Medical Tourism: For Richer or Poorer

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Please note: a longer paper can be made available on request.

Introduction

This paper has primarily emerged from an interest I have had in medical tourism for the last three to four years, where I have only started to engage in serious research on the topic this year. My research is to culminate in fieldwork to be conducted in India next year, where I will be undertaking a hospital ethnography in Mumbai in an effort to examine the "micro-macro" links in medical tourism through "studying up", the method first discussed by Laura Nader (1969). However for the purpose of this paper, I will be taking a "macro" snapshot of the industry.

If the promotional material originating from industry and the governments of an increasing number of countries are to be believed, the dynamic growth of a fledgling industry catering to the travel of people abroad for the purpose of the 'consumption' of high-tech, specialised biomedical services is set to explode internationally. Medical tourism in its contemporary manifestation may conjure images of plastic surgery undertaken in tropical locales gone wrong or of an industry profiteering from organs ripped from poor, live victims in Third World countries to transplant into wealthy foreigners. Even though elements of the organ transplant trade and plastic surgery undertaken abroad may well fall within the broader category of medical tourism, it also incorporates many other practices and is an increasingly common undertaking for many across the globe. This international market in medical tourism is ostensibly driven by the complementary pressures of high demand and cost of treatment in the West and the low cost and high quality of care in a number of Third World destinations. Although reports on the current global economic status of this service industry are wide ranging, industry reports have estimated it could be currently worth as much as US$60 billion and growing at a rate of 20 per cent per annum (MacReady, 2007:1849). Although much remains unquantified, the increasingly aggressive development of medical tourism in a number of countries indicates the importance that is being placed on the sector as vehicle for future economic development.

It is being promoted as a rational economic development strategy or "export niche" for Third World nations with a comparative advantage and a way of outsourcing healthcare for Western countries with escalating waiting lists and costs. However, behind the hospitals of excellence are local populations facing critical health issues, where social, cultural and economic inequities are widening. To exacerbate this situation many of the countries actively promoting medical tourism for foreigners are incrementally decreasing public health funding whilst continuing in patterns of health care system commercialisation. To this end, the question of healthcare ownership arises. It is clearly something that is internationally viewed as something that can be "owned" as it is bought and sold on a private market. However, the complexities in this issue abound, particularly when seen through the lens of claims on rights to healthcare, which in turn leads to question of whether healthcare services being sold in medical tourism are in fact appropriated. This paper draws on theory from both critical medical anthropology and rights-based development in order to unpack some of these issues through an exploration of current forms of transnational health care seeking, looking at the relationship of medical tourism with the increasing gaps in equity between the poor and the non-poor. To this end, this paper examines systemic structures of power manifest in the dominant discourses produced by social actors and institutions across the globe and how ideas of health and health care have changed over time.

Background and context

Although there are distinctly new trends and patterns emerging in contemporary times, international travel for health purposes has had an extensive history. From as early as the Neolithic period, people have travelled long distances to specific geographic locations across Europe in order to conduct rituals and for other perceived health benefits. Indeed this practice continued in varying forms throughout medieval times, where by the 18th century the upper strata of European classes often travelled across borders in order to bathe in thermal springs for medical purposes. (Goodrich, 1993)

However, in contemporary times medical tourism occurs both across and between both richer and poorer countries and is motivated by a variety of elements such as: cost of treatment; quality of services; length of waiting time; and availability of complementary and alternative medicine. One of the first countries to actively promote this new form of medical tourism was Cuba. In the early 1990s the Cuban government advertised "sun and surgery" packages including dental, cardiac, organ transplant and cosmetic procedures in conjunction with spa or "wellness adventures". Goodrich & Goodrich (1987) conducted one of the first academic studies of health tourism, developing an early definition of the term as:

> …the attempt on the part of a tourist facility (eg hotel) or destination (eg Baden, Switzerland) to attract tourists by *deliberately*[1] promoting its health-care facilities, in addition to its regular tourist amenities. (Goodrich & Goodrich, 1987:217)

In subsequent years, the labels health tourism, healthcare tourism and medical tourism have been used broadly and somewhat interchangeably, with the more recent addition of a number of other descriptors. Several anthropologists who have looked at the area have used the term "medical travel" (B. Kangas, 2007; B. A. Kangas, 2002; Whittaker, 2008). Another label, 'medical outsourcing', is also increasingly creeping into the discourses used by economists and the media (Bookman & Bookman, 2007; Kher, 2006; Wachter, 2006), presumably in context of India's Information Technology (IT) services boom.

[1] Author's accent

A tentative and relatively broad definition of medical tourism offered for the purposes of this paper is the movement of individuals from one location to another primarily in order to seek medical services. Further to this, my area of interest lies in the movement of individuals travelling from Western countries to Third World destinations. I also concede that further examination of this terminology is required in order to examine the usefulness, or more so the applicability of the word "tourism" in this practice. This is partially due to general definitions of tourism that denote its direct link to the pursuit of leisure based activities, which sit uncomfortably within the context of the types of health seeking behaviour examined, particularly when examined in a rights-based framework.

