

Medical Tourism

Beneficence or maleficence?

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السياحة الطبية هل هي مفيدة أم ضارة؟

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IN THIS ISSUE OF THE JOURNAL, DR. SALEH Al-Hinai and colleagues have published their results on a survey studying the medical tourism patterns of patients going abroad from the Al-Dakhilya Region of Oman.¹ They managed to obtain 40 responses to the 45 questionnaires they distributed. Basically, most of the results they obtained from the patients in their region who had sought treatment abroad were similar to those of other studies: 10% of the respondents went for treatment plus tourism, and 2.5% were healthy. Strikingly, 15% of the patients experienced complications after their treatment abroad and this is not an unusual finding in the literature. Only a few of the patient's in Al-Hinai's study used the Internet and the available medical tourism offices to obtain information on treatment abroad options instead the majority relied on word of mouth advice from friends. Most of the patients went to Thailand, and orthopaedic conditions were the most common indication for these patients to seek treatment abroad. This article is of special interest to Oman and should stimulate discussion on the advantages and disadvantages of going abroad for medical services. What are its advantages and disadvantages to the patients, and to Omani health services? Likewise, what are the advantages and the disadvantages to the host country?

Medical tourism is part of health tourism and it has a long-standing history, going back to thousands of years. Records show that in Greece, thousands of years ago, patients came to the healing god Asklepios in Epidauria.² At the same time in other countries,

people used to travel to therapeutic spas and collect waters from holy shrines. Much more recently, in the 18th century, health spas were a common feature of medical tourism. Health tourism, which includes medical tourism, is generally defined as organised travel outside one's local environment for the maintenance, enhancement, or restoration of an individual's well-being in mind and body.³ Medical tourism is regarded as more organised travel outside one's natural health care jurisdiction.⁴ Typically it is linked with engagement in leisure, businesses and other purposes.⁵

There are several types of medical tourism, and they are classified in many ways. One such classification includes: 1) "Temporary visitors abroad" who go for either check-up or treatment; 2) "Long-term residents" e.g. people who move to a location better for their health like many Americans who go to Florida or the Caribbean; 3) "Medical tourist, from 2 adjacent countries who share common borders" and have agreed upon sharing health care, and 4) "Outsourced patients"—these are patients who are sent abroad by their government, as the neither necessary treatment nor the specialist is available locally. This last definition fits many Omani patients.

Why do patients go abroad? Jagyasi gave 5 major "factors" involved in decision making: *affordable*, *accessible*, *available*, *acceptable* and *additional*.⁵ *Affordable* is probably the major reason and this is particularly true for patients from the well-off, developed countries like America and UK, where private health care is expensive, and some surgeries

are not covered by their insurance. *Available* is often because the medical treatment they need is not available in their local areas or not trusted by the patients, as is often the case with Omani patients. *Accessible* applies more particularly to patients from countries where the waiting list is long, particularly to national health service patients in the UK and in Canada. In the UK, private health care may be available locally, but is expensive. *Acceptable* applies to services, which may be affordable, available, and accessible, but they are not acceptable in the patient's own country for religious, political reasons or other social reasons. *Additional* refers to the availability of better care, perhaps better technology, or a better specialist, or simply better service and personalised care abroad compared to care in the home country.

There are several reasons, related to above, why patients choose to become medical tourists. For the Americans and Europeans the attraction is value, i.e. affordability. For example the price of a coronary artery bypass graft (CABG) is \$113,000 in the USA, but only \$10,000 in India; heart valve replacements cost \$150,000 in USA, but \$9,500 in India, and knee replacements cost \$48,000 in the States, but only \$8,500 in India.² Most references quote the prices of surgery in India, Thailand and Singapore as only 5% to 10% of the prices in the USA.⁶ A forecast by Deloitte Consulting published in August 2008 projected that medical tourism originating in the US could jump by a factor of 10 over the next decade.²

However, besides the financial benefit, there are other advantages for a patient to have treatment abroad in a centre of excellence for certain conditions. Many of the countries seeking to develop medical tourism invite specialists from well-known health care centres such as Columbia and Cleveland Clinic, Mayo Clinic, Harvard Medical International, and are thus able to offer excellent medical care. Many of them are encouraged and supported by their host governments, e.g. India has introduced a special M-Visa category for medical tourists.⁷ Malaysia's Ministry of Health has formed a special national committee for the promotion of health tourism. This has contributed to the reversal of the geographical trend of medical tourism. In the past, patients from the east were travelling to the west to get the best medical treatment. Now, patients from Western developed countries, travel east to developing countries for the best medical

and technologically advanced health care. Eastern Europe has now joined the bandwagon including Hungary and Poland which are popular for dental work.

However, there are several problems with medical tourism as discussed by several agencies and scholars.^{8,9} These include poor or no follow-up care. After being in hospital for a short while and having a vacation, the patient comes home with, perhaps, complications of the surgery or side effects of the drugs. It is a surgical principle that every surgeon looks after his own complications and obviously that does not apply for most if not all patients who have been treated abroad. Many countries have very weak malpractice laws and thus patients have limited ability to complain about poor medical care. Medical tourism also affects the host countries with the problem of internal brain drain, whereby all good doctors give up serving the public sector to go into the exotic, private health centres, which serve the medical tourists. Thailand's Bumrungrad Hospital, which treats about more than half a million international patients a year, is a major source of internal brain drain, leading to a political discussion within Thailand and a National Public Radio (NPR, USA) special programme on the shortage of Thai doctors in Bangkok because of the higher pay offered by Bumrungrad.¹⁰ Thus, globalisation impacts world health care, both in the host and the donor countries.³

