signed in 2007, stipulates that "the reimbursement of expenses for medical treatment received by Japanese nationals in Thailand shall be made in accordance with Japan's laws and regulations" (Ministry of Foreign Affairs (Japan), 2007): these regulations exclude those who travel expressly to receive care abroad.

In some cases, insurance portability may not be part of trade negotiations, but subject to bilateral agreements focusing solely on healthcare insurance portability. This is the approach adopted by Jordan. In the 1990's Jordan began to promote its health services exports. In 1998, the Ministry of Health established an office at the Queen Alia Airport to facilitate the entry of foreign patients (World Health Organization Regional Office for the Eastern Mediterranean (WHO-EMRO), 2004). Revenue from medical tourism was estimated to have crossed the US$1billion in 2003. The vast majority of medical tourists in Jordan come from the Arab world. The majority of patients seek treatment in cardiology, neurology, bone and other internal diseases. Some of the patients coming to Jordan are sponsored by their national funds. For instance, a protocol was signed between Jordan and the Algerian Social Security Fund in 1996, with the terms of payment for treatment received in Jordan linked to the Algerian Social Security Fund. Jordan has medical cooperation protocols with several other countries as well, while private sector hospitals in the country have their own agreements with government and private clients in foreign countries (WHO-EMRO, 2004).

In conclusion, insurance portability may still be an emerging issue on the trade and health agenda. However, given the potential implications for public insurance schemes, it may receive more attention in the near future. It would rise on the agenda when and if exporter countries begin to be more pro-active and request portability from importer countries. The impetus for change could also come from patients seeking to receive care abroad and to be reimbursed by their insurance plan. This is how pan-European health insurance portability became a reality, with patients resorting to courts. With the removal of this obstacle to health tourism, we could see a great increase in the globalization of healthcare, regardless of the nature of multilateral or regional trade treaties.

[1] The survey sample included 49,980 patients. The researchers estimated that this sample represented 60-80 percent of the total health tourism market, defined as patients travelling abroad expressly to receive healthcare, therefore excluding emergency care and healthcare received by expatriates.

[2] For detailed discussions of how scheduling of commitments are made within the GATS, see Blouin, Drager & Smith, 2007.

[3] Consumption of medical services in a foreign country is defined economically by that country as a 'health or medical tourism export' since it is a source of earnings that originates from abroad.

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11 Let's Make a Deal: The Commerce of Medical Tourism

Ronald Labonté

"Medical tourism is one of the biggest revenue generating industries in the world."
(Health provider CEO)

The banners proclaim it: over 2,000 attendees, 200 exhibitors, 400 healthcare buyers, 10,000 networking meetings, and 'get the most from your investment.' The conference halls are filled with suits, ties and briefcases. Everywhere posters and placards are emblazoned with 'business.' It's the fourth World Medical Tourism and Global Healthcare Congress, bringing together buyers, sellers and purveyors of cross-border healthcare for customers who can afford it. Sessions end with an almost confetti-like exchange of business cards, a celebration of business done and business to come. For an academic health researcher, the event feels surreal and oddly voyeuristic.

Walking into the 'great hall' of exhibits, one is immediately struck by three things:

First, it is like any other gathering of health conference delegates. The people at this event look main street international ordinary.

Second, it is unlike any other gathering of health conference delegates. This is a commercial meeting, marked by an appropriately inflated registration fee, a particularly American in-your-face flavour and a complete lack of public health embarrassment at its broadcasted entrepreneurial core. Countries marketing their medical tourism have booths full of conference swag (pens, bags, calculators, full colour costly brochures) to attract potential buyers (employers and health insurers), with intermediaries (medical tourism brokers) selling their abilities to bridge between the two.

> *"Our business sends European patients to have surgery abroad. At the World Medical Tourism Congress I established contact with hospital groups and key officials from almost every potential medical tourism destination in the world." (Medical tourism broker)*[1]

"Medical tourism is a direct outgrowth of the globalization of healthcare," one of the opening speakers explained in boldface. What he didn't mention is that, apart from the EU and a handful

of other contiguous countries, there is little globalization of *public* healthcare, which tends to stop at national borders. It is *private* or commercial healthcare that is able to leap huge territories in a single bound (or two).

