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Medical tourism: A review of the literature and analysis of a role for bi-lateral trade

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ABSTRACT

Objectives: With increasing globalization, many countries are considering opening their health systems to greater cross-border movement of patients. This is usually done from the viewpoint of a multi-lateral trade relationship. This paper considers the issues that arise from this debate from a bi-lateral perspective.

Methods: A systematic literature review was carried out on 'Medical Tourism' from the perspective of a bi-lateral trade relationship, using the UK and India as a case study.

Results: There is a dearth of data and discussion on such bi-lateral trade. This limited evidence offers some suggestions. *Exporting* countries may benefit from medical tourism by generating foreign exchange and reversing the brain drain, but run the risk of creating a dual system, where the local population is crowded out. *Importing* countries can benefit from alleviating waiting lists and lowering healthcare costs, but may risk quality of care and legal liability. However, evidence from a bi-lateral perspective suggests that the positive aspects can be capitalised, and the negative ones reduced.

Conclusions: The key recommendations from this paper are for more evidence to be collected at the country and international level, and for countries to consider trade in health services from a bi-lateral rather than multi-lateral perspective.

1. Introduction

Countries continue to evaluate their positions on trade liberalization in health, as part of wider bi-lateral, regional and multilateral trade agreements [1,2]. The latter especially has been the focus of the debate on the World Trade Organisation's General Agreement on Trade in Services (GATS) [3]. However, there is widespread recognition that the trade agenda (in services generally, and health specifically) is increasingly pursued at the regional or bi-lateral level [4]. Not only have multi-lateral trade negotiations 'stalled' with the ongoing Doha round, but neighbouring countries often have similar culture, language and economic systems, as well as shorter travel times, facilitating engagement in trade relations. As a result, trading blocs, such as the European Union (EU) or the Association of South East Asian Nations (ASEAN) have developed, where a significant proportion of international trade takes place. Additionally, many countries bypass the GATS system and engage in direct bi-lateral trade agreements [5].

This is an important shift in the dialogue, as greater bi-lateral and regional trade may reduce many of the concerns expressed over health services trade, and offer

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greater benefits [5]. For instance, it may result in greater quality assurance, as well as better litigation procedures. However, much of the research evidence, anecdote and opinion on trade in health services remain focussed on this multi-lateral perspective. It is important, therefore, to explore bi-lateral type in more detail, and to assess how it compares to multi-lateral trade.

This paper presents a systematic review of the literature on medical tourism, with a specific focus upon bi-lateral trade, using the UK–India as a case study. Following this introduction, the paper provides a definition and the essential characteristics of medical tourism. An outline of the methods used in the literature review is then presented. This is followed by the results of the review, giving an overview of recent and emerging global trends in medical tourism, including issues associated with this practice for both "importing" and "exporting" countries. The paper then focuses on India and the UK as a case study for exploring how these issues could be addressed in a bi-lateral relationship. The final section concludes with key messages.

2. Definition and characteristics of medical tourism

Medical tourism is defined as 'the practice of travelling to another country with the purpose of obtaining health care' (elective surgery, dental treatment, reproductive treatment, organ transplantation, medical checkups, etc.). This excludes wellness tourism, which refers to visiting spas, homeopathy treatments or traditional therapies.

The practice of medical tourism is not new; people have travelled abroad for treatment for centuries. There are several reasons why people do this: some cannot afford healthcare in their home countries [6–8]; others cannot afford to wait for their national system to provide treatment [9–11]; some treatments are not available in all countries [10–12]; or Diaspora may prefer treatment at 'home' [13,14].

Medical tourism has historically been from lower to higher income countries, with better medical facilities. However, this trend is now reversing [15,16], and most recently "hubs" of medical excellence have developed, which attract people regionally.

Many countries participate in medical tourism as importers, exporters or both. The main importing countries (those where the medical tourists come *from*) are in North America and Western Europe. The main exporting countries (those who provide the services *to* medical tourists) are located across all continents, including Latin America, Eastern Europe, Africa, and Asia. Countries have specialised in certain procedures. For instance, Thailand and India specialise in orthopaedic and cardiac surgery, whereas Eastern European countries are hotspots for dental surgery [5].

It is difficult to obtain an accurate figure on the volume of consumption of health services abroad, as data are not routinely collected; partly because trade occurs within the private sector.

3. Literature search, review methodology, and results

The methodology used by Smith [50] was followed, and more detail may be found there, as well as in Appendix A. In brief, this was as follows.

3.1. Primary and secondary literature search

Primary literature was obtained from searching MEDLINE, ISI Web of Knowledge, EMBASE, Global Health, Cochrane Library, Health Management Information Consortium and EconLit, using the search terms 'Health Tourism', 'Medical Tourism', 'Trade in Health Services' and 'GATS', which were adapted to each database, as appropriate. They were used in different combinations, in different fields (title, abstract and topic). The articles obtained were checked for relevance. In addition, the references of the selected articles were also searched. The literature search was conducted in April 2009, without setting date limits. Papers that did not specifically mention medical tourism or were not in English, Spanish or French (languages that were readily interpreted), were excluded from the review.

A secondary literature search was carried out to obtain policy documents and statistics not available in the primary literature. The following websites were searched: www.who.int, www.worldbank.org, www.ncpa.org, www.cii.in, www.unwto.org, www.wto.org, www.oecd.org, www.imf.org, www.mckinsey.com, www.deloitte.com, www.jointcommissioninternational.org, http://www.medtourismexpo.com/, http://us.rediff.com/money/2003/dec/06health.htm, http://healthcaretrip.org/ and various ministries of health.

3.2. Results from the literature search

The primary literature search yielded 98 papers, of which 63 were reviewed. The secondary literature search yielded five reports, which were all reviewed. Thus, in total 68 papers and reports were reviewed fully (a list of which can be found in Appendix B).

Most of the articles were very recent; 49 published since 2005, of which 19 published in 2007 and 17 in 2008. In terms of geographical representation, most of the articles reviewed discuss medical tourism on a global scale rather than at country-specific levels.

3.3. Evidence on volume/value of medical tourism

The articles are characterized by a dearth of data, and discussions are mainly based on speculation rather than on substantive evidence. Only eight papers [17–24] contained empirical data. One further paper was a literature review on medical tourism [25]. However, 40 papers quoted figures on the volume/value of medical travel, although they did not conduct any primary research themselves.

The references for the figures used in these papers were traced, and it was found that most were basing their statistics on interviews carried out by newspapers.