

Medical Tourism in Guatemala: Qualitatively Exploring How Existing Health System Inequities Facilitate Sector Development

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Abstract

This article explores how existing health inequities in the Guatemalan health system facilitate the emergence of its medical tourism industry. We report on our thematic analysis of 50 key informant interviews conducted with 4 groups of stakeholders in the local medical tourism sector. Participants frequently discussed the interplay between the country's longstanding health inequities and the promotion of medical tourism, characterized by 4 thematic viewpoints: the private health sector is already flourishing; the highly fragmented health system already faces multiple challenges; the underfunded public health sector has a weak regulatory capacity; and the commodification of health care has already advanced. Medical tourism and health inequities

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shape each other in low- and middle-income countries. In addition to the potential for medical tourism to exacerbate health inequities, previously existing health inequities create opportunities for the industry's growth. Although regulation of the medical tourism industry is necessary, it needs to be implemented both at the domestic and supranational levels for it to be effective in preventing greater health inequities, and it needs to address the political and economic drivers that make health systems generate health disparities.

Keywords

Guatemala, health inequities, health systems, medical tourism, qualitative methods, regulation

Medical tourism generally refers to traveling to another country for medical care. Here we use the term to include the deliberate international travel aimed at accessing private, nonemergency medical interventions, therefore excluding sick or injured travelers, expatriates using medical care, and cross-border care approved by governments. Medical tourism is growing both in terms of the number of Global South countries promoted as destinations¹ and its weight in the global economy.² Although the medical tourism industry is primarily a consumer-driven response to health care demand, many national governments promote, and even invest in, this sector.^{3,4} This is generally due to the perceived financial benefits of a sector that promises to diversify and increase the inbound flow of tourists.¹ As such, medical tourism has become a burgeoning offshoring export in numerous Global South countries, including countries in the Latin American and Caribbean (LAC) region that are pursuing the introduction or expansion of this sector.⁵ In the LAC region, countries are seeking to stimulate medical tourism through government initiatives and business platforms aimed at attracting patients from the United States, Canada, or elsewhere in the LAC region, promoting a variety of procedures such as cardiac, cosmetic, dental, and orthopedic surgeries.⁶ While Costa Rica, Cuba, Mexico, and Panama are well-established medical tourism destinations in the region, other countries like the Bahamas, Belize, Cayman Islands, Colombia, Jamaica, and Turks and Caicos are seeking to develop their sectors.⁷

The growth of medical tourism has raised concerns that this practice can generate or increase health inequities.⁸ Understanding that health inequities are unfair differences in health status that are produced by systemic disadvantages in access to health care or to the social determinants of health, it has been

argued that medical tourism could negatively affect fair access to health care in destination countries, given that medical tourists would compete with locals to utilize the same limited resources.⁹ Following this argument, medical tourism could increase health inequities through several mechanisms. For example, health care workers in the public sector could be attracted to work for private clinics serving medical tourists, thereby increasing human resource shortages in the public sector and directly impacting the availability of health care for locals.¹⁰ Additionally, an emphasis on developing the supply of upscale or specialized services may lead to the segmentation of the private sector, generating health care facilities and health care professionals that locals could not afford.¹¹ Another source of concern is that the foreign investment in medical tourism infrastructure may imply that the revenue produced by this industry would go back to a foreign country, annulling any significant benefits for the destination country.^{7,12} Although a growing body of research examines the health equity effects of medical tourism in destination countries, none addresses the interaction between already existing health inequities and the emergence of medical tourism.

This article explores how existing health inequities in the Guatemalan health system actually facilitate the emergence of its medical tourism industry. We begin by giving relevant context on Guatemala, one of several countries in the LAC region attempting to develop a medical tourism sector. Then, after describing the research methods, we report on the findings of 50 key informant interviews conducted with 4 groups of stakeholders in the local medical tourism sector. We move on to discuss our findings in light of the broader literature, to then conclude with the implications of the Guatemalan case that may be transferable to other countries that are at a similar stage in developing their medical tourism sectors.

