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'First World Health Care at Third World Prices': Globalization, Bioethics and Medical Tourism

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Abstract
India, Indonesia, Malaysia, the Philippines, Singapore, Thailand and many other countries market themselves as major destinations for 'medical tourism'. Health-related travel, once promoted by individual medical facilities such as Bumrungrad International Hospital and Bangkok International Hospital, is now driven by government agencies, public–private partnerships, private hospital associations, airlines, hotel chains, investors and private equity funds, and medical brokerages. 'Medical tourists' include patients trying to avoid treatment delays and obtain timely access to health care. Medical travellers also include uninsured Americans and other individuals unable to afford health care in their home settings. Destination nations regard medical tourism as a resource for economic development. However, attracting patients to countries such as India and Thailand could increase regional economic inequalities and undermine health equity. International medical travel might also have unintended, undesired outcomes for patients seeking affordable health care. With globalization, increasing numbers of patients are leaving their home communities in search of orthopaedic surgery, ophthalmologic care, dental surgery, cardiac surgery and other medical interventions. Reductions in health benefits offered by states and employers will likely increase the number of individuals looking for affordable medical care in a global market of privatized, commercial health care delivery.

Keywords bioethics, biomedical hubs, globalization, 'medical tourism'

A passage to India

In 2004, Howard Staab, a 53-year-old carpenter living in Carborro, North Carolina, learned that he needed heart surgery to replace a flailing mitral valve (Lancaster, 2004; Singh and Datta, 2005). Howard had no health insurance. He and his partner, Maggie Grace, tried to

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arrange the operation at nearby Durham Regional Hospital. When they met with the hospital Chief Financial Officer (CFO) they were told the total cost of the procedure would be around $200,000. With an expected hospital stay of five days to a week, the hospital bill alone was estimated to be $100,000. Fees for the surgeon, cardiologist, anaesthesiologist, replacement mitral valve and other expenses would double the cost of care. If complications occurred they would lengthen the period of hospitalization and increase the total price tag. According to the CFO, the hospital required a $50,000 down-payment prior to surgery. The remainder of the bill could be paid in instalments after the operation.

Though Howard Staab worked full time and had some savings, he could not afford the procedure. Maggie had once worked in a department of surgery at a large medical centre. She knew that insurance companies reimburse hospitals at much lower rates than what uninsured patients are charged. She tried bargaining with the CFO. She asked him to let Howard have the surgery at the same rate as insured patients. The CFO said there was no administrative procedure for offering discounted group rates to uninsured patients. Obtaining health insurance prior to the operation was not feasible. With Howard's heart problem classified as a 'pre-existing condition', any coverage he obtained would exclude reimbursement for mitral valve surgery.

Howard and Maggie began exploring other options. In such circumstances, when confronted with serious, potentially life-threatening health problems and six-figure medical bills, some individuals empty their bank accounts, sell their homes, obtain loans, borrow money from friends and purchase treatment. If the procedure goes well, they often replace a health crisis with a financial crisis. Given the cost of many medical procedures in the United States, some uninsured individuals conclude they cannot afford medical care. Inability to access medical care sometimes has fatal consequences; in other circumstances individuals survive their health problems but suffer diminished quality of life. Some uninsured individuals receive treatment when they arrive with life-threatening conditions at a hospital emergency room. Then, if their health improves, they face the challenge of avoiding bankruptcy and debt collectors. To avoid having their assets taken from them by collection agencies some street-smart individuals provide false identities when they are hospitalized.

Howard and Maggie decided they were not prepared to risk waiting until Howard was so ill that a nearby hospital would have to provide him with emergency medical care. Organized, resourceful and determined to find affordable medical care, they comparison-shopped. They considered arranging surgery in Argentina and Mexico, found a facility in Eastern North Carolina willing to provide care for $70,000, and communicated with a sympathetic Texas-based doctor who promised them he would replace the valve for the all-inclusive price of $45,000. Then, weighing their options and following advice offered by Maggie's son, at the time a second-year medical student at Stanford University, they decided to travel to India for Howard's surgery. There, at the Escorts Heart Institute and Research Center in New Delhi, Dr Naresh Trehan replaced the mitral valve. There were postoperative complications and a second visit to the operating room, but after a month in India Howard and Maggie returned home. The total cost for the procedure and all related expenses including a three-week stay in the hospital and airfare was just under $10,000. After months of recovery Howard returned to his work as a carpenter-contractor. Maggie started writing a book about their experiences.

During their stay in New Delhi, Maggie maintained a blog about the trip to India and the care Howard received at Escorts. Their website, www.howardsheart.com, provides

insight into one couple's experience of what it is like to travel to India in search of affordable health care. The details of their journey matter, but we can make better sense of why Howard Staab left North Carolina and underwent heart surgery in New Delhi by expanding our frame of analysis from one couple's experience to consideration of the larger national and international contexts within which particular lives take shape.

Over 46 million uninsured individuals live in the United States (Milstein and Smith, 2006; Starr Sered and Fernandopulle, 2005). Of course, access to health care is not just a problem for the uninsured. High premiums for health insurance mean that millions of Americans are consigned to purchasing low-budget plans that provide coverage for only a small 'basket' of health care services (Milstein and Smith, 2007; Roth, 2006). High deductibles and co-payments mean that even individuals with health insurance sometimes cannot afford the cost of treatment when they become ill. Other individuals possess health insurance but exclusion criteria based upon 'pre-existing conditions' block them from obtaining coverage for the treatments they are most likely to need. A growing body of scholarship explores how overwhelming health-related expenses contribute to bankruptcies in the United States (Himmelstein *et al.*, 2005; Starr Sered and Fernandopulle, 2005). Other researchers address how medical debt is a 'risk factor' for avoidance of hospitals and physicians and being unable to obtain timely access to health care (Doty *et al.*, 2005; Hoffman *et al.*, 2005; O'Toole *et al.*, 2004; Seifert, 2005; Seifert and Rukavina, 2006).

An important part of this national story of lack of access to health care is the wide-ranging social 'risk shift' described by political scientist Jacob Hacker (2006). Reductions in retiree benefits, 'downsizing' in the workplace and concomitant loss of employer-provided health insurance, and the widespread reduction or elimination of health benefits for employees are leaving increasing numbers of Americans without access to adequate health insurance (Blumenthal, 2006). High premiums for employer-provided health insurance mean that in some low-wage sectors of the workforce over 75 percent of employees decline coverage (Milstein and Smith, 2006). To make themselves more globally competitive, companies that once offered impressive benefit packages are now trying to lighten the economic 'anchor' of providing health care to employees and retirees.

Outsourcing health care

As US health care costs escalate, individuals, small businesses, large corporations and state governments are all attempting to control health-related expenditures. Across many industries, 'outsourcing' or 'offshoring' labour and manufacturing is a standard management strategy for reducing costs (Wachter, 2006). Call centres, transcription services, information technology departments, accounting departments and industries such as textiles, toy making, electronics and automotive parts production are commonly outsourced to regions where labour costs are far lower than in the United States. Though health care might seem the most local, rooted of practices, medical interventions are moving 'offshore' to regions where treatment is more affordable than in the US (Alsever, 2006; Appleby and Schmit, 2006; Foreman, 2006; Garloch, 2006; Kerr, 2006; Kher, 2006; Rahi, 2005; Wachter, 2006).

