Speaking for Myself

Medical tourism and its impact on our healthcare

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Ms Susan Benson (not her real name), in her late forties, is a marketing executive in New York city. Like many of her peers, she is increasingly concerned about the wrinkles and loose folds of skin under her eyes and chin. A Park Avenue plastic surgeon has advised cosmetic surgery, which will cost her about US$ 8000–9000. Her insurance cover does not include cosmetic treatment. She decides to go to South Africa for the cosmetic treatment, which is likely to cost her less than half of what she would pay in New York, with airfare, hotel stay, treatment costs and a bit of safari thrown in. It is quite another matter that she is unable to enjoy the outing because of her swollen eyelids and puffy face! She is one of the many who will escape the chilly, freezing New York weather and head for warmer climes this winter. Many will go to Bangkok, with its famous Bumrungrad Hospital which 'specializes' in treating 'foreigners'.

Mr and Mrs Patel are a couple from Mumbai in their early thirties. Married for 8 years, they have been desperately trying to conceive, without any luck. Their gynaecologist has advised an *in vitro* fertilization (IVF) treatment (test-tube baby). Although there are quite a few centres in India which are technically equipped to carry out this treatment, they choose to go to England where the cost would be more than US$ 25 000, excluding travel and possible prolonged stay.

What do these two patients have in common?

Both of them are 'medical tourists' in a sense that they are seeking treatment abroad, away from their own country, one mainly for economic reasons and the other with a perception that they will receive better quality of treatment abroad. There are other categories of patients—for instance, the Foreign and Commonwealth Office of the UK reports that many women from East European or Asian countries arrive in Britain in an advanced stage of pregnancy, to have their child born there. Until the recent amendments to the Immigration Act came into force, they were able to claim British nationality for their newborn child. This loophole has now been plugged. Nevertheless, patients like these will continue to be a drain on the resources of the host country. When the host country happens to be a developing economy, the impact of this 'tourism' on the already fragile healthcare system of these countries can be far-reaching.

Medical tourism

The term 'medical tourism' itself is a misnomer in some ways, even an oxymoron. Tourism implies a leisurely, pleasurable activity undertaken by people, often with their families, on a vacation. If a businessman attending a meeting or closing a business deal takes in the sights of a new city on a spare evening, he does not become a tourist. Why, then, call a patient seeking medical treatment abroad for whatever reason a medical tourist? Be that as it may (the term was probably coined by tour operators such as 'Surgery and Safari', or 'Rhinoplasty with Rhino', etc.), specialized medical treatment in the form of planned surgical procedures undertaken in countries other than their own, is here to stay. In fact, it is poised to take off in a big way in many Third World countries.

Medical tourism, as such, is not a new phenomenon. In ancient Roman Britain, people from the European continent used to 'take to the waters' for their healing properties at Bath, England. Wealthy English noblemen travelled to the continent, especially to the south of France for recuperation in the sanatoria and health spas when the only treatment for tuberculosis was the 'sun' and little else. However, systematic and commercial exploitation by offering 'cost-effective' medical treatment, away from the patient's home country is new. Fuelled undoubtedly by globalization and the availability of affordable air travel, people are easily attracted by glossy brochures to fly across continents to exotic places to get their noses or faces fixed and combine it with a little sightseeing.

Until about 25–30 years ago, people looked at Third World countries and their hospitals as poor imitations of those in the developed world. Western expatriates and wealthy 'natives' often flocked westwards for medical treatment, even for relatively 'minor' ailments. However, in the past two decades, the costs of medical treatment have gone up exponentially in the West, especially in the US, with the result that less expensive options such as outsourcing of treatment and various other related services had to be looked for. Another development which gave impetus to this was a simultaneous improvement in certain areas of investigative facilities in developing countries, whose medical manpower and skills had always been known to be of high calibre. In many countries, it is being actively promoted as an official government policy. The governments of Singapore and Thailand have been in the forefront in Southeast Asia and the Government of India is trying hard to catch up. India's National Health Policy 2002, for example, says: 'To capitalize on the competitive cost advantage enjoyed by domestic health facilities in the secondary and tertiary sectors, the policy will encourage supply of services to patients of foreign origin on payment. The rendering of such services on payment of foreign exchange will be treated as "deemed exports" and will be made eligible for fiscal incentives extended to export earnings.'

Although India is a recent entrant into this field, it is estimated that because of its vast pool of trained and competent medical

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(The views expressed in this article are the author's and do not reflect those of the management of the hospital.)

manpower, it could generate a revenue of US$ 1 billion by the year 2012 (Report by McKinsey and the Confederation of Indian Industries [CII]). No wonder, then, that everyone is trying to milk this cash-rich 'milch cow'. The CII, Federation of Indian Chambers of Commerce and Industry (FICCI), Maharashtra Tourism Development Corporation (MTDC) and several other government bodies are hoping to promote India as a prime destination for medical tourism. The Apollo and Escorts groups have already entered the fray with their offer of 5-star hospitality and 5-star hospital treatment. European countries are not lagging behind either. For example, the Munich international airport offers many forms of day care and minimal access surgery at the airport itself. There are facilities for MRI and CT scan as well. If the patient has to stay longer, there are tie-ups with clinics and hospitals in the vicinity.