Third, despite the private market nature of medical tourism, governments are here in complicit enthusiasm. Private medical brokers share booths with governments' external economic development corporations. Staff working for government tourism departments (and confessing little knowledge of their own countries' healthcare system) push glossy magazines and travel DVDs to show how attractive their locales can be for the accompanying family of the recovering medical tourist. It is hard to discern which word is the more important– the 'medical' adjective, or the sun, surf and exotic 'tourism.' Panama, as one example, is doing a stronger sell on its 'get sick or injured in Panama and we'll treat you free for 30 days' than on its cheaper bariatric surgery – a clear case where healthcare is marketing tourism rather than the reverse.

> *"We are happy with the fact we positioned Korea as the top destination of medical tourism through this conference" (Government minister)*.

There is scant mention of what this business means for the people living in the areas now being renovated for state-of-the-art hospitals that should be "duly accredited to US standards" and "staffed with designer doctors," as one speaker urged. His humanitarian advice: have the international designer doctors spend a day a week providing care to the poorer locals. This would go a long way to avoiding conflicts with local people and politicians who might get a bit testy with the "Mercedes crowding their streets" the other four (or five, or six) days of the week. By such an accounting, 20 per cent of the wealthier (local or global) population would receive 80 per cent of the access time; while the poorer 80 per cent of the population would receive 20 per cent of the access time (apart from trying their luck at generally poorer quality, underfunded and understaffed public facilities).

The principle of tithing part of the private medical tourism industry to a local public good is not new. Judging by the applause received when the speaker spoke of healthcare and medical tourism being not a business but a profession and a service to humanity ("patients can smell greed"), many involved in the industry would like to believe that access to private health

markets does not follow a revenue stream and that they are, indeed, performing a public service. Yet contradictions abound: the same speaker extolling his work as a profession ("you need to glow with the light of integrity") specializes in cosmetic surgery (breast enlargements, tummy tucks, buttock enhancements and labial reductions) for wealthier, image-worried women whom he invariably referred to as girls. There remains a large gap between charitable platitudes and business practice.

The 3P phrase (public-private partnerships), dropped liberally if without explanation in many sessions, captures this dichotomy. As several speakers warned, our apocalyptic demography – i.e., that there are too many old people to support – is pricing healthcare out of the reach of public funding. We need private investments. How this will keep aggregated health spending down as distinct from merely shifting it from public to private pockets, however, remains a mystery. However, private investors apparently also need public backing. This is not hard to bargain if healthcare is removed from the purview of human rights or public good and shunted into the domain of industrial growth. In some instances, governments are helping to underwrite the cost of new hospital constructions to attract paying foreign patients, or affording them special tax incentives or land deals. In others, it is the cheaper (but still-not-free) costs of public regulation of a surging private medical market that can help ensure that there are no untoward mishaps that could give the industry a bad name.

> *"I trust that harmony and singleness of purpose among our colleagues will continue to prevail in this industry that we all love" (Government tourism official).*

One country claimed to be taking a 'conscientious' approach to growing its medical tourism, evoking notions of fairness. But this country appeared to have its foreign patients more in mind than its own people. Emphasizing its political and economic stability, proximity to the US, internationally accredited facilities and new laws to enforce 'quality assurance,' the government spokesman emphasized one of the country's competitive advantages: the medical tourism industry is being established in "specialized globalized medical districts" located within "free trade zones" – which by definition do not tax inputs or outputs. This arrangement may offer employment benefits to certain of the country's health and tourism workers, but little by way of capturing revenues for its own public health\care system. A later effort to clarify if this

was indeed the case was left hanging: the people staffing the country's booth were from tourism and not the medical side. Their interpretation of free trade stopped at medical travellers and their families being able to shop in duty-free stores. It is also questionable how any one country's use of free-trade might give them a competitive advantage over another: Colombia, Turkey and other countries also referenced a no or low-tax free trade approach to their medical tourism growth strategy.

