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Cross-border Healthcare Access in South Asian Countries: Learnings for Sustainable Healthcare Tourism in India

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Abstract

Since the 19th century affluent patients from less developed parts of the world travelled to major European Medical Centres and United States for treatment unavailable in their own countries and for cutting - edge healthcare facilities. From the early 1990's there has been a reverse flow of patients from highly developed nations to less developed countries circumventing the health care services offered in their own land, where they are inaccessible, undesirable, with overburdened public health systems and long waiting periods. In the past decade the global healthcare market has grown exponentially in the South East Asian countries whereby patients accessing health care services beyond their borders are more than 5 million. This cross border access to health care is reaching proportions of US \$ 40 billion with an annual growth rate of 20 percent where South Asian countries like Thailand, Singapore, Malaysia, the Philippines and India are at the forefront primarily due to availability of manpower both skilled and unskilled, lower healthcare infrastructure and treatment costs. This paper entails the study of Singapore, Thailand and India reflecting the best practices in these countries in terms of stakeholders' perspective associated with international health tourism.

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1. Introduction

Down the ages, during the Sumerian, Greek and earlier civilizations travel for health, medical and medicinal purposes have been recorded, whose exclusive populaces travelled to far –off lands to experience hot springs, bathe in mineral waters and for general repose and rejuvenation. While modern civilization still journeys to hot springs and spas, the notion of medical tourism has progressed considerably from those early times (Altin et al, 2011).

Since the 19th century affluent patients from less developed parts of the world travelled to major European Medical Centres and United States for treatment unavailable in their own countries and for cutting - edge healthcare facilities (International Medical Travel Journal, 2008). From the early 1990's there has been a reverse flow of patients from highly developed nations to less developed countries circumventing the health care services offered in their own land, where they are inaccessible, undesirable, with overburdened public health systems and long waiting periods.

2. Fathoming Cross-Border Healthcare

Health tourism was defined by the International Union of Tourist Organizations (IUTO), the forerunner to the United Nations World Tourism Organization, as “the provision of health facilities utilizing the natural resources of the country, in particular mineral water and climate” (IUTO, 1973). Goeldner (1989) in a review of the health tourism literature, defined health tourism as “(1) staying away from home, (2) health [as the] most important motive, and (3) done in a leisure setting.”

The phrase ‘wellness tourism’ is sometimes used to portray 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 insensitive and misrepresentative, ‘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 In vitro fertilization (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 (Turner, 2007). However this term is mostly used by the media and by commercial players. In reality, patients combining medical procedures especially surgery with a sunny retreat are uncommon. The medical travellers basically fall into three categories:

Value patients are predominantly from developed nations such as the European countries and the United States, where health care is exorbitant or unaffordable. A majority of these patients are in their fifth decade and have medical problems requiring expensive medical care. These patients have limited insurance coverage, are often uninsured, or essentially require surgical and dental procedures that are not regularly covered by insurance. Cosmetic and plastic surgery is in vogue in the western part of the world, hence such patients demand affordable care.

Access patients travel from regions where there is limited availability of quality health care. In United Kingdom and Canada public health systems are overstrained, patients from such areas are looking at options for obtaining speedy health care from other nations. Newly affluent patients originating from countries with less developed health care systems are also demanding cross border healthcare.

Quality patients are traveling to obtain excellent medical and surgical facilities in terms of the most technologically advanced medical procedures available, high-tech surgery, modern methods of treatment and specialty care, the best doctors and nursing care resulting in the best outcomes. Quality patients are not generally inhibited by cost considerations, especially those traveling for critical care (Woodman, 2012).

3. Business of Medical Travel

The health tourism marketplace is consistently growing and the business of medical travel is favourable. More than 130 countries around the World are competing for a pie of this global business, by offering a diverse range of medical, surgical and dental services to their prospective patients. It is generally estimated that the present global medical tourism market is estimated to be approximately US \$ 40 billion with an annual growth rate of 20 percent

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