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The burden of pursuing treatment abroad: Three stories of medical travelers from Yemen

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Abstract

This case study features stories of patients from Yemen, a low-income country in the Arabian Peninsula, who traveled abroad for medical care. Their stories, drawn from interviews with Yemeni medical travelers in India, highlight the economic and emotional burden of pursuing treatment abroad. These stories of chronic non-communicable diseases and serious injuries depart from the common portrayal of medical tourists as wealthy elective patients from the North traveling for cosmetic surgery. The stories center on the demand and benefit of technological medicine for patients from low-income countries and raise questions about what constitutes ‘health’ when non-communicable conditions often entail ongoing efforts at treatment. The case study demonstrates that relying on treatment abroad may result in suboptimal outcomes for local health systems.

Keywords

low-income countries, medical technology, medical tourism, non-communicable conditions, Yemen

Yahya’s medical journey

A gunshot to the leg in 1993 left Yahya, a 39-year-old teacher from the low-income country of Yemen, with a shredded muscle and shattered bone. His attempts at healing involved a four-year, transnational therapeutic journey. Yahya first spent US\$4000 in Jordan for bone grafts. Five months later in Yemen, his leg broke again; residual bullet shards had infected the soft, newly grafted bone. Yahya had a second bone graft in Yemen. Surgeons inserted a metal skewer from his pelvis to his knee. A lingering infection in the incision kept Yahya in the hospital for two months. He then had an operation to clean out the ‘dirt’ inside and stayed in the hospital for five months ‘without any use,’

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he recounted to me during our interview in 1997 in his hotel room in India. Yahya decided to travel again to treat his leg. When he could not get a visa to Saudi Arabia, he returned to Jordan. There, he spent US\$2000.

In 1997, four years after the initial trauma, Yahya and his younger brother traveled to Mumbai, India. He hoped to find there the advanced orthopedic care that could finally help him. His brother accompanied him because, as Yahya explained: 'A brother has to stand by a brother. Anyone who was not a relative would only agree to accompany a patient for money. But a brother can leave and go with me in an instant.' The brother's absence was more difficult than Yahya suggested: He earned no money from his self-employment while away. And, the absence of both brothers meant that all the female household members were left alone (the father was deceased). Male relatives filled in, Yahya said, but could not replace them. Still, he concluded: 'Health is the pillar of human life; one has to do anything to obtain it.'

In Mumbai, Yahya spent over US\$3000 to replace the old skewer. When I spoke with him in India, he was preparing to leave for Yemen, after a month and a half away. The doctor recommended that Yahya return to India in a year to lengthen the one leg left nine centimeters shorter than the other. Because of the high costs, Yahya doubted he would travel again. He did not think he could add to the US\$9000 he had collected in donations and debt.

Yahya contrasted the medical services in Yemen with those in India. 'There's no comparison,' he said. 'For example, the operating room in Yemen looked like a bicycle repair shop or a carpenter's workshop with all the drills, hammers, and other gadgetry.' He continued: 'And, the anesthesia was weak; I felt pain. When they cut the bone, I felt everything. Severe pain. There's a huge difference between here and the hospital [in Yemen].'

For Yahya, trying to obtain the pillar of human life entailed a four-year journey of three trips to two countries, over US\$9000, yet remained nine centimeters too short.

Introduction

Yahya's trauma¹ and attempts at healing highlight challenges to providing and pursuing medical care for complex chronic injuries and non-communicable conditions (NCCs) in low-income countries. At the time of my research, patients like Yahya had few options other than travelling to receive care. Since that time, in the past decade, Yemen's medical system has undergone major developments involving technological medicine, yet it still relies on treatment abroad. For example, cancer patients can now receive radiotherapy in Yemen (Senior, 2008) and heart patients can undergo cardiac surgeries (Dahesh, 2009). In 2005, a renal transplantation program began in the capital, Sanaa (El-Nono et al., 2007). However, the demand for these technological procedures exceeds the capacity. Yemen's medical system will soon have greater capabilities with the opening of a 1000-bed facility, Al-Saleh Medical City, outside of Sanaa, funded with a donation from Qatar.² For now, however, Yemeni patients continue to travel abroad for medical care. A 2009 newspaper article reported that 5000 cancer patients – many of whom cannot afford it – travel abroad each year (Al-Ariqi, 2009). A February 2010 newspaper article stated that Jordan had surpassed Egypt, Saudi Arabia, and India as the preferred treatment destination for Yemeni patients (Oudah, 2010). A May 2010 newspaper article said that