Outsourcing health care to countries where surgical procedures and other forms of treatment are available at substantially lower prices than in the United State is attracting interest

from state legislators, small businesses and large Fortune 500 companies, and individuals needing medical care.

In 2006, Ray Canterbury, Delegate to the West Virginia State legislature, introduced a House bill that proposed offering financial incentives to state employees willing to travel outside the United States for health care (Foster and Mason, 2006; Searls, 2006). If passed by the House, the bill will permit West Virginia state employees to receive a percentage of the savings if they travel to low-cost destinations for elective surgery. To encourage state employees to travel to India or Thailand for inexpensive care, the bill will waive co-payments and deductibles, reimburse expenses related to travel and hotel accommodation for the patient and one accompanying person, provide patients with seven supplementary sick days, and provide a financial reward for selecting a low-cost travel option. Cost-savings from this initiative would then be used to reduce premiums and subsidize the cost of health care for state employees. West Virginia state delegates will vote on the bill in 2007.

Corporations and small businesses are also beginning to outsource medical care. The first corporate attempt to offshore employee care collapsed when the United Steelworkers Union condemned Blue Ridge Paper Products Inc.'s plan to send Carl Garrett to India for gall bladder and rotator cuff surgery (Milstein and Smith, 2006; Rai, 2006; Yi, 2006). In exchange for elimination of deductibles and co-payments Garrett volunteered to travel to India for treatment. The union argued that although outsourcing of health care for union workers might start as a voluntary scheme, it would soon become mandatory. In response to the union's objections Blue Ridge Paper Products dropped its plan to send Garrett to India. The company is now considering whether it will offer the option of outsourced health care to non-union employees in management. Since this broadly publicized event, other companies have quietly arranged health plans that offer lower premiums in exchange for employees agreeing to receive specified elective procedures outside the United States. United Group Programs, located in Boca Raton, is a leading supplier of out-of-country 'Mini-med' health plans (Foster and Mason, 2006).

Individuals are also searching for ways to obtain access to affordable health care. News media reports document the travels of 'medical tourists' leaving the United States for medical care in such countries as India, Thailand, Mexico and Singapore (Foreman, 2006; Garloch, 2006; Kerr, 2006; Kher, 2006; Lancaster, 2004; Rahi, 2005; Ramirez de Arellano, 2007). Some individuals search the internet and find doctors and hospitals advertising low-priced medical procedures. Since organizing health care in other countries requires purchasing airline tickets, finding an appropriate medical facility and suitably qualified physicians, reserving hotel accommodations for accompanying travellers, negotiating prices and arranging payment, and transferring medical records, 'medical brokerages', 'medical tourism agencies' or 'medical travel agencies' are emerging to bridge the gap between clients and caregivers. They link international health care facilities to prospective clients seeking inexpensive treatments.

Acknowledging the recent emergence of medical tourism companies, the search for relief of suffering and cure of illness or injury has historically included the possibility of travel (Connell, 2006). Hot springs, spas, desert retreats, seaside resorts and mountain sanatoriums have long attracted clients willing to journey in search of treatment. Some pilgrimages in search of healing have a powerful religious dimension. Of course, medical brokerages do not promote healing pilgrimages to sacred sites. They bring the search for healing into the era of global capitalism. Paid by customers or destination hospitals, they typically help

clients travel along an economic gradient from high-cost health care environments to more affordable settings.

Marketing to international patients

Within the United States, elite medical facilities such as the Cleveland Clinic, Massachusetts General Hospital, Mayo Clinic and Memorial Sloan-Kettering Cancer Center draw patients from around the world. As managed care organizations, consolidation in the health insurance industry and intense competition for patients reduced the profitability of hospitals in the 1980s and 1990s, many US medical centres expanded their international clientele (Hutchins, 1998; Lee and Davis, 2004; Moore, 1997; Weber, 1998). Within cities with multiple well-regarded medical centres, hospitals banded together to offer comprehensive medical services to an international clientele. Hospitals in Boston provide care to patients from Kuwait, Saudi Arabia and the United Arab Emirates. Miami-based hospitals attract wealthy business executives and their families from Argentina, Brazil, Peru and Venezuela. Medical centres in Texas regularly draw patients from Mexico. Wealthy international clients typically pay rates far exceeding what US insurance companies reimburse. Poorer international patients are sometimes able to obtain less expensive care.

Hospital executives in other countries drew many lessons from the profits generated by international patient centres at American hospitals. They learned that 'concierge medical services' generate business by offering high levels of customer service and blurring the line between hospitals and hotels. They also recognized that international clients can be charged far more than local patients as long as the international customers are offered prices substantially lower than what they would pay in their home settings or receive care that they cannot obtain in their countries of origin. Thorough physicals, comprehensive diagnostic tests, attentive patient care, luxurious rooms, outdoor pools, room service and private limousine service can all be used to attract 'upscale' customers.

Though there is nothing new about travel in search of healing, what is novel is the increasing number of individuals travelling long-distances in search of affordable, timely medical care. In addition, the direction of travel is changing (Carrera and Bridges, 2006). Elite medical facilities have a long history of attracting international patients. However, for many North American and European patients, the care offered by nearby medical centres is unaffordable. The latest phase of international medical travel involves journeys in search of inexpensive medical care. The numbers are contestable; health-related agencies and trade organizations in the United States, Canada, the United Kingdom and other nations do not track the number of citizens obtaining health care in other nations. Tourism agencies in destination nations publicize the number of international patients receiving medical care but it is unclear whether their numbers are accurate or just another marketing device intended to generate 'buzz'. Still, news media reports, the rapid proliferation of medical brokerages in countries around the world, the multiplication of regional 'medi-cities' and the increasing numbers of hospitals seeking international accreditation suggest something significant is happening. An entire new global industry is now facilitating movement of patients to regions where they can receive low-cost health care. International trade agreements such as General Agreement on Trade in Services (GATS) foster this cross-border traffic in patients (Chanda, 2002; Mutchnick *et al.*, 2005). The internet, low-cost telecommunications and economy air travel all facilitate movement in search of affordable health care.

Many labels are used to describe various facets of 'out-of-country health care', 'international medical travel' or 'health-related travel' (Carrera and Bridges, 2006; Connell, 2006; Garcia-Altes, 2005; Goodrich, 1993; Goodrich and Goodrich, 1987). 'Cross-border trade in health services' is used by trade specialists and economists but the phrase lacks popular resonance. The phrase 'wellness tourism' is sometimes used to characterize visits to spas, rejuvenation centres, massage therapists and spiritual retreats. 'Health tourism' is used to label 'preventive medicine' offerings such as executive physicals, vitamin regimens or dietary needs assessment. However crass and misleading, 'transplant tourism' is sometimes used in news media coverage of individuals purchasing kidneys in Bangladesh, China, India, Pakistan and the Philippines (Canales *et al.*, 2006). 'Reproductive tourism' is often used to refer to women and couples travelling to fertility clinics and IVF centres in such countries as India, France, Belgium, Israel, Barbados and Vietnam. 'Medical tourism' is widely used by medical brokerages and journalists to describe journeys involving cosmetic surgery, cardiological procedures or orthopaedic surgery. Some hospital executives in India use the phrase 'value medical travel' to promote India as a high-quality, low-cost destination for international health care travellers. Jason Yap (2006a), Director of Singapore Medicine, a public–private agency promoting Singapore as a 'health traveller' destination, recommends the phrase 'international medical travel'.

