

Medical Tourism and Transnational Health Care



Edited by

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1

Introduction

David Botterill, Tomas Mainil and Guido Pennings

From the perspectives of the academies associated with medicine and tourism, we will set out a position that is sceptical of the term 'Medical Tourism' yet at the same time embraces a structural bonding between two distinct and unrelated popular conceptions in the ordering of contemporary social life. Medicine and tourism have become clearly separated in contemporary popular consciousness. Medicine implies anything but a pleasurable experience, and tourism presumes a healthy disposition for participation. We argue that this popular conception of the separation of tourism and medicine ignores a historical continuity of lineage from the eighteenth-century pursuit of a 'cure' at resorts and spas to twentieth-century notions of holidays as worker welfare through global patient mobility in the quest for cutting-edge medical interventions in so-called untreatable conditions. Disciplinary divisions within the research academy have reinforced the separation between medicine and tourism in popular culture, but there is now an emergent challenge to re-think the medicine-tourism nexus. In this dynamic space and under the influence of transnational consumption, two very contrasting traditions of Western thought are now confronting each other.

International tourism markets evolved quickly following the civilian redeployment of aircraft technologies developed during the Second World War. Today those markets are characterised by a process of continual reinvention of a myriad of new segmentations in order to provide novel services to satiate consumer demand (predominantly Western but increasingly cosmopolitan). An increasingly sophisticated array of media technologies communicates the availability of custom-packaged tourist experiences. At the same time, the seemingly omnipresent desire of places to develop as tourism destinations as a driver for economic development invokes a wide range of private, public and not-for-profit stakeholders.

The medical sector has been conceived from an entirely different rationale, to care for, and hopefully cure, the ill citizen or patient. In order to do this, nations have invested heavily over several centuries in the

accumulation of medical expertise and technological sophistication. Thus, the history and dynamics of tourism and medicine have been predicated on different precepts, in different time frames and under very different circumstances. However, the separation of the medicine and tourism sectors is being challenged by a new form of patient mobility – a wave of international health-care users in search of health solutions. Today, the possibilities of finding a ‘treatment’ elide the neatly prescribed boundaries of national health-care systems and fall headlong into the ephemeral and fleeting inventions of tourism marketeers. A new market-driven ethos in health care is forcing the previously supply-side dominated health sector to incorporate many of the demand-led industry characteristics associated with tourism. Hence, we observe a ‘touristification’ of health care emerging through the adoption of tourism practices but still, of course, dependent on science and technology-led medical expert treatment. The contemporary linking of medicine and tourism presents, we would argue, a dynamic window into the clash of power between global capital investment in the service industries and its impact upon notions of social welfare and national citizenship.

The movement from medical tourism towards transnational health care

Our book title suggests some ambiguity by the inclusion of two terms: medical tourism and transnational health care. In this section we explain the factors that create that ambiguity. In recent years, patient mobility across national borders has become a contextualised phenomenon. For example, European perspectives and practices are different from Asian or American ones. European nations have well-developed social security models of health care based on the common tenet of health as a social good and access to health care as a right of citizenship. In this context, cross-border health care is a more commonly used term in the debates in the European Union about satisfying the needs of patients for health care across national borders and between national health systems. More recently, some European countries, such as Germany and the United Kingdom, have recognised that health care is also ripe for market development, although such directions of policy are still clearly contained within public health goals. Policy directions such as these within European states have often been accompanied by the introduction of the term ‘medical tourism’ in addition to the more commonly used cross-border health care.

In a completely different context, countries in Asia and on the American continent were always more open to privatised models of the provision of health care. Therefore, on these continents, the terms medical tourism and medical travel are more commonly used, and they take on a radically different shape and form from the limited use of the term in a European

context. For example, in many Asian nations the emphasis is much more on market development, and medical tourism is seen as an opportunity to drive economic prosperity in the region. Thus, medical tourism in Asia is characterised by governments as a growth industry receiving increasing numbers of international medical tourists. The markets of medical tourism are also increasingly intra-regional, with patients travelling within regions, for example, from Australia to Thailand or, in Latin America, from Columbia to Brazil.