200,000 Yemeni patients travel each year to Egypt, spending an average of US\$2000 each (Al-Khail, 2010).

Yemenis' use of medical services in other countries is part of a growing global trade in health services, popularly called 'medical tourism'.³ For patients from high-income countries, traveling to lower-cost treatment destinations has been presented as good value (e.g. Deloitte, 2008; Herrick, 2007). Cost comparisons listed on medical tourism websites attempt to attract patients with the savings: a heart bypass costing US\$144,000 in the USA goes for US\$26,000 in Thailand and only US\$10,000 in India. A US\$43,000 hip replacement in the USA costs \$18,450 in Korea and \$13,000 in Costa Rica.⁴ For Yemeni patients, however, relying on treatment abroad does not bring similar savings. In 2003, an estimated 40,000 patients sought treatment in other countries (Siddiqi et al., 2009). The Yemeni government spent US\$6.6m to send 2000 patients abroad (Siddiqi et al., 2009). Between 2000 and 2003, Yemeni medical travelers spent on their own US\$70m and US\$80m each year (Siddiqi et al., 2009). These large sums – and the hard currency – could have purchased much medical care in Yemen if it were available.

For Yemeni patients, treatment abroad involves financial, logistical, and emotional costs. The financial costs for the medical travelers I interviewed were astounding – for example, a total of US\$9000 in donations and debt for Yahya's three medical journeys, when Yemen's Gross Domestic Product (GDP) per capita in 1997 was US\$433 (and US\$839 in 2005 and US\$1356 in 2008).⁵ Additional costs were the wages lost for patients and companions. The logistical and emotional burdens include the shifting of household responsibilities and the worry of absent family members.⁶ However, many of the medical travelers I interviewed in India and Jordan would concur with Yahya: 'Health is the pillar of human life; one has to do anything to obtain it.'

The burden of non-communicable conditions for low income countries

The stories in this case study are based on my semi-structured interviews in the summer of 1997 with 71 Yemeni medical travelers in Mumbai, India (25 interviewees) and Amman, Jordan (46 interviewees). The interviewees represent a sample of convenience, individuals I located through the Yemeni medical attachés in the two cities and in hospitals, hotel rooms, and their rented apartments. For several medical travelers in Mumbai, I was able to interview the doctors as well. The interviews formed part of my two years (1996–1998) of ethnographic research on Yemenis' international medical travel, which I have described in greater detail elsewhere (Kangas, 2002a, 2007a,b).

Almost all of the 71 Yemeni patients in my study in India and Jordan suffered from non-communicable conditions (NCCs). The top five conditions were cancer (25 cases), trauma-related injuries (including Yahya's) (11 cases), kidney disease (9), non-injury-related neurological conditions (7 cases), and cardiovascular disease (4 cases) (Kangas, 2007b: 317–325). Stories of patients with cancer and renal failure have appeared in earlier publications (Kangas, 2007a: 293–294, 2010, forthcoming). Here, I feature stories of patients with injuries and a neurological condition as a way to continue to broaden discussions of NCCs (Chandra et al., 2006; Peden et al., 2004; WHO, 2006) and the role of medical travel in their treatment.