Transnational Flows of Patients and Health Care Professionals

Although it has been established that health related travel is not a new phenomena, the global direction of patient travel is purported to be shifting away from individuals travelling from poor countries to rich destination countries in order to access health services unavailable at home, towards that of individuals from rich countries travelling to poorer nations (de Arellano, 2007; Whittaker, 2008). Some of the major destinations for medical tourism currently are Jordan, Mexico, Brazil, Cuba, Thailand, Singapore, the Philippines, South Africa, and India. Another emerging destination is Dubai in the United Arab Emirates, where currently what is being dubbed a "medi-city" being built, scheduled to open in 2010.

Since the Asian financial crises of the late nineties, more affluent citizens from Asian countries who had previously travelled to the USA for health services could no longer afford to. At this time Bumrungrad Hospital in Thailand began to attract many of these clients and is now one of the most well-known medical tourist destinations in the world. This trend intensified after the September 11 attacks in New York, when Arab citizens were discouraged from travelling to the United States, where in between the years of 2001 and 2006 the number of Arabs treated at Bumrungrad Hospital rose from 5,000 to 93,000. (MacReady, 2007)

Bumrungrad Hospital has also recorded shifts in the types of health care services sought by foreigners, with the high ratio of cosmetic surgery reducing in favour of non-cosmetic procedures. Non-cosmetic treatments now amount to approximately 80 per cent of treatments received by Americans (Milstein & Smith, 2006). Milstein & Smith (2006) argue this is a direct consequence of the struggling health care system in the United States, where a marked increase in insurance premiums has been coupled with the growth of out-of-pocket payments over the past decade, leaving swathes of the populace unable to access affordable health care at home (Milstein & Smith, 2006).

A major issue emerging in the literature pertaining to medical tourism is speculation regarding whether medical tourism facilitates the internal "brain-drain" or migration of health professionals geographically and institutionally, from both rural to urban locations and public to the private health systems. However, this argument has been countered by the contention from industry that medical tourism is serving to stem the external flow of health care professionals to foreign countries.

Although the flows of health workers across and within national borders is yet difficult to quantify due to a lack of monitoring, a representative of the World Health Organisation has contended that from "initial

observations" medical tourism appears to encourage both movements (World Health Organisation (WHO), 2007), but to what ratio this 'double movement' of health workers is occurring remains unclear.

Neoliberal Economic Development and the International "Health Care Market"

As Rabinow notes, "(n)o one can doubt the growing scope and scale of market relations and the concomitant commodification of an ever-greater range of things previously held to be external to the realm of monetary value" (2005:41). The emergence of literature on the increasing role played by the market in health has featured prominently in academic journals, policy research papers for international institutions and international commissions particularly as a result of the neoliberal Structural Adjustment Programs (SAPs) implemented across many countries in the 1980's and early 1990's, generally imposed by the World Bank and the International Monetary Fund (IMF).

Critical theorists have questioned the basis of market-led health systems, where a range of social scientists have examined global shifts towards the commercialisation of health care and the consequent mounting frictions between the competing principles of health care as a commodity or a right. However, commercialisation within the health sector is not a new phenomenon, where there has been an historical precedence internationally with cycles of commercial health expansion, opposition and then retreat over time (Mackintosh 2006). Waitzkin (2000:7) has argued that the commercialisation of health care is a *fait accompli* in context of the capitalist system where "from the standpoint of private profit, there is no reason that corporations should view medicine differently from other goods and services".

Reflecting upon the main claims in the emerging literature on medical tourism, much is framed around the posited economic benefits for the "destination" country and the prospects of medical tourism in driving economic development. This can be illustrated by a study produced by Bookman & Bookman (2007), which is also the only academic book that has been published on medical tourism to date. This study predominantly examines medical tourism's potential for promoting economic development within Third World countries. The argued benefits are generally framed by three central claims. Firstly it is contended that it will increase export earnings through attracting foreign exchange into the country, hence lowering fiscal deficit and assisting the growth of the national economy. Secondly, it is argued that the combination of increased medical technologies and the growth of health specialists and greater levels of expertise will generally raise the standards of health care across the country through competitive market practices, which will eventually translate to an increase of the standards in the public sector. (Bookman & Bookman, 2007) Although in general the media, government and private sectors are maintaining medical tourism will improve the public health care system and health status of the population, rhetoric surrounding the methods in how this will be achieved is either absent or employs the widely critiqued notion of the "trickle-down" concept. The general assertion made is that economic growth derived from medical tourists will be siphoned back into hospitals, improving the technology and equipment, which will benefit the population at large. Thirdly, it is argued that the economic growth medical tourism could generate would

result in an overall increase of national income, thus creating equity in access through allowing more of the population access to private care. (Henderson, 2004; Turner, 2007)

Despite these arguments, it has been widely acknowledged that many economic development programs implemented in the past have been extremely detrimental to different sectors of the population through the disregard for their social effects[2]. Regardless of this acceptance there are many elements of medical tourism, specifically when viewed as a facilitator of economic development, which echo past development outlooks. Firstly, the high-tech nature of most medical tourism brings it association with modernism, placing it in prominently and positively in the public eye, serving as an example of the of a nation's "development". This is argued to draw attention away from faltering public health systems and public health via a distortion of priorities. (Bookman & Bookman, 2007:176) Secondly, government promotion, concessions and incentives directed towards the medical tourism industry are challenged in contexts where public health expenditure is consistently reduced (Chacko, 2005; Lautier, 2008).

