Medical Tourism

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THE most recent trend in privatisation of health services is medical tourism, which is gaining prominence in developing countries. Globalisation has promoted a consumerist culture, thereby promoting goods and services that can feed the aspirations arising from this culture. This has had its effect in the health sector too, with the emergence of a private sector that thrives by servicing a small percentage of the population that has the ability to 'buy' medical care at the rates at which the 'high end' of the private medical sector provides such care. This has changed the character of the medical care sector, with the entry of the corporate sector. Corporate run institutions are seized with the necessity to maximise profits and expand their coverage. These objectives face a constraint in the form of the relatively small size of the population in developing countries that can afford services offered by such institutions. In this background, corporate interests in the Medical Care sector are looking for opportunities that go beyond the limited domestic 'market' for high cost medical care. This is the genesis of the 'medical tourism' industry.

MEDICAL TOURISM AS AN INDUSTRY

Medical tourism can be broadly defined as provision of 'cost effective' private medical care in collaboration with the tourism industry for patients needing surgical and other forms of specialized treatment. This process is being facilitated by the corporate sector involved in medical care as well as the tourism industry - both private and public.

In many developing countries it is being actively promoted by the government's official policy. India's National Health policy 2002, for example, says: 'To capitalise on the comparative cost advantage enjoyed by domestic health facilities in the secondary and tertiary sector, the policy will encourage the supply of services to patients of foreign origin on payment. The rendering of such services on payment in foreign exchange will be treated as 'deemed exports' and will be made eligible for all fiscal incentives extended to export earnings'. The formulation draws from recommendations that the corporate sector has been making in India and specifically from the 'Policy Framework for Reforms in Health Care', drafted by the prime minister's Advisory Council on Trade and Industry, headed by Mukesh Ambani and Kumaramangalam Birla.

GROWTH OF THE MEDICAL TOURISM INDUSTRY

The countries where medical tourism is being actively promoted include Greece, South Africa, Jordan, India, Malaysia, Philippines and Singapore. 'India is a recent entrant into medical tourism. According to a study by McKinsey and the Confederation of Indian Industry, medical tourism in India could become a $1 billion business by 2012. The report predicts that: 'By 2012, if medical tourism were to reach 25 per cent of revenues of private up-market players, up to Rs 10,000 crore will be added to the revenues of these players'. The Indian government predicts that India's $17-billion-a-year health-care industry could grow 13 per cent in each of the next six years, boosted by medical tourism, which industry watchers say is growing at 30 per cent annually.

In India, the Apollo group alone has so far treated 95,000 international patients, many of whom are of Indian origin. Apollo has been a forerunner in medical tourism in India and attracts patients from Southeast Asia, Africa, and the Middle East. The group has tied up with hospitals in Mauritius, Tanzania, Bangladesh and Yemen besides running a hospital in Sri Lanka, and managing a hospital in Dubai.

Another corporate group running a chain of hospitals, Escorts, claims it has doubled its number of overseas patients - from 675 in 2000 to nearly 1,200 this year. Recently, the Ruby Hospital in Kolkata signed a contract with the British insurance company, BUPA. The management hopes to get British patients from the queue in the National Health Services soon. Some estimates say that foreigners account for 10 to 12 per cent of all patients in top Mumbai hospitals despite roadblocks like poor aviation connectivity, poor road infrastructure and absence of uniform quality standards.

Analysts say that as many as 150,000 medical tourists came to India last year. However, the current market for medical tourism in India is mainly limited to patients from the Middle East and South Asian

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economies. Some claim that the industry would flourish even without Western medical tourists. Afro-Asian people spend as much as $20 billion a year on health care outside their countries ‘ Nigerians alone spend an estimated $1 billion a year. Most of this money would be spent in Europe and America, but it is hoped that this would now be increasingly directed to developing countries with advanced facilities.