Medical tourism is thus more associated with the provision of health care on the basis of out-of-pocket fee-for-service which, in turn, locates medical tourism as an invisible export, close to other forms of tourism, and with medical patients treated as tourist consumers. However, as we show in the chapters of this book, the distinction between the old terms – medical tourism and cross-border health care – is now less easy to draw. We propose therefore a new overarching term in this book's title – transnational health care. The use of this term would aid both the consumer of medical tourism and the citizen of health-care systems to more easily recognise the emerging set of transnational structures and networks that seek to serve all patients. Further, we propose that transnational health care could become a mature global patient mobility framework, which builds on a logic of transnational health regions (regional development as a vehicle for patient mobility), transnational organisations (such as hospital chains and insurance schemes) and sustainable health destination management (governmental steering of the development of patient mobility).

Tourism studies academics and industry practitioners tend to argue in terms of market development and treat medical tourism as a tourist activity with products, services and customers, to the exclusion of the wider implications of medical tourism for national health systems. Professionals within the health-care sector start from very different positions compared to their tourism counterparts. Medical practitioners, for example, debate about medical tourism and cross-border health care in terms of medical quality and the ethical consequences for international patients within health-care systems. Whatever the differences between these two communities of practices are, we suggest they would do well to begin to adopt a more inclusive way of seeing one another's interests. Thinking in terms of transnational regional networks might make collaboration possible between a full range of stakeholders who would gain from better serving local and global patients: as both citizens and as consumers. As a contribution to these arguments we invite the reader to think about each chapter from a triad of questions:

1. What are the public health perspectives?
2. How is market development represented?
3. Is there any evidence of integration of these positions?

The critical reader will observe that, at this stage in its formation, evidence of the integration implied by our model of transnational health care is difficult to find.

The main divide in the field is that between 'medicine' on the one hand and 'tourism' on the other. The ultimate purpose of this book is to bridge the divide. When starting on this book, the editors, as representatives of the two sides, found out that they knew almost nothing about each other's perspective on medical tourism. The main benefit resulting from the bringing together of different disciplines as presented in this book may lie in the fact that perspectives, and the underlying assumptions, are brought to the fore and confronted. The perspective adopted to present the phenomenon of medical tourism cannot be neutral or objective. The goal is not to select 'the' right or most appropriate approach. There is no 'view from nowhere': every researcher inevitably has to adopt a position from which to study medical tourism. However, being aware of one's own and the others' perspectives, and about the implications and restrictions of the perspectives, is already a great advantage. At the same time, it is an uneasy mix because of the ongoing discussions on how a 'medical tourist' should be defined. This is related to the question of 'to what extent a "touristic" purpose or element should be present'. Those who see the cross-border patient as just a patient looking for treatment abroad will object to the term 'medical tourist'. As soon as this patient chooses his destination, in part because of its attractiveness as a vacation resort, the term is perfectly sensible. The same ambiguity exists on the supply side: some countries may try to attract foreign patients by playing the tourism card (the non-treatment related aspects) while others may just attempt to pull in as many patients as possible. In the latter case, it does not matter where the clinic is located. Still, even in the latter case, tourism strategies and knowledge may be used to obtain results.

The basic element underlying medical tourism is unavailability: people need or desire something that is not on offer at home or that is not on offer in the right conditions. These conditions include, amongst others, availability within a reasonable time, affordability and good quality. The 'something' that people want may be services (high-tech or standard), body material (organs, eggs, etc.) or specific interventions. This basic structure can be presented by several dualities: supply and demand, home country and destination country, patient and provider, and so on. These perspectives are characterised by different focuses in terms of patient autonomy, state obligations, commercialisation, globalisation, the nature of medicine and health, and so on. Fundamental choices will have to be made. Will we try to stop the commercialisation of health care and put a maximum effort into maintaining equitable access to health care at home? Will we give in to the pressure, largely originating in budgetary limitations and ever-growing medical needs and possibilities, by simplifying and facilitating cross-border movements while controlling and monitoring the evolution to prevent derailments?

While the fundamental questions are largely based on ethical values, evidence will be needed on whatever decision is made in order to make sure that the actions performed, the organisational structures put in place, really express the choices. Middle ways that compromise between the market and the public health-care system, and between consumers and patients may be found. The choice about where to place the balance is ours to make.

Structure of the book

The structure of the book organises the contributions of authors into three parts. The first two parts reflect the established divide between tourism and medicine referred to above. Part I – ‘Tourists as Patients’ – foregrounds the shift in identity from the tourist to the patient, largely from the perspective of the conceptual models and practices of tourism consumption. In Part II – ‘Patients as Tourists’ – the semantic shift in the opposite direction displays the very different preoccupations of health researchers. In Part III – ‘Entanglements with Medical Tourism: Policy, Management and Business Responses’ – we use the word entanglements to consider how the transition from medical tourism to transnational health care takes its form within specific policy, management and business issues.