Several smaller Caribbean countries proximate to the US had their government delegates speaking to both sides of the medical tourism exchange: sending patients abroad for specialized surgery their own country could not provide (with their American counterparts busily selling their own locations as ideal venues for such out-of-country care, underscoring their international airports, nice weather, beaches, shopping malls and, oh, yes, good hospitals); while actively constructing new facilities to attract underinsured American patients for more routine procedures less expensive than in their own states. "We are very close to the USA, our people are very entrepreneurial, so you could go to China or Thailand, but why would you?" queried one government official, unequivocally looking for new investors to beef up her country's medical tourism "business platform."

> *"[We] had over 100 one-on-one meetings with potential clients and look forward to establish more business opportunities." (Government official)*

Whether small Caribbean countries can compete for American patients against a nation like Turkey, even with its longer flying time, may be moot, since proximity to the US can also carry higher comparative costs owing to the wage pull created by the US. The same likely applies to the many South American countries jockeying for a piece of the international medical market, given one private insurer's estimate of these nations' medical costs rising roughly 14 percent annually.[2] Two market dynamics may be at play here: One of price inflation in some destinations, and another of price competition, given the still lower-costs of medical treatment abroad, that has been argued as potentially driving down private provider costs in the US. Could we soon witness a 'flat' global market in private medical care, approximating the rapidly flattening costs of tourist facilities around the world regardless of how rich or poor a country and its currency is? Not if Turkey has anything to say about it.

Turkey was this year's Congress "Platinum Sponsor," buying almost as much display area as all the other countries combined. It played host to receptions, belly dancing exhibits and more Turkish delight candies than any person with minimal waist concerns could possibly eat (without, perhaps, a later visit to one of the many cosmetic clinics offering their wares). It also aggressively promoted itself on price ("only 10 percent of costs in the USA" – the ubiquitous comparator), JCI accreditation (the putative gold standard of American-styled quality), excellent cuisine and historic tourism. Americans flying for surgery in Turkey are even eligible for hefty discounts on Turkish Airlines that, according to a speaker in one of the sessions, feature amazingly comfortable flat beds and on-board chefs in business class. Turkey is considered a model 'success story' in medical tourism. As the chair of its government-backed Health Tourism Board explained enthusiastically, this resulted from the surge of private investment in private hospitals that followed economic liberalization policies in the 1990s, part of a deliberate strategy to "attract medical patients from high-income countries."

Initially offering only cosmetic surgery (which seems to be the entry point for most medical tourism start-ups), Turkey now claims to offer almost all forms of "cutting-edge" surgeries "at the right price" in 29 JCI-accredited hospitals ("the largest number of any country"). Transplantation surgery is one of the specialities on offer, with one-third of all liver transplants in the country going to international patients. Given that the population ratio of medical tourists to Turkish citizens is roughly 1:150, if this was the case, their 1:3 grab on transplants works out to a 50:1 advantage.[3] Although life expectancy at birth for both men and women during the first decade of the twenty-first century in Turkey improved more rapidly than the European average, it still ranks poorly in the league tables: male life expectancy ranks 39 out of 50, female life expectancy sits even lower at 44 out of 50. Infant mortality rates remain double the European average, half of healthcare spending is still out-of-pocket, primary healthcare remains underfunded and, despite the large government subsidies to private hospitals, the number of hospital beds per capita sits near the bottom of the European ladder while the number of physicians per capita is only one quarter the European average (Savas, Karahan & Saka, 2002; European Regional Office of WHO, 2011). The more these

comparatively scarce resources are applied to foreign patients, the less there are for Turkish citizens. As a 2002 report on Turkey's rapidly growing private health market cautioned:

> The last few years have seen a rapid expansion of the private health care sector in Turkey. However, while this process may contribute to the development of healthcare infrastructure by increasing the number of healthcare facilities, and may satisfy patients who are able to pay for private healthcare, it exacerbates existing inequalities in access to healthcare among those with different levels of income (Savas, Karahan & Saka, 2002, 97-98).

