

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

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*“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)<sup>1</sup>*

“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.<sup>2</sup> 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.<sup>3</sup> 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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<sup>1</sup> Italicized quotes are taken from published on-line testimonials from previous Congresses, available at: <http://www.medicaltourismcongress.com/en/testimonials.html>.

<sup>2</sup> 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.

<sup>3</sup> 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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