Overview of Guatemala's Health System and Medical Tourism Capacity

Guatemala has an area of 108,000 km² and is located in Central America. Of its estimated population of 15.6 million, 51% are women, 36% are under 15 years of age, 41% are indigenous, and 51% live in rural areas.¹³ Although its 2017 gross national income (GNI) of US\$4,060¹⁴ reclassifies it from a lower-middle income country to an upper-middle income country, 59% of its population lives in poverty and 23% in extreme poverty,¹³ reflected in gross economic inequalities like a Gini coefficient for income distribution of 0.59.¹⁵ Social and economic exclusion are more dramatic among indigenous peoples who live in rural areas, where poverty levels can be close to 90%.^{13,15}

Guatemala's health system is segmented and fragmented, and it is composed of a loosely coordinated network of public, private nonprofit, and private

for-profit institutions.¹⁶ Immediately after the end of its civil war in 1996, Guatemala introduced neoliberal health sector reforms aimed at increasing the participation of the private sector in health delivery and financing, by redefining the role of the public sector as coordinator of the health system and promoter of public-private partnerships. These reforms were introduced primarily as conditions attached to “structural adjustment” loans from the Inter-American Development Bank and the International Monetary Fund.¹⁷ Guatemala’s total health expenditure is low in comparison with other countries in the region, and 55% of it is out-of-pocket.¹⁸ Public health expenditure grew from 1.4% to 2.0% of gross domestic product (GDP) between 1995 and 2001, but since then it has fluctuated between 1.8% and 2.2%.¹⁸ Private health expenditure grew from 2.4% to 4.6% of GDP between 1995 and 2001, and since then it has fluctuated between 4.0% and 4.7%.¹⁸ These trends indicate that the public health care sector remains underfunded, while private care facilities have proliferated.

Despite the disproportionate increase in private health expenditure, the majority of the population uses public health care facilities. Estimates from 2014 show that Guatemala’s public health care sector served 58% of the country’s population, while the private sector covered 11%, with 31% not having any health coverage.¹⁸ Although underfunded public health facilities generally serve the poor, while private care is accessed by those who can afford the costs, Guatemalan health care utilization data finds that 26% of those utilizing private clinics are poor, and 41% of those using public health care centers are non-poor.¹³ Overall, between 2000 and 2014, the percentage of population utilizing private clinics decreased (from 37% to 22%), while it increased for public health care centers (from 15% to 19%), public hospitals (from 9% to 18%), and private hospitals (from 3% to 5%).¹³ These data suggest that although private care facilities serve a small proportion of the population, the poor are starting to use them when they do not find solutions through the underfunded public sector. Inequitable access to health facilities likely underpins inequalities in key health outcomes, notably in the maternal mortality rate per 100,000 births (country average 140, urban 34, rural 66, indigenous 163, non-indigenous 78) and the percentage of births in health care facilities (country average 51%, urban 77%, rural 36%, indigenous 29%, non-indigenous 70%, no formal education 25%, secondary education 89%).¹⁹

Notwithstanding Guatemala’s apparent failure to provide equitable or adequate health care access to its own population, the country’s medical tourism industry, although presently small, has grown constantly over the past decade.²⁰ The medical tourism sector consists of clusters of private hospitals, clinics, hotels, and tour operators, primarily located in Guatemala City and Antigua Guatemala.²¹ These service providers have consolidated their work through the Guatemala’s Tourism Commission for Health and Wellness, which is part of the Guatemalan Association of Exporters (AGEXPORT). This sector has received

governmental support through the Ministry of Economy and the Guatemalan Tourism Institute (INGUAT), mainly in the form of marketing and promotion within Guatemala and at business fairs in the United States. There have also been conversations about introducing tax incentives.²¹ No health care facilities are dedicated solely to serve medical tourists, and the sector's strategy is for medical tourism to fill private care facilities' unused capacity.²¹ While the current number of medical tourists in Guatemala is reportedly low, with the majority being from the diaspora or from neighboring LAC countries, the sector aims to attract patients from the United States and Canada through marketing efforts.²⁰

Methods

This analysis is part of a larger study aimed at identifying the health equity impacts of the growth and development of medical tourism sectors in the LAC region on health inequities. Health inequities are understood as the differences in health outcomes or status between societal groups that are systematic and unescapable, and thus unfair or unjust.²² To identify these impacts, we sought to find anticipated or already occurring health system and policy changes related to medical tourism with special attention to their influence on increasing or decreasing health inequities. We looked for changes across 5 domains: public health care, private health care, health human resources, investment, and domestic government involvement.

We employed comparative case study methodology, which aims at generating a nuanced understanding of a phenomenon and its context, characteristically by drawing on multiple sources of information.²³ The case study sites were Barbados, Guatemala, and Mexico. Although we have presented comparative analyses elsewhere,^{24,25} we concentrate here exclusively on the Guatemalan case because it provides insights that enrich current discussions about the relationship between medical tourism and health inequities and how these existing inequities are enabling sector growth.

Consistent with our comparative case study design, we initially conducted an extensive review of media and policy documents about medical tourism in Guatemala and the health system in general.²¹ We then conducted site visits to observe and understand the dynamics that surround medical tourism development. The visits included public and private health care facilities and informal conversations with government officials, representatives from the country's 2 committees promoting medical tourism, and health workers. Finally, we conducted 50 key informant interviews aimed at identifying potential health equity impacts of the country's medical tourism sector development. These interviews form the basis of the current analysis.