Though 'medical tourism' is widely used in popular news media reports, critics of the term argue that the phrase risks trivializing the experience of travel in search of affordable health care. 'Sun, sand, and surgery' remains a slogan used by some brokerages (Connell, 2006). Still, numerous commentators recognize that the phrase 'medical tourism' evokes images of fun, relaxation, pleasure, sightseeing and adventure when many individuals travel because of serious health problems. They note that no one calls work-related travel 'business tourism', even though business trips often involve hotels and aircraft. 'Medical tourism' is more an artful advertising term, journalistic turn of phrase or eye-catching newspaper headline than insightful label. Still, the term dominates popular media coverage and is widely used by medical brokerages and destination medical facilities. However misleading or even offensive the term, 'medical tourism' aptly captures the fusion of travel agencies and the health care industry.

What medical brokerages promote

Within the United States, the most visible medical brokerages include such companies as Planet Hospital, Global Choice Health Care, Med Journeys and Med Retreat. Smaller operations include brokerages such as Merit Global Health and Medical Discounts International. Variations on traditional travel agencies, these businesses arrange trips to facilities offering comparatively inexpensive health care. Though brokerages seek to differentiate themselves from their competitors, some common denominators make it possible to provide a general description of the medical brokerage industry.

The standard 'menu' of packages offered by medical brokerages extends from 'wellness packages', spa retreats, Ayurvedic medicine and traditional Chinese medicine to cosmetic surgery, orthopaedic procedures, cataract surgery, dental care, cardiac surgery, organ and bone marrow transplants, and stem cell injections.

Cosmetic surgery procedures—because they typically constitute a personal expense even in countries offering publicly funded health insurance—remain a standard offering of medical brokerages and destination medical facilities. Such companies as Plenitas and Surgeons and Safaris continue to offer low-priced cosmetic surgery packages to Argentina and South Africa. However, to equate 'medical tourism' with cosmetic surgery excursions is an error. As the size of the uninsured and underinsured populations in the United States expands, and as treatment delays in publicly funded health care systems persist or worsen, medical brokerages are expanding their offerings to include hip and knee replacements, cardiac procedures, dental surgery and ophthalmologic procedures.

Treatments marketed by medical brokerages and destination medical facilities have two key attributes. First, there needs to be a significant spread between the average price of the procedure in country of origin and the cost of the procedure in the destination setting. There must be financial justification to travel after taking into account the cost of the procedure, accommodation, travel expenses and all other expenses. Second, the health problems precipitating travel cannot require emergency medical care.

Recognizing that lack of health insurance and the unaffordable price of health care in the United States are important market-drivers, websites for medical brokerages commonly display cost comparison charts and price schedules. Typical charts list the price of a coronary artery bypass graft or hip replacement in such countries as Singapore, Thailand, Mexico and India. Including expenses associated with travel and accommodations, advertised prices for procedures in India are often one-tenth of the prices of comparable surgeries conducted in the United States.

Some brokerages specialize in arranging travel to single countries. For example, Raleigh-based IndUShealth, located a short drive from where Howard Staab and Maggie Grace live, arranges trips to hospitals located in New Delhi, Chennai, Bangalore and Mumbai. Taking advantage of currency exchange rates and the economic aftermath of the Argentinian economic crisis, Merit Global Health and Plenitas arrange packages to hospitals in Buenos Aires.

Though some companies advertise medical travel packages to just one country, a more common contemporary marketing strategy involves providing clients with multiple 'price points' and travel options from which to select. Someone wanting to purchase care within the United States might arrange surgery at underutilized hospitals in Albuquerque or Las Vegas. A 'mid-range' package could involve travel to a hospital in Singapore, Belgium or France. Digitizing and then transferring medical records to the destination hospital, providing airport-to-medical centre limousine service, booking side trips to nearby tourist destinations, reserving a post-operative stay at a holiday resort, and coordinating follow-up care back in the patient's local community would increase the total cost of travel. Customers searching for the least expensive surgical procedures commonly select treatments in India or Thailand. Malaysia, Indonesia, the Philippines and several other countries also compete for the lowest-priced end of the medical tourism market.

Promoting consumer choice by maximizing destination options, side trips to tourist attractions and price alternatives is a goal mentioned by several medical brokerages. To serve this objective of catering to different budgets and consumer preferences, Planet Hospital facilitates packages to Belgium, Costa Rica, India, Mexico, Singapore, Thailand, Argentina, Brazil, El Salvador, Panama, Uruguay and the United States. Med Retreat's list of destinations

includes Argentina, Brazil, Costa Rica, India, Malaysia, South Africa, Thailand and Turkey. Within the United States, companies promoting cosmetic surgery packages typically offer trips to hospitals in Argentina, Brazil, Costa Rica, the Dominican Republic, Venezuela and Thailand. Brokerages promoting orthopaedic and cardiological procedures market medical facilities in low-cost destination nations such as India, Singapore, Thailand and Malaysia. Taking advantage of inexpensive airfares to destinations in Eastern Europe, United Kingdom-based brokerages typically promote inexpensive procedures available in such countries as Hungary, Latvia, Ukraine, Russia and Poland. Countries such as Czech Republic, Lithuania and Slovakia also market themselves as destinations for international medical travellers.

Signalling 'quality'

Brokers as well as destination facilities understand that many prospective clients need to be 'sold' on the quality of care in such countries as India, Thailand, Malaysia, Indonesia and the Philippines. Though 'First World health care at Third World prices' was once a commonly used slogan, many destination sites are now trying to distance themselves from the negative connotations associated with being labelled 'Third World' health care facilities.

To mitigate concerns, brokers and destination hospitals use various markers of quality to signal high standards of care. Physician training in such countries as the United States, Canada, Australia and the United Kingdom is widely used as an indicator of professional competence. Postgraduate training at National Institutes for Health, Johns Hopkins University, University of Birmingham and other reputable institutions are typically noted in the web profiles of physicians. US board certification of physicians is another marker used to display quality and expertise. Some websites place small British or American flags beside the names of individual physicians. This promotional device presumably helps potential customers select particular surgeons or clinicians. Establishing trustworthiness and alleviating concerns about risk are two goals served by emphasizing the training and expertise of physicians.