Part I – Tourists as Patients

In Chapter 2, David M. Bruce reminds us that travelling to ‘take the waters’ was a preferred option over and above medical interventions closer to home because, prior to around 1850, such intervention was rather more likely to kill than cure. Through the pages of guide books used by tourists as patients, Bruce paints a vivid picture of aspects of health, sickness and death and of tourism in the nineteenth century. In Chapter 3, Cornelia Voigt and Jennifer H. Laing bring the historical continuity of tourism and medicine up to date with a twenty-first century conceptual mapping of the differences and overlaps between wellness and medical tourism providers. They provide background information on the broader environment of health care and Western consumer culture that have influenced medical and wellness tourism providers. They present five provider models where the lines between medical and wellness tourism have been blurred, and they discuss areas for future research.

In Chapter 4, Jeremy Snyder and his team of co-authors provide a study of non-resident health care on the popular tourist destination island of Barbados. Barbados has an established history of providing health care to ill vacationers, other Caribbean residents and, more recently, the small but growing numbers of medical tourists seeking fertility care. Drawing upon its experience in developing tourism services, the Bajan government is aggressively promoting the development of a medical tourism industry, including the facilitation of the development of a mid-sized private hospital catering

primarily to medical tourists. The authors conclude that the development of medical tourism services in Barbados carries with it not only the potential for some economic gains but also significant risks to health equity if mismanaged or left unregulated. The final chapter (Chapter 5 by Angie Luther) in this part of our book examines tourists with serious disabilities. Luther provides a sensitive and illuminating account of how the medical condition of cervical spinal cord injury impacts the tourism aspirations of people with a serious disability. Through the lived experiences and perceptions of individuals with cervical spinal cord injury, Luther provides insights into the risks taken by tourists who are patients in their everyday lives. This chapter closes by highlighting the possible policy implications that could facilitate and/or enhance participation in tourism for individuals with cervical spinal cord injury and other similarly disabled groups.

Part II – Patients as Tourists

Cosmetic surgery tourism is one of the most popular instances of medical tourism. In Chapter 6, Ruth Holliday and co-authors explore the connection between the mental renewal offered by a touristic trip and the physical renewal that follows a cosmetic intervention. They also emphasise the tension between the anticipated feeling of pleasure linked to the touristic place and the anticipated feeling of pain linked to the operation. Their analysis shows that clinics use images of the country and culture to connect with elements that attract patients, such as quality of care, low cost, hospitality and cultural proximity. More than for other forms of medical travel, this type of cross-border treatment is built on myths and stories about particular locations.

Reproductive tourism is a peculiar form of medical travelling as it is frequently the result of national legislation. Certain applications of medically assisted reproduction and genetics are forbidden in some countries and allowed in others. This legal diversity creates several problems and opportunities. In Chapter 7, Wannes Van Hoof and Guido Pennings focus on two specific controversies: the problem of payment and donor anonymity within the practice of gamete donation, and the problem of exploitation and comity (incompatibility of legislations in different countries) within the context of international commercial surrogacy. These problems are the result of divergence in ethical evaluation and are hard to solve. The evolution of cross-border reproductive care is difficult to predict as it depends on several dynamic conditions such as scientific developments, ethical and religious convictions, and changes in legislation.

The most dramatic form of medical travelling takes place in the context of organ transplantation. People desperate for an organ and confronted with a long waiting list at home seek a solution abroad. These decisions are contentious mainly because of the ethical context in which donor organs are obtained in many developing countries. Both the exploitation of poor

people and the use of executed prisoners as organ donors in the People's Republic of China violate basic ethical principles. In Chapter 8, Thomas D. Schiano and Rosamond Rhodes analyse the numerous statements issued by professional societies on transplant tourism. They also scrutinise the arguments in the debate on payment for organs. They conclude that the first task of the societies is to adopt measures to guarantee the health and safety of the donors.

In Chapter 9 Tomas Mainil and his co-authors point out that within the European context the patient is as much a citizen as he is a consumer. The recent Patients' Rights Directive expresses this idea. Based on this duality in the patient, a typology that incorporates and covers various other typologies suggested in the field is proposed. This important aspect of the transnational patient has implications for the policy discussion on the effects of transnational health care for the health-care systems. Other considerations, such as the willingness of people to seek health services abroad, socio-economic differences between countries and the general economic climate, also play a role. Finally, a number of scenarios regarding the future evolution of cross-border medical treatment are presented.