Research Participants

We sought to recruit 50 key informants to participate in semi-structured face-to-face interviews, using purposeful sampling²⁶ to identify key informants with specialized knowledge or experience relevant to medical tourism in the context of the Guatemalan health system. We identified potential participants by locating names in our review of media and policy documents, through the networks of our local nongovernmental organization (NGO) collaborators, and through site visits. We sought key informants from 4 sectors: (1) civil society (NGOs, community groups, and the media); (2) government representatives (authorities, administrators, and managers from the Ministry of Health and the Ministry of Economy, and representatives from the Municipality of Guatemala City); (3) health human resources (health care workers, health human resources experts, and authorities from medical and nursing schools); and (4) medical tourism sector representatives (owners of private clinics, private hospital board members, tourism experts, investment experts, and members of the 2 committees promoting medical tourism in the country). We aimed to recruit 5 civil society representatives and 15 representatives from each of the other 3 sectors. We contacted the majority of potential participants via email, explaining the study and interview details. In some cases, we approached potential participants in person or by phone when the circumstances made email less appropriate. In all cases, those who received an invitation were asked to reply by phone or email to express their interest in participating in the study, after which we scheduled an interview at an agreed upon time and location.

Data Collection

We conducted semi-structured interviews between June and December 2013 in Guatemala City and Antigua Guatemala, the 2 main sites of medical tourism sector development in the country. Interviews lasted 45 to 90 minutes and were conducted one-on-one, with the exception of 2 participants who were interviewed together. The interview guide included a set of common questions asked of all participants, as well as questions specific to participants' areas of expertise. The majority of questions focused on the 5 health system domains of interest: public health care, private health care, health human resources, investment, and domestic government involvement. Interviews were conducted in Spanish by the first author and an assistant who was hired by our partner NGO. Informants were advised of their rights as participants and asked for verbal consent to participate in the study. Receipt of verbal consent was recorded on a form.

Ethics

The study protocol received ethics approval by the institutional review boards of Simon Fraser University (2012 s0148) and the University of Ottawa (1104-12-13). All study participants provided their free and informed written consent.

Data Analysis

Digital audio recordings of the interviews were translated and transcribed. We independently reviewed a selection of transcripts to identify topics for thematic analysis and develop a coding scheme. We then imported all 50 transcripts into NVivo 10, a qualitative data management program,²⁷ where a single investigator coded the full dataset to enhance continuity and methodological rigor. After coding was complete, we extracted the codes related to health equity and inequity in the dataset and reviewed the extracts to identify emergent themes. The thematic analysis then focused specifically on exploring how existing health system inequities facilitate development of Guatemala's medical tourism sector. Four central themes were identified and shared with the research team to confirm interpretation and then compared and contrasted with existing literature.

Findings

Participants frequently discussed the interplay between the country's longstanding health inequities and the promotion of medical tourism. While promoters of medical tourism identified existing health inequities among the industry's strengths and opportunities for growth, other participants pointed to the low priority that medical tourism regulation should have from a health care system perspective because of the pressing need to address these same inequities. In the remainder of this section we explore 4 thematic viewpoints that characterize these perspectives:

1. The private health care sector is already flourishing and having an impact on the supply of services and human resources dynamics in the public sector; thus, medical tourism does not change this reality, although it may exacerbate it.
2. The health system already faces numerous challenges, including segmentation and fragmentation, which facilitates medical tourism sector growth while making it a low regulatory priority.
3. The public health care sector is already underfunded and inefficient, especially in its regulatory capacity, and medical tourism does little to address this.
4. The commodification of health care is already implemented through a segmented and tiered private sector that differentiates access based on purchasing power, which is something that medical tourism capitalizes on but does not create.

In the discussion that follows, we identify some of the connections between these findings.

Flourishing Private Health Care Sector

Guatemala's private health care sector has thrived in the past 20 years. There are approximately 400 private hospitals and 4,000 private clinics, two-thirds of which are concentrated in the Guatemala City metropolitan area, with participants noting that the majority of these were founded after 1996 and the adoption of neoliberal health reforms. The size of the private health sectors is in stark contrast with the country's 44 public hospitals and 333 health centers,²⁸ which are more evenly distributed although primarily in urban areas. Participants commonly noted the high concentration of health care professionals and private clinics in urban areas. Participants explained that the growth of the private sector has had 2 effects relevant to medical tourism: (1) it has led to excess capacity in big urban centers that medical tourists can take advantage of; and (2) it is already draining nurses and physicians from the public sector into the private sector, which means that private clinics targeting international patients are attracting those health workers.