Aware that some hospitals and universities are globally recognized 'brands', hospital executives and government leaders in such countries as India, Dubai and Singapore partner with elite universities and hospital chains in the establishment of medical schools, continuing medical education programmes, clinics and medical facilities. Duke University, for example, will receive over US $350 million from the Singapore government to create a graduate medical school in conjunction with National University of Singapore (Wagner, 2006). Cornell University's Weill Cornell Medical College runs a medical school in Qatar. Harvard Medical International and the Mayo Clinic are partners in Dubai Healthcare City. India's Wockhardt Hospital chain promotes itself as an Associate Hospital of Harvard Medical International. Johns Hopkins Medicine International is affiliated with Apollo Hospitals Incorporated in India. Johns Hopkins Singapore International Medical Centre provides care to patients seeking cancer treatment in Singapore. The Royal College of Surgeons in Ireland runs the Medical University of Bahrain and RCSI Dubai. These 'brand names' are widely used in marketing and advertising campaigns. They signal quality of care; enable hospitals and academic institutions in the United States, United Kingdom, Australia and elsewhere to gain access to emerging health care markets; and help local facilities gain

international recognition. This trend continues as medical centres in China's privatizing health care system partner with American universities and businesses.

Just as professional training and US-board certification are used to promote the competence of individual physicians, international accreditation is used by hospitals seeking a global clientele. The Joint Commission International (JCI)—the international offshoot of the US Joint Commission on Accreditation of Health Care Organizations—assesses the quality of health care facilities around the world. Accreditation by JCI is used by hospitals and medical brokerages to demonstrate that health care offered by a facility is of 'international quality'. Assessment by the British Standards Institute and International Standards Organization (ISO designation) is also used to evaluate—and market—medical centres. However, most international hospitals now seek JCI accreditation. Recognizing the value of standardization and certification, countries such as Thailand and India established national hospital accreditation bodies. Though several evaluative bodies are used to assess institutional quality, Joint Commission International is now the dominant global player in the international hospital accreditation business. It has accredited approximately 100 hospitals outside the United States and recently opened regional offices in Singapore and Dubai. JCI accreditation is used in marketing campaigns directed toward international patients. Its hallmark icon is the gold seal of approval.

Medical brokerages also market the 'concierge services' customers receive when they obtain health care abroad. To attract international clients, such hospitals as Bumrungrad International and Bangkok Hospital Medical Centre emphasize personalized nursing care for patients, massage therapies, five-star hotel quality room accommodation, prompt access to expert medical care, door-to-door transportation services from airport to hospital and delectable meals prepared by chefs from popular local restaurants (Chantarapitak, 2006). Patients are assured they will be greeted by a company representative upon arrival, nurses will be available in abundance, and caring physicians will readily respond to questions and concerns. Some hospitals provide international patients with flat-screen television screens, wireless internet access, guest suites and side trips to local tourist sites. Bunrumgrad International Hospital in Bangkok promotes the comforts of home by offering a Starbucks, Au Bon Pain, McDonald's and Dairy Express. Health care facilities use such offerings to compete for clients and increase market share. How much customers pay determines what amenities they receive.

Advanced medical devices and innovative procedures are also used to attract clients. Iconic, futuristic-looking symbols of technology displayed on web pages, advertisements and promotional brochures are used to persuade clients that destination hospitals have the latest advanced biotechnologies. Apollo Gleneagles Hospital in Hyderabad, for example, promotes its PET/CT scans. Bangkok Hospital notes that it is the only hospital in Thailand that possesses a Gamma Knife. Medical technologies, in addition to having the obvious practical function of permitting particular clinical interventions, also serve to locate international hospitals within a global network of advanced, elite, modern biomedical facilities.

Finally, medical brokerages and destination hospitals promote exotic side trips such as visits to the Taj Mahal, Temple of the Emerald Buddha, and the vineyards of Stellenbosch. Using sophisticated marketing techniques—many of them drawn from the repertoire of promotional strategies used by international patient centres at American hospitals—they attempt to make a compelling case for 'outsourcing' medical care.

Global proliferation of medical brokerages

Though the United States has many medical brokerages, such companies can be found in countries around the world. Their source of clients is connected to the broader context of health care within the countries where they are situated. Canada, a country where holders of provincial health insurance cards have access to publicly funded, universal health care, has at least 20 companies dedicated to 'outsourcing' health care. Companies such as Speedy Surgery, Timely Medical Alternatives and Surgical Tourism Canada assure prospective customers that they can escape from pain, discomfort and long delays in receiving treatment by arranging care in such countries as Cuba, India and Thailand. Three additional companies help Canadians arrange care at the Cleveland Clinic, M.D. Anderson Cancer Center and Johns Hopkins International. These companies market packages to customers dissatisfied with long waits for elective surgical procedures in Canada. Brokerages also market procedures, drug regimens and diagnostic tests not covered by provincial health insurance plans. United Kingdom-based brokerages extend similar offers to attract clients tired of waiting in National Health Service queues. Brokerages in the United Kingdom include Globe Health Tours, Taj Medical Group, Private Healthcare UK and the Medical Tourist Company. Comparable brokerages are located in the leading 'destination' nations. MedAsia Health Care is located in Bangkok. Medical Tourism India is located in Delhi. Serokolo Health Tourism is based in Johannesburg, South Africa. Of course, given the role of the internet in connecting hospitals and brokers to prospective clients, the physical location of 'home' offices is in some respects insignificant.

Though brokerages are important nodes in the global network of international health-related travel, private hospital associations, medical facilities and government ministries in destination nations are equally significant. Hospitals and health care chains directly advertise their services through websites, 24-hour call centres, advertisements in airline magazines, special sale offers, regular press releases, public relations campaigns and international patient centres. National and regional tourism agencies, government–industry partnerships, national airlines and medical tourism boards strive to attract customers to local health care facilities. In countries around the world, both public and private hospitals compete for paying customers. Often, they compete not as isolated players but as integrated components of regional initiatives.

'Medical tourism' and national economic development

In countries throughout Asia and Latin America, economic crises during the late 1990s squeezed the size of middle-class populations and collapsed regional markets for privately funded health care. Private hospitals in Thailand, for example, started expanding their international customer base after the Asian financial crisis devastated Thailand's economy. As the Thai *baht* was devalued, unemployment skyrocketed, the Thai stock market plunged and many Thai families lost their savings, the cost of importing medical devices into Thailand multiplied and local citizens could no longer afford to purchase private health care (Chantarapitak, 2006; Talbot, 2001). Thailand's Bumrungrad International Hospital and Bangkok Hospital Group both significantly increased their market share of international patients following the drop in value of the *baht*. Low prices for sexual reassignment

surgery, cosmetic surgery and other medical procedures transformed Thailand into a major destination for inexpensive international health travel. Bangkok's Bumrungrad International now provides care to over 430,000 international patients a year (Bumrungrad International Hospital Fact Sheet, 2006; Foster and Mason, 2006).

The increasing volume of international patients travelling to Thailand sent a powerful message to private equity firms, clinics, hospital chains and government ministries around the world. Medical facilities located in regions with low wages, low rates of corporate taxes or special economic zones with no corporate taxes, inexpensive real estate, low-cost or non-existent malpractice insurance, favourable currency exchange rates and competent medical care could attract an international clientele. The prospect of low-cost health care—in particular, inexpensive cosmetic surgery, cardiac procedures, orthopaedic procedures, dental surgery and ophthalmologic surgery—could attract long-haul consumers from such countries as the United States, United Kingdom, Canada, Australia and Sweden.