PROMOTION OF MEDICAL TOURISM

The key ‘selling points’ of the medical tourism industry are its ‘cost effectiveness’ and its combination with the attractions of tourism. The latter also uses the ploy of selling the ‘exotica’ of the countries involved as well as the packaging of health care with traditional therapies and treatment methods.

Price advantage is, of course, a major selling point. The slogan, thus is, ‘First World treatment’ at ‘Third World prices’. The cost differential across the board is huge: only a tenth and sometimes even a sixteenth of the cost in the West. Open-heart surgery could cost up to $70,000 in Britain and up to $150,000 in the US; in India’s best hospitals it could cost between $3,000 and $10,000. Knee surgery (on both knees) costs 350,000 rupees ($7,700) in India; in Britain this costs ‘10,000 ($16,950), more than twice as much. Dental, eye and cosmetic surgeries in Western countries cost three to four times as much as in India.

The price advantage is however offset today for patients from the developed countries by concerns regarding standards, insurance coverage and other infrastructure. This is where the tourism and medical industries are trying to pool resources, and also putting pressure on the government. We shall turn to their implications later.

In India the strong tradition of traditional systems of health care in Kerala, for example, is utilised. Kerala Ayurveda centres have been established at multiple locations in various metro cities, thus highlighting the advantages of Ayurveda in health management. The health tourism focus has seen Kerala participate in various trade shows and expos wherein the advantages of this traditional form of medicine are showcased.

A generic problem with medical tourism is that it reinforces the medicalised view of health care. By promoting the notion that medical services can be bought off the shelf from the lowest priced provider anywhere in the globe, it also takes away the pressure from the government to provide comprehensive health care to all its citizens. It is a deepening of the whole notion of health care that is being pushed today which emphasises on technology and private enterprise.

The important question here is for whom is ‘cost effective’ services to be provided. Clearly the services are cost effective for those who can pay and in addition come from countries where medical care costs are exorbitant - because of the failure of the government to provide affordable medical care. It thus attracts only a small fraction that can pay for medical care and leaves out large sections that are denied medical care but cannot afford to pay. The demand for cost effective specialized care is coming from the developed countries where there has been a decline in public spending and rise in life expectancy and non-communicable diseases that requires specialist services.

MEDICAL TOURISM AND PUBLIC HEALTH SERVICES

Medical tourism is going to only deal with large specialist hospitals run by corporate entities. It is a myth that the revenues earned by these corporates will partly revert back to finance the public sector. There is ample evidence to show that these hospitals have not honoured the conditionalities for receiving government subsidies - in terms of treatment of a certain proportion of in patients and out patients free of cost. ‘If anything, increased demand on private hospitals due to medical tourism may result in their expansion. If they expand then they will need more professionals, which means that they will try to woo doctors from the public sector.’ Even today the top specialists in corporate hospitals are senior doctors drawn the public sector. Medical tourism is likely to further devalue and divert personnel from the public sector rather than strengthen them.

Urban concentration of health care providers is a well-known fact - 59 per cent of India’s practitioners (73 per cent allopathic) are located in cities, and especially metropolitan ones. Medical tourism promotes an ‘internal brain drain’ with more health professionals being drawn to large urban centres, and within them, to large corporate run specialty institutions.

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Medical tourism is going to result in a number of demands and changes in the areas of financing and regulations. There will be a greater push for encouraging private insurance tied to systems of accreditation of private hospitals. There is a huge concern in the developed countries about the quality of care and clinical expertise in developing countries and this will push for both insurance and regulatory regimes. The potential for earning revenues through medical tourism will become an important argument for private hospitals demanding more subsidies from the government in the long run. In countries like India, the corporate private sector has already received considerable subsidies in the form of land, reduced import duties for medical equipment etc. Medical tourism will only further legitimise their demands and put pressure on the government to subsidise them even more. This is worrying because the scarce resources available for health will go into subsidising the corporate sector. It thus has serious consequences for equity and cost of services and raises a very fundamental question: why should developing countries be subsidising the health care of developed countries?

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