The main selling point of medical tourism is the attraction of 'First World' medical treatment at 'Third World' prices. The cost differential is substantial and can be as much as one-fifth to one-tenth of the cost in the affluent countries. Open heart procedures which cost from US$ 75 000 and upwards in the USA and at least US$ 50 000 in the UK, cost between US$ 5000 and 10 000 in the best of India's hospitals. The question arises, however, for whom is the treatment cost-effective? Why should a developing country such as India, with its teeming millions below the poverty line, subsidize the treatment of the likes of Ms Benson (the American lady referred to in the beginning of the article)? Make no mistake about it, subsidized it is, because the hospital where she will be treated (whether corporate or not-for-profit) will have received various concessions in the form of land prices, floor space index (FSI), customs duty exemption, tax concessions, etc.

The protagonists of medical tourism argue that one cannot ignore the enormous financial gains that will accrue in the form of foreign exchange. Though the estimated earnings to India from medical tourism could reach US$ 1 billion by the year 2012, to say that part of this can then be utilized in improving the various infrastructural facilities and providing healthcare to the masses is a myth. The financial gains will certainly enrich the corporate sector and a very small portion, if at all any, will trickle down to the public sector or the masses. The revenues will lead to further expansion of these facilities in the corporate sector, which will draw more personnel from the public sector, which is already understaffed. It makes more sense, in the long run, to improve the tourism infrastructure and aim at exploiting our rich cultural and architectural heritage to generate revenue.

Impact on healthcare

There are several other implications as well. India has one of the lowest ratios of number of beds per 100 000 population. Even if a small proportion of these are blocked by patients from overseas, it will further reduce the number of beds available to the local population. Most good hospitals have a wait-list for patients seeking admission—this will increase substantially. It may even have an adverse impact on emergency admissions. A patient coming to the emergency department with chest pain, for example, may have to be diverted to another facility if a bed is not available.

Most tertiary care hospitals are located in urban areas and so are the healthcare providers. Almost 60% of them (and 75% of allopathic doctors) are in urban and metropolitan areas. This disparity will increase further due to migration from semiurban locations as the job potential increases in big cities. The 'internal brain drain' from the public sector and rural areas to the corporate sector in the metros will have far-reaching consequences on the equity of healthcare distribution in India.

Other issues

Continuity and quality of care are two very important aspects of healthcare which are often overlooked in this context. True, some patients treated in such settings do not require too much after-care or nursing attention (cardiac patients do) but it does not mean that complications do not occur. If they occur in the early postoperative period, the surgical team would take care of them, but if they take place after the patient returns home, it will be the responsibility of the home country's healthcare system.

Moreover, many developing countries have weak malpractice laws or a convoluted criminal justice system that may preclude any recourse to local courts for redressal. Since the main plank of medical tourism rests on cost, a patient is akin to a customer at a supermarket—he will often choose a product, which is offered at the lowest price. It promotes the concept that medical services can be bought off the shelf from the lowest price provider and, by so doing, puts quality as a secondary consideration. We are all too familiar with the experience of many of our patients who felt that patients from the Middle East were given preferential treatment during the 1980s and 1990s when the 'Arab influx' into our hospitals was at its highest. To take a parallel example from the travel industry, we are equally aware of the perfunctory treatment we as 'natives' receive from the flight attendants on international flights, while they kow-tow to 'foreign' tourists. This distortion of priorities makes one feel uneasy about the possible negative impact of medical tourism on our healthcare system.

One needs to take all these factors into account and have a balanced perspective on this issue. It is all too easy to be swayed by the possible gains in the short term, and ignore the lasting harm medical tourism will bring to our fragile healthcare system, unless we address these issues. Is it prudent to barter the future of many for enriching the present of a few? Hospitals must always primarily focus on the healthcare needs of our own population while devising healthcare delivery plans. A prudent product mix catering to different socioeconomic segments of the society will enable hospitals to be financially viable through intricate cross-subsidization. And as the business grows, the private healthcare sector must start contributing to the healthcare needs of the underprivileged section of society as its moral obligation.

As Dr Franz Inglefinger, a previous editor of the prestigious *New England Journal of Medicine* wrote when he lay dying of terminal cancer: '…I want to believe that my physician is acting under a higher moral principle than a used car dealer. I'll go further than that. A physician who merely spreads an array of vendibles in front of his patients and says, "Go ahead, you choose, it's your life", is guilty of shirking his duty, if not malpractice.'