Regional and national governments in India, Thailand, Singapore, Malaysia, the Philippines and Indonesia regard the 'medical tourism' trade as an important resource for economic and social development (Kuan Yew, 2006; Mudur, 2003, 2004a). In these countries, revenue generated from tourism is a significant part of the national economy. Leaders there see integrating the tourism industry with the health care sector as a progressive vehicle for diversifying their economies, attracting foreign investment, promoting job creation, building the health services industry and using regional strengths to benefit from the doctrine of comparative advantage.

Though health-related travel to India and Thailand receives considerable media coverage, Singapore has the most well-conceived and systematically implemented national strategy supporting international health travel (Kuan Yew, 2006; Yap, 2006a, 2006b, 2006c). Singapore promotes international travel to Singapore-based hospitals and clinics through its public–private partnership Singapore Medicine. Through the Singapore Medicine website, prospective travellers can identify hospital chains, specific hospitals, international patient centres, and individual clinicians and their specialties. The website provides easy access to all of Singapore's major health care facilities. To date, the Singapore Medicine strategy is working. International patients seeking health care in Singapore increased from 150,000 in 2000 to 374,000 in 2005 (Yap, 2006a). Government planning documents indicate that the Singapore government's goal is to reach 1 million international patient visits per year by 2012.

Government ministries, private hospital associations and tourism agencies in India, Malaysia, Indonesia, the Philippines and South Africa learned from Bumrungrad International's marketing tactics and Singapore's comprehensive national strategy to expand the international patient market. India's national health policy recognizes care of international patients as an 'export'. Special zoning laws, reductions on tariffs for imported medical devices, lowered corporate taxes and government investment in transportation infrastructure support India's national policy of promoting trade in health services. The provinces of Goa and Kerala in India have regional medical tourism policies. Malaysia and the Philippines are developing similar public–private initiatives. Government ministers in Taiwan, South Korea and Vietnam recently recommended that government agencies and private hospitals in these countries attract more patients from other nations. Most government ministries draw upon a core package of arguments when promoting international

medical travel as a progressive national economic strategy. Singapore provides an informative example of how and why particular countries attempt to attract international patients.

During the 1990s, government ministers and business executives in Singapore decided the local economy was overly dependent upon the microelectronics industry and vulnerable to changing economic conditions. One facet of their plan for economic reform involved establishing Singapore as a 'biomedical hub' (Gin, 2005). To achieve this objective, they created Biopolis (Cyranoski, 2001; Smaglik, 2003). Biopolis is a research centre fostering work in such fields as genomics, bioengineering, nanotechnology and bioinformatics. Singapore recruited scientists from around the world and used low corporate tax rates, low personal income tax rates and other government incentives to attract biotechnology start-ups, venture capital and larger pharmaceutical companies. Fostering basic research in the life sciences is one important part of Singapore's strategy to transform itself into a biomedical hub. Promoting clinical research and expanding the provision of health care are two other components of the hub strategy. Government representatives and business executives regard building health care infrastructure as a prudent long-term investment. To members of Singapore's political, economic, and medical elites, 'exporting' health care by 'importing' patients is an important form of development in a country with few natural resources.

'Medical tourists' are among the most profitable visitors the city-state receives. Singapore's Tourism Board estimates that the average 'spend' for regular tourists is US $144 per day. In contrast, the daily expenditure for 'medical tourists' is estimated to be US $362 per day (Travel Smart–Asia Watch, 2006). According to the Singapore government, international medical travel brings foreign currency into the country, promotes job creation, reveals the cultural attractions of Singapore and thereby encourages return visits, and offers significant economic benefits without the pollution generated by manufacturing and other resource-dependent industries.

Leaders in Singapore argue that, with a relatively small local population, Singapore must attract medical travellers to generate the patient volume needed to recruit and retain specialists (Kuan Yew, 2006). In Singapore, as in Thailand, Malaysia and the Philippines, the development of international medical travel is regarded as an important tactic in reducing emigration of health care providers to wealthier nations. The United States, Canada, United Kingdom and Australia attract significant numbers of physicians and nurses from countries around the world. Countries such as Singapore, Malaysia and the Philippines want to counteract this trend by reversing the flow and making the provision of health care a core component of their national economies. With additional revenues flowing into hospitals and clinics, private medical centres can flourish, public hospitals can generate increased revenue and provide better care, salaries will rise and aid retention of staff, professional opportunities will expand, specialization and sub-specialization of clinical practice can occur, physicians, nurses and other health care providers will be deterred from seeking better career opportunities elsewhere, expensive medical devices will become more affordable, and 'trickle-down' effects will travel through the city-state's economy.

Proponents of international medical travel argue that increased patient volume has the advantage of promoting economies of scale, maximizes institutional efficiencies, and helps hospital chains and government ministries negotiate better contracts with companies selling medical devices, hospital supplies and pharmaceuticals. Advocates of international medical travel argue that increased patient volume generates better clinical outcomes as high volume

combined with specialization enables providers to reduce errors in case management. Supporters of medical tourism state that revenue generated from treating international patients can be used to cross-subsidize publicly funded health care. Rather than harming local patients by blocking them from gaining access to services, the expansion of the market for international patients is supposed to lower the overall cost of providing publicly funded and privately purchased medical care to residents of Singapore.

National and regional proponents of international medical travel, whether they speak from the public sector or from private industry, argue that medical tourism provides a long-term economic justification for building infrastructure, encourages economic and social development, permits expansion of the private and public health care sector, complements efforts to promote public health and preventive medicine, and serves the interests of even the poorest members of society by generating additional revenue for the provision of publicly funded health care (Chantarapitak, 2006; Mudur, 2003, 2004a; Samandari *et al.*, 2001).

With support coming from government agencies, the private health care sector, representatives of publicly funded health care facilities, private equity funds, venture capitalists, tourism agencies, hotel associations, airline executives, private investors and journalists, local criticism of medical tourism in countries such as Singapore, Malaysia, and India is muted.

Substantial private and public investments are going into upgrading older facilities and building new hospitals and clinics in India, Thailand and Singapore. Industry leaders and government ministers in a host of nations are attempting to use the economic doctrine of comparative advantage to 'export' health care by 'importing' patients into their countries. They are confident that the global health care market for international patients will expand in dramatic fashion.

For North Americans, one of the more remarkable aspects of international health-related travel is that Canadians and Americans are travelling around the world in search of health care. Unable to obtain timely access to care or lacking adequate health insurance, they use brokerages and the internet to seek out what they hope will be low-price, high-quality health care. Although business leaders, health care professionals and government representatives in such countries as Singapore, Thailand and India want to attract customers from Europe and North America, the largest and most profitable sources of medical travellers are likely to be much closer to home.