The rising epidemic of NCCs in developing countries has gained increasing attention (e.g., Adeyi et al., 2007; WHO, 2005, 2010). Eighty percent of total deaths due to non-communicable diseases (NCDs) and 90 percent of all injury- and violence-related deaths occur in low- and middle-income countries (WHO, 2010: 8). In addition, 80 percent of people living with disabilities and serious mental disorders live in low- and middle-income countries (WHO, 2010: 9). Global health initiatives to avert the threatening burden of NCCs have focused on prevention and the use of cost-effective interventions for those already afflicted (e.g. Adeyi et al., 2007; WHO, 2008). These global initiatives often target four main NCDs – cardiovascular diseases, diabetes, cancers, and chronic respiratory diseases – along with their four shared risk factors: tobacco use, physical inactivity, unhealthy diets, and harmful use of alcohol (e.g. WHO, 2008).

Yahya's story, and the others in this case study, underscores the demand and benefit of technological medicine (medical care centered on technology) for patients with NCCs in low-income countries. Yahya's story demonstrates that these patients would prefer the level of care available to patients from high-income countries, rather than be relegated to operating rooms resembling carpenter's workshops or bicycle repair shops and weak anesthesia. I am not advocating the proliferation of costly and constantly advancing medical technologies. I am arguing that access to technological medicine is a pressing issue for global and regional consideration, rather than something easily separated into solutions for high-, middle- and low-income countries.

In addition, Yahya's experience complicates the definitions of 'health' in decisions about the cost-effectiveness of interventions for NCCs and the benefits of relying on treatment abroad. Policy recommendations have considered the 'price of purchasing a unit of health' (Laxminarayan et al., 2006: 37) in order to obtain 'value for money' (Adeyi et al., 2007: 29) and the 'best buys' in health (Jamison, Jha, and Bloom, 2009: 127). This case study suggests that health – what Yahya calls 'the pillar of human life' – is not a clear-cut product to buy. Rather, it is often an ongoing process of successes and setbacks. After Yahya's initial bone graft in Jordan, everything looked good. Five months later, however, an infection in the grafted bone sent him back in the market for health. Yahya may have finally bought health with a new skewer in Mumbai, although his shortened leg might still lead him to another purchase.

Najiba's story

Road traffic injuries (RTIs) have begun to receive global attention (Peden et al., 2004). The growing volume of traffic (in part from additional motor vehicles) has led to an increase in RTIs in lower- and middle-income countries (Norton et al., 2006: 739). Indeed, between 1994 and 2004, vehicle ownership in Yemen increased from 32.6 to 49.3 per thousand of the population (Karim, 2008). In 1996, the country's central hospital treated 1933 men for traffic-related injuries, compared to 114 women and 422 children (Kangas, 2002a: 103).

The story of Najiba represents injuries, not to a car occupant, but to a pedestrian, a particularly vulnerable group of road users (Peden et al., 2004: 3). Her story demonstrates the long process of rehabilitation that severe injuries can generate and the abilities of reconstructive surgery to restore function.

At age 11, in 1992, Najiba was hit by a truck. The accident ‘totally destroyed’ her pelvis, her Mumbai surgeon told me in 1997. ‘She could control neither her stool nor her urine,’ her older brother recounted in our interview. She sought treatment in Yemen, but they could only stop the bleeding. Najiba then made her first trip to India for an operation on her pelvis and urinary tract. She stayed in the hospital for three months; she was then able to control her urine. She returned to Mumbai in 1994 for a skin graft to fill in with tissue her ‘female place’ where nothing had been, her older brother said. The grafting took three months. In 1997, Najiba, 15 years old, traveled again to Mumbai. The surgeon repaired her vagina, since, as he told me, ‘she’s going to have a married life and everything.’ He then shaped a muscle from Najiba’s thigh around the anus for her to regain control of her stool.

Najiba’s three medical journeys cost US\$9000, which the family covered with US\$3000 from the Yemeni government, a loan from the brother’s employer, and the sale of the brother’s car. Najiba’s brother told me that she needed to return to Mumbai in a year or two to have the area of her stomach refilled where skin had been removed to use elsewhere, news that he kept from Najiba at the time.