Not that the rest of Europe wants to be outdone or seen only as a market for the outbound medical traveller. Germany's trade booth lauds its many spas and historic towns, though little is said about its Euro-denominated pricing. France has little presence apart from an English language brochure advertising its even quainter old towns and the promise of multilingualism. England grabs the patient-inbound limelight, with a presentation noting how, in London alone, there is over US$500 million earned annually in international medical travel ("a conservative estimate"), paid for by people deliberately seeking care in the UK. They are served in private hospitals or in the private wings of the UK's NHS public hospitals, the exclusive part of the public system which generates revenue for its overall budget by treating private paying customers. Public hospital competition for international patients is projected to grow substantially as retrenchment in the NHS continues. The London legacy, in turn, is traced to Britain's colonizing influence in the Middle East and the great 1970s Oil Rush, which created a number of very wealthy and occasionally sick Middle Easterners who had few local facilities at their disposal. The volume in foreign patient trade is now tapering off, perhaps due to competition from some Middle Eastern states such as Jordan, Dubai and the UAE that have set up their own medical tourism facilities. But "the revenues are still going up" since "the cases we see [in London] are getting more complex and technically more costly."

There are definitely parts of Europe where the outbound flow is the only direction: Russia, the Ukraine, and others of the Russian-speaking former Soviet Union states. At least 17 million people in Russia are wealthy enough to buy medical care abroad, and 11 million of these already take regular overseas holidays. This is a market in the making. The advice of one

medical tourism broker located in Eastern Europe to the providers she is looking for (her business, after all, is the go-between) is that they identify vulnerable areas in what remains of the Russian public system, set up close to these areas in one of the many border countries surrounding Russia, employ some good Russian speakers and then, please, let her know. Another speaker added another incentive: many of the Commonwealth of Independent States' (CIS) governments are now offering women financial incentives to give birth to four or more children in an effort to offset the post-communism population decline. This heralds a growth market for reproductive and obstetrics/gynaecological medical tourism, if not also for Russian-speaking storks.

But perhaps Russian-speaking medical tourists might like a visit to Colombia? Although clearly targeting an American market, this is a country that seems bent on over-supply. Its government strategy is one of "providing First World health care in a Third World country" with a goal that "by 2032 Colombia will be recognized as a world leader in medical tourism…generating $6 billion in revenues each year." Different Colombian urban centres have created (or are creating) 'Cities of Health,' specialized zones in which both public and private hospitals concentrate on serving international travellers. In the case of Medellin's already established Health City, a promotion feature is conveying people from Bogota's airport to their hospitals by private jet. Services provided in these special zones will be treated as exports, with all of the tax advantages that lie therein. As with many other South American countries, however, healthcare access for Colombians remains highly unequal despite some attempts at primary healthcare reform. More troubling is a controversy surrounding Bogota's effort to create its own City of Health. The municipal government is proposing to demolish two large and established lower income barrios (neighbourhoods) that happen to be home to five public and one private hospital. In their place developers will build new apartments for the upper-middle income strata, partly to meet market demands for such housing, but perhaps also to 'sanitize' the area for the higher-income patients it wants to attract. What of the tens of thousands of local residents and the hundreds of local businesses that will be displaced in this gold rush to global private health?

Forty-eight hours of resounding silence on the (un)fairness of these extolled developments, and the unquestioned acceptance of the beneficence of private healthcare markets, begs the question: What's a Canadian, still fondly hanging on to a publicly-funded and administered health system, doing here, anyway? It is clear that the medical care sellers, their tourism fellow travellers and the international brokers are targeting the US health insurance and corporate market. There is the odd passing reference to Canadian medical travellers, but the patient testimonials that pepper many of the infomercial sessions invariably feature happy American patients. One of the opening keynotes helped to explain why. It focused entirely on the rising healthcare costs in the US, and how the *Affordable Care Act* (if it survives court challenges on its requirement of individual responsibility to purchase coverage) will result in individuals paying the equivalent of up to 20% of their gross income for healthcare insurance. Another conference session also cited healthcare premiums or co-payments already exceeding monthly rent or mortgage payments for many Americans. The US government, in turn, was recently mandated by its conservative-dominated Congress to find over $1 trillion in immediate budget savings, including a 30 percent cut to its publicly funded Medicare programs. The dismal state of American fiscal, taxation and healthcare policies is seen as a booming opportunity for outsourcing to less expensive countries.