Though they are both countries with widespread poverty and striking inequalities, China and India have rapidly expanding middle-class populations. In India, long-term national economic growth has occurred at approximately the same time as the widespread deterioration of the public health care system. In India, the vast majority of patients seek access to private health care facilities (Mudur, 2003; Sengupta and Nundy, 2005). Over 80 percent of health care is purchased as private, out-of-pocket expenses. In China, the emergence of a sizeable middle class and a rapid shift from rural agrarian to urban life likewise occurred over a period of significant privatization of health care services. China is experiencing a major health equity problem as economic polarization occurs in conjunction with economic development and its poorest citizens lose access to primary health care. The private health care sector in both China and India is rapidly expanding. Members of the growing Chinese middle class, much like the economic elites of Myanmar, Vietnam, Brunei, Bangladesh and many other nations, commonly travel to other countries for health care. Countries such as Singapore and Thailand hope to benefit from these regional developments. Leaders there

are aware of rapid proliferation of private health care facilities throughout India and China. However, with large numbers of patients travelling to Singapore from Qatar, Saudi Arabia, the United Arab Emirates and other countries in the Middle East, Singaporeans know it is possible to expand the health care industry by promising quality health care. Whereas India competes on the basis of price, Singapore asserts that it offers high-quality health care to the 'well-heeled medical traveller'.

Though China might ultimately provide the highest volume of outbound medical travellers to regional biomedical hubs, government representatives and business leaders in Singapore, Thailand, Malaysia, the Philippines and Indonesia look to North America as well as Europe and see potential for significant increases in patient volume from these regions. Canada has now had a serious problem with waiting times for orthopaedic procedures such as knee and hip replacements through three successive federal governments. Patients seeking access to health care through the United Kingdom's National Health Service are often confronted with lengthy delays in receiving access to care. The problems facing Canada and the United Kingdom are quite typical of countries providing universal coverage for health care. To control public expenditures on health care expensive 'elective' surgical procedures are rationed. With budgetary caps placed on the number of procedures that hospitals can perform, waiting lists increase even where sufficient numbers of health care providers are available to provide care. In contrast, in the United States, lack of health insurance or underinsurance in the form of excluded procedures, high premiums and high deductibles force individuals to travel elsewhere for affordable health care.

Government representatives and business leaders in countries such as India, Thailand and Singapore look to countries such as Canada, the United Kingdom and the United States and see long-term trends that will favour outsourcing of health care to other countries. Curtis Schroeder, Group CEO of Bunrumgrad International in Bangkok, argues that countries such as Canada, the United Kingdom and Sweden will continue to have difficulties providing timely access to medical care. Hospital executives in India and Singapore see in the United States a country with a growing population of uninsured individuals, an ageing population whose needs for health care will increase over time, rising national expenditures on health care, escalating prices for drugs, and a predicted long-term shortage of physicians and nurses. They see companies in the airline and automobile manufacturing industry shedding employees, health benefits and retirement benefits, and they feel confident that large numbers of Americans are going to be forced to look abroad for affordable health care.

With hospital chains in Singapore and India expanding at a rapid pace and medical brokerages proliferating around the world, we are at a moment when proponents of international medical travel need pay little heed to their critics. The business is changing in important ways. Attracting individual clients is a time-consuming, inefficient business proposition. Medical tourism companies are learning how to achieve high volume for their businesses. Though they continue to target individual clients searching for low-cost medical procedures, the leading medical tourism brokerages now offer corporate packages (Foster and Mason, 2006; Milstein and Smith, 2006; Yi, 2006). These plans turn 'outsourcing' medical care into yet one more health care alternative. Health plan purchasers capable of paying high prices for 'deluxe' medical care will bear the expense of obtaining access to health care in the United States. Individuals requiring lower monthly premiums and no deductibles will select packages offering out-of-country care for non-urgent elective medical

procedures. As brokerages shift to establishing out-of-country health care for corporate clients, international medical travel is becoming bureaucratized, standardized and normalized.

Growth of an industry

Arnold Milstein and Mark Smith (2006; 2007) suggest that small self-insured businesses are the 'early adopters' in the corporate turn toward medical tourism. Larger corporations are concerned about liability issues; they do not want to serve as a legal lightning rod when an employee uses employer-sponsored health insurance, accepts a financial incentive to receive out-of-country medical care and is harmed while receiving medical care at a facility in Bangkok or Mumbai. Whether medical tourism brokerages will fully integrate with the health insurance and health plan industry is at present unclear. Many medical tourism agencies now offer corporate packages. At least two major health plan providers offer 'Mini-med' plans that include out-of-country medical care for elective medical procedures. The philosophical and economic justification already exists for letting health consumers use portable, borderless health insurance to receive out-of-country medical care. Additya Mattoo and Randeep Rathindran (2006), two economists within the World Bank's Development Research Group, provide a powerful critique of the 'discriminatory' nature of health insurance programs that do not allow purchasers to reduce premiums and deductibles by taking advantage of out-of-country health care providers. The basic intellectual, institutional and economic building blocks for promoting widespread outsourcing of medical care are already in place.

With the economic justification for national 'medical tourism' policies driving public–private initiatives within Singapore, Thailand, Malaysia, Indonesia and the Philippines, and with the purported individual and corporate benefits of medical outsourcing widely touted on the websites of medical brokerages, the case for international medical travel is well publicized. Health-related travel appears set for global expansion.

With rates of migration increasing around the world, even without medical tourism marketing campaigns more individuals will receive medical care outside their countries of origin. Expatriates increasingly expect an 'international' level of care in countries where they work. With the emergence of internet search engines, email, economy airfare and digitized patient records, more individuals than ever before are going to comparison-shop in pursuit of the best care they can afford at the lowest possible prices. Furthermore, as countries such as China and India undergo rapid economic expansion, more health care facilities designed to 'international standards' are being built around the world. For sufficiently wealthy patients, international differences in quality of health care will likely diminish. Regional variations in the price of health care could play a powerful role in the 'outsourcing' of medical care as consumers comparison-shop for affordable health care.

Grounds for concern

Medical brokerages, destination facilities and national governments emphasize the multiple benefits of international medical travel. In contrast, the possible shortcomings of health-related travel receive less consideration. At a time of considerable support for international medical travel it is worth considering grounds for concern.

Brokerages insist that their clients are responsible for their choices. They should exercise due diligence when deciding where to obtain medical care, what treatments to select and whom to choose as their physician. Although brokers provide information about hospitals, medical specialists and destination sites, brokers state that they do not offer medical advice to their clients. Because brokers are typically not medical professionals and do not dispense medical advice, they do not see themselves as responsible for reviewing risks and benefits associated with particular courses of treatment. Clients can arrange trips to distant health care facilities, purchase airline tickets, reserve hotel rooms, schedule surgery, make deposits, or even pay for the entire excursion without being provided a comprehensive account of risks and benefits associated with treatment or non-treatment. How much information is provided to international medical travellers at destination health care facilities is unclear. Legal standards for informed consent and information disclosure vary across countries. Professional norms are highly variable. Practices of communication often differ from legislated standards and official institutional policies. Detailed case studies are needed to make informed judgements about the quality of information disclosure provided to international medical travellers. Since such studies do not exist, there is no way of knowing how much patients are told prior to undergoing what are often quite serious medical procedures. Though the level of communication between international patients and their health care providers is unknown and possibly quite variable across different local contexts, economic incentives could have a powerful framing effect upon what prospective clients are told.