Najiba’s story underscores the difficulties in deciding how best to spend limited resources and the conflicts between individual- and population-based decisions. The treatment of patients abroad helps alleviate some of the constraints on Yemen’s human and infrastructure resources until adequate treatment is provided locally. However, the sponsoring of patients for treatment abroad costs much; the Yemeni government cannot afford to cover fully the expenditures of patients and their families. The contribution of US\$3000, for example, was too small to cover all of Najiba’s reconstructive surgeries, and yet became a large amount for the government to bear when added to all the patients receiving assistance. As mentioned earlier, for an average of US\$3300 for each of 2000 patients, the Yemeni government spent in 2003 US\$6.6m (Siddiqi et al., 2009). Najiba’s family had to sell a car and go into debt to provide her care.

Fatima’s story

Neurological disorders and the burdens they place on patients and family members have begun receiving the attention they deserve (Chandra et al., 2006; WHO, 2006). A final story illustrates the role of technology in diagnosing epilepsy and the requirements for its treatment. At the time of my research, MRI (magnetic resonance imaging) was nonexistent in Yemen, although it is now available.⁷ For Fatima and her family, an MRI provided a reassuring physiological explanation for her inappropriate and uncontrollable social behavior and ended a five-year search among a range of healers within Yemen’s pluralistic medical system (Kangas, 2002b: 52). However, the treatments still required much effort.

When she was around 14, Fatima began having strong convulsions and a fiery psychological condition, her father told me in their Mumbai hotel room. She started running away during the day and night. At times, she did not recognize people. She lashed out at everyone, ‘the big and the small,’ her father said. For five years, the family sought treatment. ‘There was no place we didn’t try,’ her father told me. They visited psychiatrists who took x-rays, herbalists, diviners, Qur’anic healers, and hospitals in three Yemeni cities.

Finally in 1996, Fatima and her father traveled to Saudi Arabia. There, they did an MRI, which ‘discovered the disease, the precise diagnosis,’ her father recounted. The doctor assured them the disease was in her brain; it had nothing to do with *jinn* [spirits]. Fatima began treatment ‘appropriate for that condition,’ her father said. With only a two-week visa, however, they had to return to Yemen without completing the treatment.

A year later, Fatima, her father, and mother traveled to India with the hope of finding a cure for her epilepsy. The family had received US\$500 from a governmental medical committee and borrowed additional sums,⁸ but could not cover the high costs for the operation that a neurosurgeon in Mumbai recommended. Finally, the family resigned themselves to there being no real cure for Fatima’s condition, only medications to calm its effects. They told me they were unsure whether the medications that Fatima needed for the rest of her life would be available in Yemen.

For Fatima, the first step in obtaining health was finding a diagnosis. The treatment she received in Saudi Arabia seemed to help, but had to stop when her visa expired. The operation a neurosurgeon in Mumbai recommended was inaccessible, too expensive for the family to pursue in India, and unavailable locally in Yemen because of the lack of the required equipment, facilities, and expertise (Chandra et al., 2006: 631). The most health that the family could buy, therefore, were medications to calm the epilepsy’s effects. Because of Fatima’s dependence on the medications, they need to be available and affordable in Yemen for the rest of her life, a purchase her country may or may not be able to help provide.

Conclusion

The stories of Yahya, Fatima, and Najiba highlight how in many developing countries, medical travel is driven by a lack of resources and health infrastructure. In dramatic contrast to the more common image of medical travelers as wealthy patients from the North utilizing the lower cost health care systems of the South, the cases presented here remind us that much travel involves patients from lower income countries seeking care and technology unavailable in their home countries. Yet, the cost of such care for both the health systems of the sending countries and the patients themselves is unsustainable. Relying on treatment abroad also does little to alleviate the inadequacies within the local public health systems. The growing epidemic of non-communicable conditions in low income countries also means that demand for technological medicine, such as the bone grafts, inserted skewers, reconstructive surgeries, and MRIs described earlier, and other interventions such as cardiac surgeries or radiotherapy for cancer patients, will become even greater burdens for the health systems of lower income countries. Questions of the funding of such interventions and their accessibility to people like Yahya, Fatima, and Najiba are urgent global priorities.