Ironically, this will not necessarily lead to less pressure on public revenues. Medical tourism costs incurred by Americans (including a couple of weeks of post-surgical recuperation in five star beachfront resorts) are tax deductible if they are more than a modest 7.5 percent of one's gross income: yet another form of public subsidy to private markets (Woodman, 2009).

> *"The medical tourism industry seems poised to grow in volume and significance within the next few years." (Health provider marketing director)*

Yet there is a billowing storm cloud threatening to rain on this boisterous parade. Is the projected annual two million patient/USD one hundred billion-plus industry more myth and marketing than done deals? Yes and no. Yes, if you consider Taiwan's impressive bid to join the global carousel. Taiwan is still waiting for investors to pour their monies into the fancy new private hospitals that would cluster into an Asian 'Health City' like the ones already constructed or planned in Latin America and the Middle East. But so far there are few takers. No, if you

bother to gaze on the many gleaming temples of specialized medicine that already exist catering to four or five star international patients. But yes again, if the era of cheap air travel, already showing wrinkles, starts to shrivel further, the ignored poor in destination countries grow impatiently fractious for their turn, or the global supply begins to so exceed the international demand that the business of medical tourism ceases to be adequately profitable.

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[1] Italicized quotes are taken from published on-line testimonials from previous Congresses, available at: http://www.medicaltourismcongress.com/en/testimonials.html.
[2] Presentations were awash with numbers but, in contrast to most academic conferences, references for the data were rarely or never provided; and many of the 'educational sessions' sounded more like infomercials than studied papers.
[3] Ratios based on Turkey population of 74.8 million and an estimate offered in one of the Congress educational sessions of 500,000 medical tourism visitors to Turkey expected by the end of 2011.

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12 Conclusions: Medical Tourism Today and Tomorrow

Vivien Runnels, Corinne Packer, Ronald Labonté and Raywat Deonandan

INTRODUCTION

For patients, medical tourism is a means of reducing costs, jumping wait queues and obtaining surgeries and health services not yet available or approved in their countries of residence. For countries inviting international patients, medical tourism is a means of obtaining foreign investment in healthcare facilities and making new technologies available. For private businesses, medical tourism is a lucrative business facilitated by inexpensive travel and a discourse of an economically globalized world.

As a manifestation of the globalization of healthcare, with its pattern of asymmetrical development between wealthier and poorer nations, medical tourism is at different levels of maturity across the range of countries engaging in it, as demonstrated in Labonté's Chapter 11. Much of the industry is fledgling, although by (largely anecdotal) accounts many individuals appear to have received health benefits through medical tourism, and the industry itself seems to be preparing confidently for a certain future.

The different contributors to this volume have reported variously on the nature of the industry, identifying its principal components: *Actors*: patients, medical brokers, physicians, nurses and other health professionals; *businesses*: hospitals, clinics, insurance companies, tour companies, airlines and hotel chains; and, *policy contexts*: domestic governments and their health and tourism policies, as well as global trade agreements. Identifying these components may be relatively straightforward; far more complex are the many unanswered questions and unsettling issues that define the industry. Assessing the situation of individuals needing healthcare and their experience of medical tourism is a starting point. However, a common thread throughout the book is the lack of collected knowledge about medical tourism, particularly quantitative data, which prevents a balanced assessment of medical tourism. Much of what the industry itself presents is difficult to confirm.

Additionally, ethical questions loom: Is medical tourism, as a manifestation of the commodification of health and healthcare and as something to be bought by those that can afford it, necessarily a bad thing? Should medical tourism continue to be viewed with suspicion as it is by some? Can some of the problems currently related to medical tourism, and raised by several contributors to this book, be addressed and stand up to critique? In our conclusion we attempt to answer these and other questions woven into the thematic threads of the chapters.

INDIVIDUAL EXPERIENCE AND DECISION-MAKING

Despite living in a high-income country with a highly developed and complex public healthcare system, Hopkins (Chapter 7) demonstrated her need to access care in a way and at a time when she needed it. This was after her careful attempts to seek advice and care in Canada. What her experience and the 'lived experiences' portrayed in Johnston, Crooks and Snyder's Chapter 6 demonstrate is that decision-making at the individual level is rarely simple with a number of considerations being made by the individual and his/her family. Hopkins, as a well-informed individual, was able to take control of her access to healthcare. Decisions are based not only on an individual's freedom to choose, but also on their domestic healthcare context compared with alternatives offered by medical tourism in other countries. Inability to access care in one's own country in an affordable, available or acceptable way provides significant motivation for individuals to seek care beyond their borders. Gender may also play a role in such decision-making, although with the exception of abortion tourism, there has been little in the way of critical analysis of medical tourism through the lens of sex and gender.