Many participants see the excess capacity in the private sector and the high concentration of private facilities and health care professionals in metropolitan areas as opportunities for the development of the country's medical tourism industry. As one participant put it, "I know of a lot of colleagues that [. . .] would not go to a very remote town in the rural areas to make a living. But suddenly they are in the city without a constant flow of clients. I do not think it is unethical to chase the kinds of opportunities given by [treating] foreign clients." A private clinic operator further explained that "some [medical] equipment is especially delicate, and the electric energy peaks aren't very stable in the interior of the country, and they are in Guatemala City. Some places don't even have electricity . . . all that damages the equipment," adding that "we have to grow [in the city to] provide the same kind of service we offer to foreigners, which is high-quality service." Similarly, a medical tourism advocate argued that "we are already ready for the international market, [and once we] go out in an organized manner we will be at an advantage," given that private clinics with excess capacity and professionals are already in place. Finally, a tourism operator said, "we already have the capacity to treat a great portion of international patients," adding that hospital directors "with vision" see the advantage of increasing hospital occupancy "with patients who have the [purchasing power] of a middle-class person from a country like the United States."

A complex relationship exists between private and public health care facilities in Guatemala, illustrated by a bidirectional flow of nurses, physicians, and patients. Participants told of how nurses try to get hired in a public hospital, which offers job stability and benefits, and supplement such employment with 1 or 2 jobs at private facilities for extra income and schedule flexibility. Physicians look for the same perks, but they also like to offer access to public diagnostic and therapeutic resources to private patients when costs or equipment offer an

advantage. A participant speculated the same spillover into the public sector could happen when treating private medical tourists and explained how “some [patients] come [to this public hospital] from private [clinics] and have a higher economic status, and they come because they know a physician [who works here].” The participant further explained that those patients “are the ones we call the VIP [very important patients]” and that they usually are physicians’ friends, relatives, or patients from their private practice, or sometimes they are referred by a private clinician with a close relation to one of the hospital’s physicians. The same participant stressed that “nurses treat everyone the same, but you can tell the difference in the medical treatment,” because the VIP “get the best possible medical care,” and that these differences “in a certain way, affect the public.” Although the potential impact of medical tourism on this particular type of referral from the private to the public sector is only speculative at this point, the fact that this differential and status-driven practice exists and is accepted suggests that growth in medical tourism is likely to exacerbate these existing discriminatory inequalities.

Health System Already Overwhelmed With Challenges

Every study participant talked about the overwhelming challenges the Guatemalan health system faces. As explained by a participant: “the problems with the health system are rooted in government corruption, but this is a whole different topic” than medical tourism. Similarly, a civil society representative said that “health inequalities are so striking that I do not understand why we are even talking about medical tourism” and showed his surprise to learn that public resources (e.g., tax incentives, government-funded committees) were being devoted to promoting the sector. In contrast, one of the promoters of medical tourism acknowledged the systemic health system problems before adding that “there are problems with the health system but here we are talking about an industry that can create jobs and wealth,” emphasizing that a focus on the country’s health system problems would be a distraction. A sense of the complexity of the challenges is captured in a comment made by a representative from the medical education sector, who has also worked for the public and private sectors: “if we want to look at the problems with the health system, we have to go back to the Spanish colonization period,” which started a history of social and economic inequalities and public health institutional weaknesses so tremendous that “we don’t even know where to start.” Similarly, the manager of a private clinic said: “I don’t understand how we can provide high quality services for outsiders while we cannot for our own [. . .] I don’t know how to solve this issue [. . .] but what we do know is that there is a serious health care problem that needs solving.” Overall, there was a sense that health system challenges are so overwhelming and action to resolve them is so insufficient that, even if

medical tourism contributes to health inequity, growth in this sector is not enough of a concern to focus on relative to other problems.

Because the magnitude and urgency of Guatemala's health system challenges are so great compared to the capacity to address them, many participants observed that this situation has created opportunities in the private care realm that the medical tourism sector is taking advantage of. For example, as one participant explained, "medical tourism only benefits those big health companies," noting that only a handful of large private health care companies already operating in the country are seeking to attract international patients. Participants explained that medical tourism will do little to increase confidence in and use of an underfunded public health care system providing poor quality services. One went as far as to say that "I don't know much about medical tourism, but it will only come to make the contradiction [between public and private care systems] more profound," because advances in care for privately paying international patients will not have an impact on "the average Guatemalan." Overall, there was a sense that the growth of the private sector is inevitable because it satisfies the demands of the few who can afford its services, including international patients, and its growth is synergistic with the failure of the public health system to respond to the internally generated challenges (e.g., funding, human and material resources) it faces.