Notes

1. Injuries from weapons and traffic were the most common traumas seen by Yemen’s central hospital at the time of my research. According to hospital statistics for 1996, 2545 men were treated for stab wounds (1966 men) and gunshots (579 men), compared to only 114 women and 115 children total (Kangas, 2002a: 103).

2. See the plans for this beautiful facility at [www.designandhealth.com/uploaded/documents/Awards-and-events/WCDH2009/Day3/Session8/Ken-Schwarz-\(UK\)-Creative-Design-Solutions-for-Healthcare-Cities,-A-Case-Study-in-Sharjah,-UAE.pdf](http://www.designandhealth.com/uploaded/documents/Awards-and-events/WCDH2009/Day3/Session8/Ken-Schwarz-(UK)-Creative-Design-Solutions-for-Healthcare-Cities,-A-Case-Study-in-Sharjah,-UAE.pdf).
3. Because of the suggested frivolity within the term 'medical tourism' and its emphasis on the industry over the patients (Kangas, 2010), I use 'international medical travel'.
4. <http://medicaltourism.com/compare-cost.php?lang=en>.
5. <http://data.un.org/Data.aspx?d=SNAAMA&f=grID%3A101%3BcurrID%3AUSD%3BpcFlag%3A1>.
6. See Kangas (2007a) for details about the burdens that Yemeni medical travelers faced.
7. The Yemeni company Natco-AlRazi advertises its role in installing the first MRI in Yemen. Available at: www.natco-razi.com.ye.
8. See Kangas (2007b: 305–308) for additional information about governmental medical committees.

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Résumé

Traitement à l'étranger, un fardeau lourd à porter: Trois expériences de touristes médicaux originaires du Yémen

La présente étude de cas décrit l'expérience de patients originaires du Yémen, pays à faible revenu de la Péninsule arabique, qui se sont rendus à l'étranger pour recevoir des soins de santé. Leurs histoires, issues d'entretiens avec des touristes médicaux yéménites qui avaient séjourné en Inde, mettent en évidence le fardeau économique et émotionnel qu'impliquent ces voyages à l'étranger pour se faire soigner. Ces histoires de maladies chroniques non transmissibles et de blessures graves diffèrent radicalement des cas habituels de touristes médicaux décrits comme des Occidentaux riches désireux de bénéficier d'actes non impératifs de chirurgie esthétique. Elles se concentrent sur les besoins

en médecine technologique des patients de pays à faible revenu et sur les bienfaits qu'elle procure à ces populations, tout en s'interrogeant sur la signification du terme 'santé' pour les personnes présentant des maladies non transmissibles qui impliquent souvent des efforts thérapeutiques continus. Cette étude de cas démontre que le recours à un traitement à l'étranger peut donner lieu à des résultats moins satisfaisants que s'il avait été administré au sein du système de santé du pays d'origine.

Resumen

La Carga de ir en Busca de un Tratamiento en el Extranjero: Tres Historias de Turistas Médicos de Yemen

Este estudio de casos prácticos muestra las historias de pacientes de Yemen, un país con bajos ingresos económicos en la Península Arábiga, que viajaron al extranjero en busca de asistencia médica. Sus historias, extraídas de entrevistas con los turistas médicos de Yemen, subrayan la carga económica y emocional que supone ir en busca de un tratamiento en el extranjero. Estas historias de enfermedades crónicas no contagiosas y lesiones graves parten de la común interpretación de turistas médicos tales como pacientes programados adinerados del Norte que viajan por razones de cirugía cosmética. Las historias se centran en la demanda y el beneficio de la medicina tecnológica para pacientes procedentes de países con bajos recursos económicos y plantean preguntas sobre qué constituye la 'salud' cuando las condiciones no contagiosas a menudo suponen continuos esfuerzos durante el tratamiento. El estudio de los casos prácticos demuestra que depender de un tratamiento en el extranjero podría tener resultados subóptimos para los sistemas de salud locales.

Biographical note

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