As the overview chapter by Labonté outlines, the sheer variety of travel routes both reported in the literature and based on anecdotal reports suggests that no two journeys are quite the same. Contrasting with 'typical' experiences, Johnston, Crooks and Snyder (Chapter 6) showed that there are outliers; medical travellers' experiences can differ substantially and many international healthcare-seekers do not incorporate the 'tourism' aspect of the industry, even when such activities are initially planned.

KNOWLEDGE OF MEDICAL TOURISM

The claims that are made for the extent of medical tourism, in terms of numbers of tourists and procedures, revenues and the potential for growth in the industry are questionable. We found very little literature that provides basic or convincing 'hard' evidence, with much of the data speculative and difficult to confirm. Some of these data are not publicly available, or are held in private hands. Projections are seemingly based on optimism and enthusiasm, or a number of assumptions that are difficult to track and substantiate. Data are often contributed by consulting companies and others who may have a vested interest in the development of medical tourism for business purposes. As Labonté similarly points out in Chapter 1, the aggressive promotion of medical tourism is not proof in itself of buoyant activity in this area.

Our particular interest in Canada led us to look into the availability of Canadian governmental travel data. International Travel 2010 (2011) summarizes the characteristics of travellers entering and leaving Canada by country, province, state, as well as by transportation mode, purpose of trip, length of stay, and other variables. It also provides data on worldwide tourism and travellers. However, the statistics that we seek to describe and confirm the extent of Canadians travelling abroad for medical purposes are not available. The best data at hand can be found in Statistics Canada's 1998 National Population Health Survey, where 17,000 Canadians (at that time representing 0.1% of the population aged 12 years and over) reported seeking healthcare as the main purpose of their trip.

Some of the qualitative data that we found concerns the harms and potential harms of medical tourism. In matters of health, the bioethical axiom, 'primum non nocere' (first, do no harm), with its origins in the Hippocratic Oath, continues to be used to help guide how medical practitioners conduct their duties in principled ways. This guide can be applied at different levels to assess harms, and has been used (albeit generally implicitly) to guide national governments' regulatory bodies and standards. At the individual patient level, medical practice does risk harm to the individual, but risks are taken in order to achieve some sort of greater benefit. Deonandan (Chapter 9) provides solid ground for the analysis of ethics with regards to

certain types of medical tourism. His specific focus is on those involved in India's 'surrogacy tourism' industry: the surrogate mothers ('gestational carriers') who carry foetuses for medical tourists, the doctors who perform such procedures, and the agencies and country policies that support them, not only analyzing the effects of medical tourism to the recipient of care, but expanding the analysis to stakeholders of medical tourism in general.

In early 2012, Canadian media raised the issues of 'birth tourism,' where a foreign national comes to Canada to give birth allowing the baby to claim Canadian citizenship. Using the term 'birth tourism' Canada's Immigration Minister accused mothers giving birth on Canadian soil (with the unwitting offspring being referred to as 'passport babies') of taking advantage of Canada's "generosity" or "taking Canada for granted" (Yelaja, 2012). In the US, another of the exceptional countries that grants citizenship to babies born on its soil, some companies advertise birth tourism packages to expecting parents (Dwyer, 2010). Of sensationalist interest in an era where anti-immigrant sentiments appear to be rising (or at least manipulated for political ends) the evidence of this practice is quite anecdotal and estimated to account for a very small number of actual births; although the commercialization of the practice in the US exemplifies the problematic relationship between profit, people and states that is a recurrent issue in this book's contributions.

Questions in reproductive health care and assisted reproductive health technologies are inherently highly sensitive. With the addition of medical travel, ethical and political economic issues (of power, of choice) increase exponentially. In countries that do not have institutions with responsibility for dealing with these issues as they arise, ,[1] any satisfactory resolution is likely to be difficult, including the risks for surrogate mothers, adoptive parents and the babies born in such an arrangement.