Medical brokerages profit from selling travel packages to clients. Likewise, hospitals in such countries as India and Thailand benefit from attracting international patients. In a context where brokers are not bound by legal, ethical or professional codes and standards of practice, and where destination health care facilities have made significant economic investments in trying to enlarge the international patient market, the overall effect could be to encourage clients to receive treatment and minimize possible risks and complications related to treatment. This criticism is not specific to international medical travel; it can be applied to any context in which health care is offered as a market commodity. What distinguishes international medical travel from market-driven delivery of health care within the context of a particular country is the lack of clarity concerning what transnational or local legal, ethical and professional standards are in place to limit profiteering, ensure that patients are offered only medically indicated care and guarantee that prospective patients are given sufficient information to make thoughtful choices. It is possible that low-priced international health care is accompanied not just by an information deficit but by minimization of risks, exaggeration of benefits and encouragement to pursue treatment.

Perhaps the greatest risk facing international medical travellers is that low-cost health care is sometimes inferior medical care. In 1998 the Centers for Disease Control (CDC) published a report describing mycobacterial infections in nine patients who underwent liposuction and liposculpture in Caracas, Venezuela (CDC, 1998). In 2004, the CDC published a report about twelve women who travelled from the United States and developed nontuberculous mycobacterial infections after receiving cosmetic surgery in the Dominican Republic (CDC, 2004; Sherman and Betances, 2004). Bumrungrad International Hospital is the target of a criminal investigation and lawsuit after Joshua Goldberg, a 23-year-old American, died there while receiving care. These reports raise troubling questions about

the treatment of particular patients at specific facilities around the world. However, given the absence of systematic comparative data collection it is impossible to draw broad conclusions about the quality of international medical care. With no reliable statistics collected on movement of individuals seeking care around the world, no quality-of-care indicators for most facilities around the globe, and no peer-reviewed analysis of mortality and morbidity rates at facilities frequented by out-of-country patients, it is impossible to provide a careful analysis of the quality of the care international medical travellers receive when they travel for care.

Comparatively inexpensive care can be high-quality health care. However, it is possible that some travellers assume significant additional risk when they obtain out-of-country medical procedures. Quality of care is a legitimate concern when low prices and sales packages are used to attract patients to particular health care facilities. To ensure that the provision of health care remains profitable, there are many ways in which health care providers can reduce costs and maximize earnings. Some of these techniques—using older medical equipment during operations, providing inferior quality medications, utilizing poorly trained health care providers, maintaining inadequately stocked operating clinics or emergency rooms, implanting older-generation medical devices—pose significant risks to patients (Mudur, 2004b). Obtaining legal redress after patients are harmed during the provision of care is another issue worth noting.

Promotional material used by several medical brokerages and destination health care facilities note that one reason inexpensive health care is available in such countries as India and Thailand is because physicians pay low fees for medical malpractice insurance. Courts in these countries do not award significant financial settlements to patients who are harmed while receiving medical care. When patients are harmed while receiving care, some international health care travellers will likely find that the legal systems where destination facilities are located offer few remedies. They will also face significant practical barriers associated with navigating judicial systems outside their home country. Language barriers, cultural differences, questions concerning jurisdiction and travel costs can make the search for legal redress very difficult. The reduced likelihood of obtaining legal remedies after medical malpractice or negligence occurs is a risk that needs to be recognized when weighing the advantages and disadvantages of international medical travel. Of course, when patients have no means of obtaining timely, affordable health care in their home settings they might be tempted to discount these risks or conclude that the risk of receiving inferior medical care is less than the harms that will flow from failing to receive care in their home communities (Mooney, 2006).

The absence of professional standards or codes in the medical brokerage industry and the lack of medical training of most brokerage employees raises questions about how effectively brokerages evaluate the quality of care offered by the health care facilities that they promote to clients. Customers who sign contracts and liability waivers with medical brokerages are typically informed that brokers are not medically trained, do not dispense medical advice and merely facilitate arrangements with destination facilities. Clients are expected to sign waivers releasing brokerages from legal responsibility if out-of-country medical care generates an adverse outcome. They are told to exercise diligence; ultimately clients are responsible for choosing particular physicians, medical procedures and health care destinations. They are also informed that, in the event of harm to patients, legal remedies have to be pursued against

health care providers in destination nations. For medical brokerages, waivers of liability are intended to serve as a shield against legal action.

Efforts of medical brokerages to disavow legal duties to clients harmed while receiving care from a brokerage-identified health care facility have not yet been tested in a court of law. However courts might adjudicate such lawsuits, medical brokers have no code of conduct, do not require health-related training and are bound by no formal, explicit standards when establishing referral networks. Some medical brokerage websites mention the doctrine of *caveat emptor* and the responsibility of international medical travellers to gather information and make their own decisions concerning quality of care in destination medical facilities. However, when clients arrange health care through medical brokerages, it is unclear to what extent consumers are informed and knowledgeable about the procedures they are arranging.

When journalists express concerns about possible dangers associated with international medical travel, they commonly focus upon risks to individuals leaving Canada, the United States and the United Kingdom and travelling to comparatively inexpensive health care facilities. Though risks to health travellers require much more detailed exploration and far better data collection, few commentators address possible harms to inhabitants of destination countries (Mudur, 2003, 2004b; Sengupta and Nundy, 2005). While business executives and government ministers in these countries commonly emphasize the benefits of expanding local markets for international medical travel, some serious, undesired outcomes could emerge from increasing the flow of Europeans and North Americans into health care facilities located in such countries as India, Malaysia, Singapore and Thailand.

Perhaps the greatest risk for inhabitants of destination countries is that increased volume of international patients will have adverse effects upon local patients, health care facilities and economies. Many countries are making significant investments to become regional 'biomedical hubs'. However, there will presumably be winners and losers in the struggle for market share of international patients. Public resources might better be put into publicly funded health care rather than into promoting for-profit initiatives intended to generate trickle-down effects through the larger economy. In some countries, cost–benefit estimates leading to the conclusion that there will be a significant return on investment of public and private funds are likely to be wrong. India, Thailand and Singapore are already well positioned to attract patients from other countries. It is unclear that Indonesia, Hong Kong, Malaysia, the Philippines, South Korea and Taiwan will all benefit from similar national economic strategies. Investing public funds into preventive medicine, public health care and basic social infrastructure might generate more predictable population-level benefits. Directing public funds toward specialized medical centres and advanced biotechnologies is a particularly questionable decision when most citizens of a country lack access to basic health care and social services.

The phenomenon of 'crowding out' is another problem associated with drawing international patients to health care facilities in India, Thailand and Singapore. If large numbers of international patients flow into a country, the cost of health care will likely climb for local patients. Salaries of physicians, nurses and other health care providers will escalate. Health care could become less accessible to local patients. This problem could disappear if economic benefits ripple through society and entire populations benefit from national economic development. However, if benefits are captured by socioeconomic elites and never reach the poorest members of society, some local citizens could have even worse access to

health care than they had prior to the arrival of large numbers of international medical travellers.