Absence of Effective Health System Oversight

Most participants saw little to no role for existing regulatory bodies, such as the Ministry of Health or the medical and nursing professional associations, in effectively overseeing or monitoring the medical tourism sector. Although all recognized the role these bodies play in the accreditation and certification of Guatemalan health care facilities and professionals, they also were clear about their limited impact. For instance, in order to operate, health care facilities need registration and accreditation from the Ministry of Health, which are periodically renewed. However, a participant explained that "the Ministry of Health only wants to know if a hospital or clinic has the minimum needed to offer health care without obvious risk to the patients, but they are not looking at the quality of services you offer to your clients." Given that facilities targeting medical tourists already meet more than the minimum requirements, Ministry of Health oversight was seen as irrelevant to the sector, neither hindering nor facilitating its growth (this is a point we discuss in detail elsewhere).²⁹ In contrast, registration and accreditation of physicians and nurses is ultimately in the hands of the corresponding professional bodies, including the Guatemalan Medical Association and the National Nursing School. Although the registration process involves medical and nursing school certification and Ministry of Health supervision, remaining certified mainly comes down to being current with professional dues. As a nurse mentioned, "[professional bodies] do not even have personnel to effectively follow up when there are indications that

something is wrong.” However, the accreditation of medical specialties earned in foreign countries can be harder to obtain if they are not clearly supported by a university-recognized program, as happened to the founder of a radiotherapy clinic targeting medical tourists, whose specialization obtained in the United States was not recognized in Guatemala. This denied him the ability to perform clinical procedures or to make clinical decisions in his practice.

Participants talked about the ongoing changes in health worker education as opportunities and challenges to the development of medical tourism. For instance, some participants from the medical tourism industry mentioned their interest in promoting the creation of nursing programs and medical specialty programs directly targeting medical tourists, while others reported interest in increased English language training opportunities for those in medical and nursing schools so as to better prepare health workers for treating international patients. In contrast, some participants with roles in health human resource education showed concern over the proliferation of medical schools and nursing schools in the past 20 years and the absence of effective oversight of clinical education and quality of care in Guatemala. Medical degrees, offered by only 2 universities in the 2 largest cities in the 1990s, are now offered by 5 universities spread throughout the country. A medical educator explained: “now you can be authorized to run a medical school in your home’s garage because there are no standards of what a medical school should look like.” Nursing degrees have gone from being offered only through the National School of Nursing and through the public health system to now being offered in 4 universities. A participant expressed concern for the lack of standardization in nursing education, which is becoming more relevant with the proliferation of programs. In addition to the university-level nursing degrees, various types of nurse’s aide degrees are now offered at the high school level, making certification virtually impossible. These high school-level degrees only need to comply with Ministry of Education requirements, and people who earn them are not qualified to work in the public sector but may be employed in the private sector. A medical education administrator said about the proliferation of nurse’s aides that “nobody is supervising that [those schools and their students] meet quality standards [. . .], and quite frankly I do not think there would be capacity to supervise all those schools and their graduates.” The proliferation of laxly regulated health care professionals in the context of the expansion of the country’s fragmented and tiered private sector offers opportunities to produce professionals that respond to the needs of the medical tourism industry. At the same time, it has the potential to reinforce the delivery of different levels of quality of care to distinct segments of the society, depending on financial capacity.

An Already Tiered Private Sector

The synergy between public sector attrition and private sector growth has resulted in a health system that is increasingly segmented along exclusionary

lines. Most participants pointed out that it has become normal for people to go to a private clinic if they can, but also that there are exclusive private services where most locals are priced out of health care. Because of this, developing a medical tourism sector that exploits these same services was seen not as creating a new form of inequity but, instead, as exacerbating an existing one. For instance, as one participant explained, in the private sector “we speak of 2 types of medicine here, the medicine that looks for a lot of local patients, these deal with emergency problems and the ones who don’t have alternatives,” and another one “that targets the few local patients who can choose what they want because they can afford it.” The participant went on to note how hospitals in Guatemala are already categorized according to who is being treated, for what, and for how much, and “the fact that we would be treating many international patients won’t affect the local patient” who receives care in the lowest tiered facility.

Other participants favored having an elite group of physicians and clinics focus only on medical tourists, thus creating a new segment in an already segmented market. As one explained, “in Costa Rica I have a friend that 97% of his patients are foreigners, he doesn’t treat the locals, and everyone he sees is from abroad. This is how we should do it, there are excellent clinics here for plastic surgery.” Since it was also acknowledged that differential pricing already exists in private sector, with many providers charging higher prices to those who can afford them, it was thought that medical tourism would not change this. As one participant explained, a clinician would not “charge the same to the lady who sells tacos around the corner” as they would to a banker.