There are other risks which medical tourism poses to patients. For example, patients may not tolerate travel very well, or may not have inherent resistance to some of the diseases in the host countries.⁶ We therefore need to have better scientific studies on the impact of medical tourism on the health care services of the source and destination countries as well as on the patients themselves. We need more statistics on the rate of complications. The article in this issue of this journal reported a 15% complication rate;¹ granted we do not know how severe those complications were, but that is what needs to be studied. A survey was carried out by the British Association of Plastic, Reconstructive and Aesthetic Surgery. They received responses from 203 out of 325 members.⁴ A total of 37% of them had seen a patient in the National Health Service with complications arising from overseas cosmetic surgery. In another survey in the UK, 60% of complications were of emergency

nature requiring inpatient admission.⁴ Americans and Europeans now realise that they need to analyse the impact of medical tourism—beneficent or maleficent—on the patients and the country's health care system.

Many medical tourists are satisfied, but satisfaction does not always parallel good outcome. Often satisfaction can simply be a result of good service. It is of special interest to note that “outsourced patients,” those who were sent by the government are often dissatisfied with the total experience compared to the true self-financed medical tourist.⁴ That is why an institution has to be accredited for good medical care with a good quality assurance programme rather than just good service. Now more and more of the provider institutions try for accreditation by either the Joint Commission International (JCI) or Trent or for Canadian accreditation. The JCI has accredited Wockhardt Hospital in India and several other institutions.

Patients going abroad need to get good advice. According to the World Tourism Organization's Global Code of Ethics for Tourism, tourists should have the same rights as citizens of destination countries.¹¹ Unfortunately, that is not always the case and that is another potential source of problems. For example, personal data is stored electronically and may not be treated as confidentially as the patients have a right to expect. We have no control over that when patients go abroad. Another major problem is informed consent, is it always informed?

A further potential significant problem with medical tourism is that sometimes it impacts the source country's health care system. A source country may become complacent by being able to send its citizens abroad for certain procedures and thus fail to develop the appropriate national services. The development of positron emission tomography (PET) in Oman is an example of this. This has been delayed for years now as patients are simply sent abroad for PET imaging. Sending patients abroad is not only costly to the government, but it also dilutes the political support and the will to develop certain essential national services. This situation often helps create a 2-tier system in the destination country whereby the local population receives second-class treatment while medical tourist gets much better treatment in the more sophisticated, well-equipped, state-of-the-art hospitals.

Among the disadvantages of medical tourism

is the one related to health insurance companies, who may refuse to cover a patient going abroad for legitimate reasons, or may actually encourage patients to go abroad if the treatment is cheaper, but then not cover the airfare and other expenses. The other side of the coin is that there is now pressure on insurance companies to cover the cost of all overseas treatment and this may mean raising premiums—yet another negative side to medical tourism for some patients.

The organisations that provide accreditation need to consult with each other and establish a uniform, or at least a fairly similar level of accreditation to ensure that the patient is the winner. They can do that only if they share experiences, ideas and methodology. One of the problems of medical tourism is that it generally raises the cost of health care in the host country. For example, India claims that they are improving the services for the local citizens by having more tourists and improving the health care in those tourist centres. But, the truth is that in most places, and certainly in almost all small towns and villages in India, they do not have even labour rooms and people suffer from severely overcrowded hospitals where patient bed space is both under as well as on the bed. This is exacerbated by the internal brain drain of hospital administrators and of doctors described above.

One of the major concerns related to medical tourism is the ethical aspects of treatment.⁸ These should be examined and the risks discussed with the patient, but, on the other hand, it is important that patients have their own autonomy in decision-making. Beneficence and nonmaleficence are the basis of medical ethics. Thus it is our responsibility to promote patients' welfare, treat them with justice and improve their health while we avoid harming them. These ethical principles are not easily upheld in the delicate balance of commerce versus medical ethics. Another aspect of medical ethics is the ownership of responsibility for treating the complications of the treatment given abroad. Another ethical consideration is that each country may have a different standard of medical ethics. For example, what is considered experimental therapy in one country, like stem cell therapy, is routinely used in the private institutions providing care for medical tourists in other countries. Likewise, the medical ethics related to organ transplantation differ from country to country. While most

countries do not allow the involvement of money in organ donation, it is a common practice in some countries, and donors can even be a living non-relative. The Declaration of Istanbul on Organ Trafficking and Transplantation Tourism, 2008, has condemned organ transplant tourism.¹²

It is the responsibility of the medical profession to stop the trend of treating medicine and health care like goods and services traded in business.^{13,14} Burney has pointed out in SQUMJ that medical tourism may receive "uncalled for treatment".¹⁵ The quality assurance trend in health care has introduced the term "consumer" to describe patients in an effort to improve the quality of care in hospitals. Unfortunately, the term "health consumer" is now misused in the business of delivery of health care.

The quality and safety of medical treatment abroad has to be studied and questioned and it should be under the scrutiny of the medical profession and the Ministry of Health in Oman. Unless we have good grip on the quality of the care that our patients are receiving abroad, their safety may be at risk. We need more statistics, better studies and better reporting systems. The question of who will look after these patients when they return, has not been answered, but must be tackled.

Thus, there is a major lack of systematic data about health services provided abroad, not only for Omanis, but, also for citizens of many other countries. More organised studies are needed and specifically outcome studies. Research into the delivery of health care has not yet adequately evaluated medical tourism. The issue of lack of data must be taken very seriously. Medical tourism has some benefits, but there are more problems with it and, as physicians, we have to keep in mind our basic principles of beneficence and nonmaleficence.

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