The challenge international medical travel poses to health equity is perhaps the greatest problem facing countries promoting medical tourism. Singapore promotes international medical travel while also dedicating substantial public resources to preventive medicine and publicly funded health care. Even with this investment, visitors to Singapore commonly have access to therapies most local citizens cannot afford to purchase.

Government documents in Singapore express concern that local citizens might demand higher-quality, more expensive medical care if they see what international patients receive. Policy documents note the possibility that the 'demonstration effect' of providing expensive, specialized, advanced care to international patients could lead to demands for costlier health care. One proposed solution to this problem involved segregating Singaporean patients and international patients, and ensuring they receive treatment in different facilities. This arrangement was dismissed by government planners as impractical. The more serious problem that the Singapore government needs to face, as with other governments promoting the regional medical hub strategy, is that promotion of international medical travel will generate a scenario where patients from other countries can purchase considerably better health care than what most local patients can afford. Focusing upon the 'demonstration effect' obscures fundamental questions about social justice and how to improve access to health care for the poorest members of society.

The health equity problem facing Singapore is even more significant in such countries as India, Indonesia, Malaysia and Thailand. With appropriate financing, auditing and regulatory mechanisms, perhaps revenues generated from international patients could be used to improve access to care for local citizens. However, if profits from providing care to international patients are not used to cross-subsidize and improve care of local patients, the already massive health equity gap in India and Thailand will widen. What could emerge in many countries is what has already taken shape in India. Elite, high-quality medical facilities could offer health care that is unaffordable to all but a tiny segment of local individuals. Access to the best medical facilities would be limited to the wealthiest local citizens and paying patients from other countries. Instead of contributing to broad social and economic development, the provision of care to patients from other countries might exacerbate existing inequalities and further polarize the richest and poorest members of society (Gawande, 2003; Sengupta and Nundy, 2005; Wibulpolprasert *et al.*, 2004).

Conclusion

The US $190,000 gap between what Howard Staab was told he would have to pay for health care in Durham and what he was charged in Delhi helps explain why some uninsured and underinsured Americans are travelling to India, Thailand and other countries in search of affordable health care. They simply cannot afford health care in the United States. If the cost of health insurance was lower, their earnings were higher or the United States offered universal health insurance, most of these individuals would presumably prefer the convenience and comfort of receiving care in their local communities. In Canada and the United Kingdom, universal health insurance means that local health care is publicly funded.

However, long treatment delays and rationing decisions that block access to particular drugs, medical devices and medical procedures prompt patients to travel for health care.

Medical brokerage closes the gap between prospective patients in one country and medical facilities elsewhere around the world. Inexpensive air travel, low-cost telecommunications and the internet help patients arrange travel to affordable health care destinations. As small businesses, larger corporations and government agencies get involved, international medical travel is shifting toward a more institutionalized and bureaucratized process. If businesses and governments begin offering economic incentives to encourage travel to low-cost health care facilities, we might see a rapid increase in the number of patients travelling in search of health care to countries such as India and Thailand. How common international health travel will become is impossible to predict. Textile plants were once a major source of jobs for American workers. The textile industry has now largely relocated to other countries. Automobile manufacturing once provided a huge number of jobs for American factory workers. Automotive plants remain in American but large numbers of factories have relocated to Mexico, China, Thailand and other countries. The health care industry will never entirely relocate from the United States, Canada, the United Kingdom or any other country. Some aspects of health care must be locally offered and received. Emergency medical care needs to be locally available. With inexpensive forms of health care there is no reason to travel elsewhere in search of treatment. However, it is possible that multiple factors could push an increasing amount of health care from such countries as the United States and Canada and toward such countries as India, Thailand and Singapore. Various bodies—governments in these nations, tourism agencies, medical brokerages, private hospital associations and investors—are working to achieve this outcome. Their actions are generating results.

A global marketplace in health services will permit some patients to receive care that they could not afford to obtain in their local communities. Travel for health care will benefit some individuals. However, widespread marketing of 'medical tourism' fails to acknowledge the harms that could flow from a global health care bazaar. For-profit hospitals in India, Thailand and other countries could undermine quality of care at public health care facilities in these regions. With higher salaries at private facilities, public health care institutions might suffer a 'brain drain' as doctors, nurses and other health care providers move to better-paid jobs. Fewer health care providers at public institutions will undermine health equity and even further reduce access to care in communities where access to basic health services is already severely circumscribed. The medical tourism industry also contributes to the further commodification of health services. Countries offering universal health care emphasize treating patients according to need. The medical tourism industry arranges care based upon what customers can afford. Sufficiently wealthy clients can arrange travel packages with numerous amenities. Comparatively poor customers must settle for the cheapest services they can find. Some patients will presumably receive excellent care. In other instances, the desire of destination hospitals to maximize profits and minimize expenses could have a significant effect upon quality of care and patient safety. If clients are harmed while receiving care they will often find themselves unable to obtain legal redress. Medical tourism agencies insist that customers sign waiver of liability forms. Physicians at many leading medical tourism destination sites pay low premiums for medical malpractice insurance. As a result, medical tourists who are victims of negligence or medical

malpractice might find themselves unable to obtain compensation for their suffering. Marketing campaigns by destination hospitals and medical tourism agencies emphasize the merits of health-related travel. The disadvantages of travelling in search of affordable health care have received much less consideration in popular media. With sufficiently wealthy patients able to afford elite medical facilities, the greatest risks are likely to be faced by patients purchasing the least expensive treatments available. Whatever the advantages and disadvantages of 'medical tourism' there now exists a global health services marketplace. Health care, for so long that most local of activities, is now 'de-territorialized' as patients fly great distances in search of treatments they can afford to purchase.

Epilogue

Last year, Bradley Thayer, a retired apple farmer from Washington, was quoted in *USA Today* after he had torn knee ligaments repaired in Mumbai (Rahi, 2005). Taylor mentioned to the reporter that he thought India should anchor a hospital cruise ship in international waters off Los Angeles. He proposed 'One deck for orthopaedic surgery, one deck for cardiology. We need a change in America, we need cheaper medical treatment. We need a big hospital ship from India.' Physician-entrepreneurs in India see merit in such a plan. In 2005 Dr Naresh Trehan, Howard Staab's cardiac surgeon, spoke with Senator Clinton and US Chamber of Commerce President Tom Donohue about his plan to build a Medicity in the Bahamas (Landers, 2005). 'We'd staff it with the best people in the world outside the United States. Let's see if we can deliver better medical care than America at half the price and half an hour away.' Trehan reasoned that, if some Americans would not come to India, perhaps Indian health care could come to America. Well-funded competitors beat Trehan to the Bahamas. Early in 2007, India's Apollo Group, a competitor to the Fortis HealthCare chain of which Trehan's Escorts Heart Institute and Research Centre is now a part, signed a memorandum of understanding with the American International Medical University in Bahamas and St Lucia (Times News Network, 2007). The Apollo Group will build specialized teaching, treatment and research hospitals in Barbados and the Bahamas. They will be staffed by students and physicians from India. Company representatives note that they see a significant business opportunity in bringing inexpensive health care closer to the United States.

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