Another of the most widely employed criticisms refers to the further entrenchment of a two-tiered health system, where it could cause or exacerbate a dual market structure consisting of: (1) a high quality and high priced sector catering to foreigners and affluent nationals; (2) a resource constrained and lower quality sector catering to the majority of the local population (Chanda, 2001; de Arellano, 2007; Whittaker, 2007). I also contend that medical tourism is contributing towards the increased medicalisation of care, where the dominance of biomedicine has been raised by A. S. Gupta (2004) who contends that:

> 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 technology and private enterprise.

Following critical medical anthropology (CMA) theory, I also contend that medical tourism's growing prominence in the international system is a result of its compatibility with the growth of the international market economy and through its capacity to support the dominant capitalist class, in a manner that transcends national borders.

Human Rights and Health

The view of health as a human right has evolved alongside other human rights discourses. Although not expressly stated as a right within the United Nations *Universal Declaration of Human Rights* (1948), the UN Economic and Social Council have directly stated that "(h)ealth is a fundamental human right indispensable for the exercise of other human rights" (ECOSOC (United Nations Economic and Social Council), 2000). The World Health Organisation has had substantial involvement in the promotion of health as a human right, as illustrated in the influential 1978 Alma Ata Conference and consequent Declaration which defines health as "a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity" (WHO 1978). This declaration expressly states that *health is a human right*,

[2] Such as the Structural Adjustment Programs (SAPs) delivered by the World Bank and the IMF to many third world countries from the 1980s on.

requiring the engagement of a range of other social and economic areas in order to realise the maximum level of health.

More recently, a growing number of theorists are engaging in health and human rights related discourses particularly in relation to health inequities. Farmer (2002) contends that equal access to medical care is a social and economic right, as essential to human rights as that of civil rights. He additionally argues that violations of this right are a result of "structural violence", a theoretical proposition that has been taken up by many in a range of fields. This terminology is generally used to describe indirect systemic violence that is imposed upon the "oppressed".

When placing medical tourism in a rights-based framework, initial questions of inequity emerge as a primary consideration. The definition of inequity, in terms of health, is usually explained in conjunction with health inequality. Most simply defined, "inequity is an unfair and remediable inequality" (Feachem, 2000:1) where health inequality is the relative disparities in health status between differing groups as defined by characteristics such as social, cultural, regional, economic and gender. Hence, the concept of inequity entails a moral or ethical dimension and is focused upon "creating equal opportunities for health and with bringing health differentials down to the lowest level possible" (Whitehead, 1991:221). Although equity approaches in health are broad in scope, most question the ostensibly conflicting understandings of the way health and health care should be distributed. This is pertinent to medical tourism, particularly in countries such as India and Thailand, as the industry is being developed as technologically advanced, highly specialised health services specifically targeting those with considerably higher economic capacity rather than the general populace. This can also be related to depictions by Scheper-Hughes (2005) of the organ transplant trade, where she speaks of a "globalized apartheid medicine" that benefits one group of patients over the other due to class.

Conclusion

Despite the growing significance of medical tourism in the international arena, it has been a distinctly under-studied area in academia. To date, normative claims of neoliberal economic development have directed the majority of discourses on the subject. These discourses have not allowed space for the investigation of the potential social effects it may have, particularly on equity for the more vulnerable groups within destination countries. Many issues have not been considered and a number of assumptions remain unquestioned, such as: will market mechanisms actually intrinsically ensure that the growth of medical tourism will assist the wider health systems in poorer countries? Who are the main groups and actors to actually benefit from the policies and new institutions created for the promotion of medical tourism? What are the major social risks created through the growth of medical tourism and which groups are most likely to be subjected to them?

The importance of roles played by different social actors and groups in the promotion and proliferation of medical tourism remains unclear, with international institutions such as the WTO representing a new arena of pressure with regard to the rules and regulations it has the power to enforce. Governments in Third World nations seem to also be playing a dominant role in the facilitation of trade in medical tourism, but what ideologies are their decisions based upon? How do the ideologies of the private market impact upon biomedical institutions, particularly when they are reconfigured as corporate entities? What is the impact of

commercial pressures upon the role of health professionals in their working lives? These questions and many others raised by this paper highlight the significant gaps in knowledge in the area of medical tourism, specifically in the context of Third World countries and the challenge remains for a range of disciplines in academia, particularly anthropology at its critical best, to engage in these issues of power, place, rights and ownership in order to allow for the voices of not one, but many, to be heard.

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