Part III – Entanglements with Medical Tourism: Policy, Management and Business Responses

The final part of this book ends with the contributions of scholars from different disciplines who are tangling with medical tourism. Contributions are made from disciplines such as ethics, philosophy, medical sociology, health economics and social policy. Taken together, the chapters in Part III attempt to map the full complexity and challenges of medical tourism.

Chapter 10, by Leigh Turner, presents a comprehensive overview of the medical tourism industry in Canada. While doing so, he distinguishes different types of companies playing in the field, such as medical tourism companies, cross-border medical travel facilitators and private health insurance companies. A detailed analysis is provided of the destination countries, the health services marketed, the marketing message and the additional services that are offered. The medical tourism industry grows despite a publicly funded health-care system that gives access to medically necessary treatment. Shortcomings of the system in combination with 'experimental' procedures not offered within the system can explain why people seek care outside the country.

Guido Pennings begins Chapter 11 with the assertion that access to health care is a human right. As a consequence, governments have the task to guarantee this right. He argues that medical tourism should be seen as a health-care system reform and should be evaluated by means of Daniels' benchmarks of fairness. However, the ethical evaluation is rendered highly complex because the results differ depending on the ethical theory that one adopts. Generally speaking, four theories on the just distribution of scarce

resources can be distinguished: utilitarianism, egalitarianism, prioritarianism and sufficientarianism. The main discussion focuses on the prioritarianist position since this is the main concern expressed in the literature. Medical tourism should not make those who are already worst off (poor patients in developing countries without access to basic health care) even worse off. The brain drain resulting from the inflow of foreign patients is taken as an illustration of this approach. He finally concludes that governments should regulate and control the developments by adopting measures to guarantee fair access to good-quality health care.

In Chapter 12, Tomas Mainil, Vincent Platenkamp and Herman Meulemans link the legacy of Jürgen Habermas' ideas with transnational health care, and in so doing make the case that cross-cultural management in medical tourism should be a professionalising exercise. In his later work, Jürgen Habermas drew a distinction between communicative and strategic action. The authors demonstrate this distinction within medical tourism by juxtaposing historic and dialogical ways of communicative action – the 'lifeworld' of patient and medical doctor interactions – with the strategic for-profit ways of action in the medical tourism marketplace. They argue that by developing a deeper cultural understanding and sensitivity among hospital staff who work with international patients, a better balance between Habermas' two lines of action could be achieved. Furthermore, such management intervention could contribute to medical tourism becoming a more sustainable practice.

In Chapter 13, Melisa Martínez Álvarez, Richard D. Smith and Rupa Chanda take the entanglements into the developing world. These authors show that low- and middle-income countries providing medical tourism services may indeed benefit from generating foreign exchange, attracting – and retaining – health professionals, and improving facilities and quality of care. But these countries also risk diverting scarce resources to cater for foreign patients who can bring in higher revenues, thereby neglecting the needs of the local population. The authors analyse three types of trade agreements that countries can engage in when providing medical services to international patients: multi-lateral, regional and bi-lateral. Bi-lateral trade offers countries the greatest scope to capitalise on the benefits and reduce the risks of engaging in medical tourism, as seen in a case study from a potential UK–India relationship.

Daniel Horsfall and his author colleagues focus on the Internet as a source of data for understanding medical tourism. In Chapter 14 they research dental tourism websites that target potential medical tourists. Their analysis shows that commercial sites aimed at people seeking dental treatment abroad generally appear extremely professional. This apparent professionalism of dental tourism sites masks the fact that important information is often missing from sites. Consequently, dental tourism consumers are unlikely to be fully informed of all aspects of the dental tourism process.

Finally, the range of features adopted by dental tourism sites to engender trust is broadly couched but often, in effect, meaningless. The authors make it clear that addressing the poor quality of information on dental tourism sites is extremely important to assure quality of treatment; however, for many reasons a regulatory approach is neither viable nor even desirable.

In the final chapter of Part III, Chapter 15, Tomas Mainil and his colleagues introduce the idea of a destination management framework for transnational health care. The chapter begins with a consideration of the definitions and concepts that inform an analysis of transnational health care, governance and sustainability. A model is constructed drawing upon the building blocks of destination management, specifically stakeholder, ethical and branding theories, to demonstrate how the linkages between destination management and transnational health care can be constructed. Case study examples demonstrate how regional development in relation to health and health care is an active practice in the European Union.



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