GLOBAL GOVERNANCE, REGULATION AND THE QUALITY OF MEDICAL TOURISM

Multilateral trade alliances and trade agreements (such as the WTO-GATS), and an increasing number of bilateral trade agreements, can accelerate and lock-in cross-border rules

that enhance the medical tourism industry. Governments concerned with medical tourism's impacts on their domestic public health system (and the regulatory space they require to manage the public/private mix that characterizes almost all of the world's nations health care) need to attend to trade negotiations since many of these treaties could affect their regulatory authority over health. At the same time, as Blouin points out in Chapter 10, medical tourism is not likely to be halted or slowed through a lack of commitments by governments to liberalize their health or health financing systems in trade treaties. However, with the exception of some bodies that specifically accredit international facilities (which is not in itself a defining characteristic of medical tourism), global governance of medical travel, including regulatory mechanisms, standards setting and patient protection, are lacking. In these respects, there are significant lags behind the trade and commercial frameworks and networks which enable medical tourism to be promoted, organized and operated globally. Systems need to be in place to ensure safety, ethical compliance and equitable outcomes of such activities. Although surveillance of travellers and other migrant populations are a component of the International Health Regulations[2] (the only international regulatory health instrument that all countries are legally required to conform to), the Regulations are not designed to address or include issues that relate to international trade in healthcare, such as medical tourism.

The issue of quality assurance and accreditation deserves some attention itself. Presumably because the majority of Northern medical travellers are American, American standards are used to set the bar for institutional accreditation throughout the world through such organizations as the JCI, and foreign hospitals' affiliations with well-known medical schools and clinics that are 'brands' in themselves, such as Harvard Medical School, Johns Hopkins, and Mayo Clinic. Accreditation is becoming an increasingly important component of medical tourism, and certainly a central feature of its marketing. That American standards have become the basis on which private healthcare in other countries competes for international patients, is indicative that medical tourism is following the same trajectory of other economically globalizing industries.

MEDICAL TOURISM, HEALTH EQUITY AND HUMAN RIGHTS

Some aspects of medical tourism clearly demonstrate social and economic inequalities. For example, the purchase and sale of organs, such as kidneys, for transplantation in medical tourists, where poverty forces poor people to sell to survive, is often accompanied by cumulative harms to, or worsening health of, the donor. That some individuals are able to travel and purchase healthcare, thereby jumping queues or accessing services not easily accessible or affordable in country, also means medical tourism increases inequities in access to healthcare. The very existence of these international healthcare options allows a country's economical elites to avoid making demands on their own state to develop public health systems of care that would also benefit the poor.

The class divide represented in medical tourism raises important questions about how this industry (largely driven by private sector actors and interests) affects the provision of primary healthcare to local populations in low- and middle-income destination countries attempting to join what they may perceive to be a foreign currency gravy train. Since the Alma Ata Declaration in 1976[3], health system strengthening and expanding universal coverage for primary care services has featured on the agendas of a number of meetings at the world level. Adequate provision of primary healthcare in a number of medical tourism destination countries is questionable. For example, Chanda (Chapter 4) paints a stark picture in her description of low levels of Indian public healthcare, with high levels of out-of-pocket payments, and the availability of private insurance and healthcare to those who can pay. The poor are significantly disadvantaged in access to and receipt of healthcare; a situation that medical tourism can reinforce. The juxtaposition of private healthcare that features sophisticated surgery and high technology and luxury accommodations with extreme poverty and lack of public healthcare becomes the pervasive portrait of a system askew by almost any account of social justice.

The example of India is also one where public investments wind up favouring the private sector, fitting the category of a 'perverse' subsidy in which the poor end up subsidizing the rich. Medical tourism does not operate in isolation from publicly funded healthcare systems. In many parts of the world medical tourism is dependent on the existence of public funding that

provides or pays for training doctors, nurses and allied health professionals, hospitals and clinics and other capital arrangements; as well as for the structures and mechanisms of governance which support health systems. There is some irony in the provision of sophisticated and complex health services to the visiting rich from foreign countries by governments that have consistently failed to institute or provide basic healthcare to citizens. These governments struggle to fulfil their international human rights obligations to ensure their citizens the "highest attainable standard of health possible" (Office of the High Commissioner of Human Rights, 1966) while private hospitals located within these states offer five-star healthcare to foreigners. The extreme health inequity painted by this picture is formidable.