Some participants advocated for no price differences within Guatemala’s private health sector, regardless of where a patient is from or how much they can afford to pay. In other words, equal price for equal treatment. This implies a belief that part of addressing inequities in the health care systems is to enforce standard pricing. However, there was awareness that such an approach would lead to some Guatemalans being priced out of care while some medical tourists would be receiving particularly advantageous pricing. A clinician and strong medical tourism sector advocate asked:

Why would I offer lower-quality services to a Guatemalan and not to an American? I don’t think there’s a difference. If I perform any kind of procedure on you, I’ll charge the same to you, and I don’t care where you’re from, the color of your skin, if you’re a man or a woman. It doesn’t matter to me. Other people do charge differently, if their patients are national or foreign. I don’t think that difference should be made, but everyone’s free to charge whatever they want.

Along these lines, if higher technology treatments are made available with the intent of offering them primarily to international patients, single-point pricing will most certainly price out most Guatemalans. “I think higher costs are a

possibility. I think that most people would increase their costs if there's a lot of medical tourism and if they think they can take advantage of that. The negative impact would be for the local population, because those costs would be really high.”

Discussion

Our thematic analysis presented above suggests that the development of a more robust medical tourism sector is likely to exacerbate longstanding health inequities in the Guatemalan health system. The 4 themes capture different viewpoints on the growth of medical tourism as it intersects with the country's health system: an existing and growing private health sector, health system challenges that facilitate growth in this sector, weak public health regulatory capacities, and a segmented and tiered private sector that determines access based on purchasing power. While some participants viewed these conditions as opportunities for the development of a medical tourism industry, others saw them as evidence that growth in medical tourism and a resulting influx of international patients is unlikely to afford any improvements in the country's health system. We discuss first interrelations between these 4 themes before describing the implications of our findings for medical tourism development and its implications for health equity. This logically leads us to a consideration of policy implications for growth in this sector, as well as future research directions.

The 4 themes we identified in this analysis are interrelated. For instance, the private health care sector has flourished since the 1990s in tandem with the stagnation of the public health care sector as the country adopted political, legal, and administrative measures that have facilitated “privatization by attrition.”¹⁷ The concurrence of private sector growth and public sector stagnation has led to a tiered private sector with overcapacity in its more expensive and specialized market segments. In turn, this has shifted the demand for health human resources that universities and nursing schools now try to fulfill. Similarly, the stagnation and weakening of the public health sector limits its capacity to address inequities at the same time that it reduces its ability to regulate the private health care sector, which in turn allows privatized care to grow in ways that are conducive to the development of medical tourism. Existing research has established that the interplay between the public and private sectors in promoting medical tourism is a manifestation of each sector's role in economic development, health care, and tourism in a given country.⁷ Once a country decides to promote medical tourism, the sector will develop along lines that are consistent with the country's existing health system configuration. For example, while Cuba has developed its medical tourism industry through the public sector, the private sector has been the industry's primary driver in India. Similar to India, in Malaysia and Costa Rica, both with strong public health care sectors, medical tourism has developed primarily through

large investments in the private sector. This has also happened in market-oriented health care systems, like those in Thailand and Chile. In contrast, Guatemala's medical tourism sector is developing as a result of opportunities posed by existing inequities and dysfunction that shape the relationship between the public and private health systems in the country.

Unused capacity in the high-end private health care sector seems to be the main element that is opening the door to the development of medical tourism in Guatemala. Although the private sector has built partnerships with the tourism industry and has sought government support for the promotion of medical tourism, our findings signal that private specialists and their clinics and hospitals are a fundamental driving force in the local efforts at developing the sector. This finding is consistent with local analyses on the topic.²⁰ In contrast, elsewhere in the LAC region, medical tourism has been conceived as a form of diversification of the tourism product and driven forward by tourism-focused initiatives centered in promoting economic growth.⁷ For instance, Colombia, Chile, and Costa Rica have included medical tourism in their economic development strategies and, consequently, have devoted public and private resources (including tax incentives) for industry promotion and for creating infrastructure that combines health care with other touristic activities. Moreover, in some LAC countries, facilities or wings of large hospitals purposely built for medical tourism are being funded through national or international investment, with the intention of creating the capacity needed to generate or sustain the demand by foreign patients. For example, while Cuba has used local public investment and Cayman Islands has relied significantly on foreign private investors, they have both followed an analogous strategy ultimately aimed at generating economic growth.

