Conclusions: Medical Tourism Today and Tomorrow

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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 1 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.

[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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