There is awareness of these inequities by a number of actors. Although still a contentious case, Indian private hospitals receiving state subsidies are required to provide a percentage of beds and care for the poor (Chapter 4), a legal obligation recently affirmed by a Supreme Court ruling in India (Headlines Today Bureau, 2011). Less formally, the concern for patients expressed by stakeholders in medical tourism is strong. Carrying out commitments such as serving 'the poor,' are attractive and suggest altruism and magnanimity of the rich to the disadvantaged. In Ferreyra's Chapter 5, we find one non-profit organization established as a philanthropic extension of a for-profit organization, set up to distribute care to the poor. However, the extent of its involvement in offering help to the poor is difficult to verify. Individual medical brokers who have been health workers themselves sometimes refer to their personal and corporate sense of 'giving back' to communities, as do individuals who have had first-hand observation of poverty when receiving care in a developing nation, such as recounted in Chapter 3. At the same time, helping the poor may just be one reluctant cost of doing business as the comments reported in Labonté's Chapter 2 suggest.

Concerns with the health equity impacts of medical tourism are increasingly coming to the fore, owing to the logic that the industry favours those that can afford to pay and undermines the basic premise of healthcare financing: cross-subsidization of access by the rich for the poor, and by the healthy for the sick. Examined in the context of an asymmetrical economic globalization, at least one moral philosophical argument suggests that it is unethical for those in rich countries to even seek healthcare in poor countries that are unable (or

unwilling) to provide even basic coverage for its poorest citizens (Meghani, 2011). At the same time, these cross-border patients are demonstrably in need of relief from suffering: Is it ethical to deny their agency in seeking remedy elsewhere?

Thus, we do not argue against medical tourism, because it serves a purpose. Yet, at minimum, medical tourism should not come at the expense of citizens to whom governments have primary responsibility. Assigning responsibility to governments as duty-bearers for the health and welfare of 'rights-holders' or citizens is nothing new and is set out in international law. For example, General Comment 14 (2000) by the UN Committee on Economic, Social and Cultural Rights sets out the scope of legal obligations of states with regard to the health of citizens as "to respect, protect and fulfill" the "right of everyone to the enjoyment of the highest attainable standard of physical and mental health" (Office of the High Commissioner for Human Rights, 1966). Both source and destination countries need to carefully explore the ethical, social, cultural, and economic consequences of the growing phenomenon of for-profit international medical travel.

The study of medical tourism, particularly from a Canadian perspective, has increasingly served to expand and change our understandings of healthcare. Because our perspectives are derived and grounded in support of the Canadian publicly-funded healthcare system, it is somewhat inevitable that our preferences lean towards an approach that favours equity in access through the principles of cross-subsidization. We recognize that it is the shortcomings of many of the world's public health systems, including Canada's, that motivate individuals to pursue private healthcare as medical tourists. However, it is market failures on private provision that worry us more, and the uneasy relationship of public with private healthcare that is only available to those who can afford to pay, while continuing to build on the back of public training and public funding. The decision to travel for healthcare remains with the patient, but the consequences remain with the population.

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[1] Canada's federal government has recently disbanded Assisted Human Reproduction Canada (AHRC) a regulatory body which was put in place to advise on and oversee a number of Assisted Reproductive Technologies (ARTs) including surrogacy.

[2] These regulations are described as "global rules to enhance national, regional and global public health security" and provide "a new framework for the coordination of the management of events that may constitute a public health emergency of international concern, and will improve the capacity of all countries to detect, assess, notify and respond to public health threats" WHO, International Health Regulations (2005). Accessed December 1, 2012 from http://www.who.int/ihr/en/.

[3] More information on the Declaration of Alma-Ata, see http://www.who.int/hpr/NPH/docs/declaration_almaata.pdf, accessed December 1, 2012.

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Index