We noted in the introduction that there is a longstanding debate surrounding the health equity impacts of medical tourism. Although some sources speculate that medical tourism can convey opportunities for improving health equity,⁷ most existing empirical and analytic evidence shows that medical tourism has the potential to cause or exacerbate health inequities.⁸⁻¹⁰ In Guatemala, stakeholders worry that the development of medical tourism will have a negative impact for the country by shifting the emphasis of health worker training, recruitment, and retention toward the for-profit private sector, while devoting public resources to the promotion of medical tourism, as we have described elsewhere.²⁵ This is consistent with what has been described for other countries in the region, including Barbados.^{6,24} However, the findings presented in this article show that Guatemalan stakeholders generally are not worried about the potential for medical tourism to create a tiered health care system in which foreign patients could access quality specialized care that domestic patients could not, due to its costs, because such a system already exists in Guatemala. Moreover, our findings show that the existence of this tiered system is the key driving force for the industry's development. Although this is a novel finding in the medical tourism literature, we consider that its occurrence is likely not unique to Guatemala, given that other

highly segmented health systems have developed similar overcapacity in the context of increasing social and economic inequalities and the implementation of liberalization policies.

It has been argued that countries could use two types of policy interventions to avoid exacerbating health inequities through the introduction of medical tourism. On the one hand, the taxable income produced by the medical tourism industry could be intentionally allocated to enhance the public health sector through macroeconomic redistribution policy.⁷ On the other hand, the regulation of health professions, health care facilities, and tourism intermediaries could be used to shape how the medical tourism sector grows, so that it would not negatively impact availability, accessibility, or quality of health care for locals.³⁰ However, what we can see from this case is that fiscal policy and sector regulation may lessen the exacerbation of inequities but is unlikely to address or mitigate the existing health system inequities that are allowing the sector to grow. This analysis points to the importance of civil society and health advocates in monitoring private health sector initiatives such as medical tourism as well as assertively promoting a dialogue about resolving health inequities. As with other transnational health and health care practices that aggravate inequities, such as organ trafficking and access to essential drugs, medical tourism requires interventions both at the domestic level and at the supranational level that are based on an analysis of the political economic drivers of the phenomena.

Future research should look at the political economy of developing medical tourism in relation to the country's macroeconomic policies concerning taxation and fiscal incentives. Moreover, given that Guatemala has adhered to the Sustainable Development Goals (SDGs), an examination is needed of how the country's implicit commitment to achieving universal health coverage is affecting domestic policies that may redefine the equilibrium between the public and private health sectors, potentially reshaping the medical tourism industry.

These findings need to be interpreted in light of the study's strengths and limitations. Regarding the sample, while a strength is that participants included a balanced sample of stakeholders from sectors related to medical tourism (civil society, government, health human resources, and medical tourism industry), this resulted in a study limitation, namely that the sample did not offer perspectives balanced by gender, ethnicity, social class, or urban versus rural place of residence. Similarly, while the systematic data collection and analysis presented here offers a robust description of the Guatemalan case that supports the transferability of our results, we do not offer a comparison to other cases, limiting the generalizability of our findings and conclusions.

Conclusion

Medical tourism and health inequities shape each other in low- and middle-income countries. Our analysis of 50 interviews in Guatemala shows that, in

addition to the potential for medical tourism to exacerbate health inequities, previously existing health inequities create opportunities for the industry's growth. While the private health sector is already flourishing and impacting service delivery, the underfunded public health sector lacks the capacity to regulate a fragmented and segmented health system that already differentiates patients according to their financial capacity. A political economy analysis of both the underlying health inequities and the development of the medical tourism industry is necessary to tackle its potential for exacerbating health disparities. Although regulation of the medical tourism industry is necessary, it needs to be implemented both at the domestic and supranational levels for it to be effective in preventing greater health inequities, and it needs to address the political and economic drivers that make health systems generate health disparities.

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References

1. Sandberg D. Medical tourism: an emerging global healthcare industry. *Int J Healthc Manag.* 2017;10(4):281–288.
2. Beladi H, Chao C, Ee M, Hollas D. Medical tourism and health worker migration in developing countries. *Econ Model.* 2015;46:391–396.
3. Pocock N, Phua K. Medical tourism and policy implications for health systems: a conceptual framework from a comparative study of Thailand, Singapore and Malaysia. *Global Health.* 2011;7:12.
4. Lautier M. International trade of health services: global trends and local impact. *Health Policy.* 2014;118:105–113.
5. Smith R, Chanda R, Tangcharoensathien V. Trade in health-related services. *Lancet.* 2009;373(9663):593–601.
6. Alsharif M, Labonté R, Lu Z. Patients beyond borders: a study of medical tourists in four countries. *Glob Soc Policy.* 2010;10(3):315–335.

7. Bookman M, Bookman K. *Medical Tourism in Developing Countries*. 1st ed. New York, NY: Palgrave Macmillan; 2007.
8. Álvarez M, Smith R, Chanda R. The impact of medical tourism in low- and middle-income countries. In: Botterill D, Pennings G, Mainil T, eds. *Medical Tourism and Transnational Health Care*. London, England: Palgrave Macmillan; 2013:208–222.
9. Johnston R, Crooks V, Snyder J, Kingsbury P. What is known about the effects of medical tourism in destination and departure countries? A scoping review. *Int J Equity Health*. 2010;9:24.
10. Hopkins L, Labonté R, Runnels V, Packer C. Medical tourism today: what is the state of existing knowledge. *J Public Health Policy*. 2010;31(2):185–198.
11. Labonté R, Runnels V, Crooks VA, Johnston R, Snyder J. What does the development of medical tourism in Barbados hold for health equity? An exploratory qualitative case study. *Glob Health Res Policy*. 2017;2:5.
12. Hoffman L, Crooks VA, Snyder J, Adams K. Health equity impacts of medical tourism in the Caribbean: the need to provide actionable guidance regarding balancing local and foreign interests. *West Indian Med J WIMJ Open*. 2015;2(3):142–145.
13. INE. *Encuesta Nacional de Condiciones de Vida 2014*. Guatemala City, Guatemala: Instituto Nacional de Estadística; 2016.
14. World Bank. GNI per capita, Atlas method (current US\$). <https://data.worldbank.org/indicator/NY.GNP.PCAP.CD>. Published 2017. Accessed July 15, 2019.
15. Cabrera M, Lustig N, Morá H. *Fiscal Policy, Inequality, and the Ethnic Divide in Guatemala*. Washington, DC: Center for Global Development; 2015. Working Paper No. 397.
16. Becerril-Montekio V, López-Dávila L. Sistema de salud de Guatemala. *Salud Publica Mex*. 2011;53(Suppl 2):S197–S208.
17. Verdugo J. The failures of neoliberalism: health sector reform in Guatemala. In: Fort M, Mercer M, Gish O, eds. *Sickness and Wealth: The Corporate Assault on Health*. Cambridge, MA: South End Press; 2004:57–68.
18. MSPAS. *Cuentas nacionales en salud: financiamiento de la salud en Guatemala, período 1995-2014*. Guatemala City, Guatemala: Ministerio de Salud Pública y Asistencia Social; 2015.
19. MSPAS, SEGEPLAN. *Diagnóstico nacional de mortalidad materna, Guatemala 2007*. Guatemala City, Guatemala: Ministerio de Salud Pública y Asistencia Social, Secretaría de Planificación de la Presidencia; 2010.
20. Chaclán O. *Turismo médico y la oportunidad de mercado en Guatemala*. 1st ed. Guatemala City, Guatemala: Camaja; 2012.
21. Cerón A, Flores W, Crooks VA, Labonté R. *An Overview of Guatemala's Medical Tourism Industry; Version 2.0, British Columbia*. Burnaby, Canada: Simon Fraser University Medical Tourism Research Group; 2014.
22. CSDH. *Closing the Gap in a Generation: Health Equity Through Action on the Social Determinants of Health*. Geneva, Switzerland: World Health Organization; 2008. Final Report on the Commission on Social Determinants of Health.
23. Gerring J. *Case Study Research*. 1st ed. Cambridge, England: Cambridge University Press; 2017.
24. Snyder J, Crooks VA, Johnston R, Cerón A, Labonté R. “That’s enough patients for everyone!”: local stakeholders’ views on attracting patients into Barbados and Guatemala’s emerging medical tourism sectors. *Global Health*. 2016;12:60.

25. Johnston R, Crooks VA, Cerón A, et al. Providers' perspectives on inbound medical tourism in Central America and the Caribbean: factors driving and inhibiting sector development and their health equity implications. *Glob Health Action*. 2016;9:32760.
26. Patton M. *Qualitative Research and Evaluation Methods*. 3rd ed. Thousand Oaks, CA: SAGE; 2002.
27. QSR International. *NVivo Version 10* [Software]. Melbourne, Australia: QSR International; 2012.
28. Flores C. *Diagnóstico Nacional de Salud*. Guatemala City, Guatemala: Ministerio de Salud Pública y Asistencia Social; 2017.
29. Labonté R, Crooks VA, Cerón A, Runnels V, Snyder J. Government roles in regulating medical tourism: evidence from Guatemala. *Int J Equity Health*. 2018;17:150.
30. Chen YY, Flood C. Medical tourism's impact on health care equity and access in low-and-middle-income countries: making the case for regulation. *J Law Med Ethics*. 2013;41(1):286–300.

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