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Chapter

Impacts of Medical Tourism on Healthcare Access

Iskra Alexandra Nola and Zdeslav Radovčić

Abstract

Today, medical tourism is underrated and mostly perceived as a beauty tourism. However, except dermatological and dental services also organ transplantation, IVF and many other therapies are well present in medical tourism travel arrangements. Medical tourism without any doubt impacts access to healthcare. Healthcare system in many countries allows access to some of these services but all-around world approaches differ. We believe that healthcare access could greatly benefit by opening this kind of services to wider population while at the same time not endangering patient' safety. Harmonized propositions, accreditations and certificates for medical tourism industry access covered by both, private and public health insurances, would contribute to service transparency and patient' safety while taking care of moral aspects of such services. Therefore, if consciously incorporated, medical tourism, as a part of global healthcare could easily become an efficient and effective additional access to healthcare.

Keywords: accreditation, certificates, healthcare access, healthcare insurance, liability, medical tourism, patient's safety

1. Introduction

Medical tourism is an individual or organized journey outside of place of residence due to the use of medical service in another country. However, according to WHO, currently there is no internationally accepted official definition of medical tourism [1]. This could be seen as an obstacle while not having the uniform approach to the subject is often the reason why services differ all over the world. In addition, non-uniform approach to the given subject could slow or enable, depending on country, the process of establishing criteria for services that could or should be welcomed under the health and public health systems.

However, knowing that accessibility to health care in patients' places of residence can be limited for a number of reasons, including cost, distance to the closest health facility and waiting times, medical tourism represents a sector that could significantly improve healthcare access. Unmet care needs may result in poorer health for people forgoing care and may increase health inequalities especially if such unmet needs are concentrated among poor people. Traveling for health is a realistic option to overcome this issue.

The use of some kind of health care outside of place of residence is not a new phenomenon. Ancient Greeks, from the area around the Mediterranean, traveled to Epidaurus, to get the medical advice of Aesculapius. In the 18th century, patients from England visited various spas abroad, while they believed their immune

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system and overall health would be boosted by the different climate and water [2]. In the late 19th and at the beginning of 20th century Austro-Hungarian nobility discovered healing effects of water and air of the Croatian north coast, especially cities like Crikvenica and Opatija. However, finding balneal and climate therapy only, soon became insufficient. During the 20th century, wealthier people from less developed areas traveled to more developed regions to access better health facilities, highly trained medics, and new or more available procedures. Through the time, another group of medical travelers becomes more interested in finding good but less expensive institutions where they can get the same standard of specific medical care but for less money. This led to the new paradigm of medical tourism – patients that travel seeking for health service but also willing to combine they stay with the experiences that other country could give them. They became tourists with the plan [3].

Nevertheless, the shifts that are currently visible in the medical tourism show the main differences in services provided. Some countries develop specific "supply" of services based on specific "demands". In Europe Union (EU), there are countries that are much wealthier than the other European countries and thus some medical treatments are very expensive. For example, dental and dermatological services are often sought in eastern or southern European countries where the prices are much lower than in the northern and western countries [4]. The highest rate of hip replacement, which is most sought method when it comes to hip arthritis and related pain, are in Switzerland and Germany, among the countries members of Organization for Economic Co-operation and Development (OECD countries) [5]. This procedure has long waiting list if the health care access is organized through public clinics. Therefore, many patients opt to travel abroad to be operated sooner and at more affordable rate. In the past ten years, there is a visible in the number of outpatient hip replacements in United States of America (USA).

Not only the price is the cut-off value for the decision to go out of own country and seek the medical service. Sometimes the inability to get a specific medical help in one's own country is the main reason to travel for health (procedure or technology). In Europe, there are mutual agreements that cover such situations by existing national health insurances [6, 7], but the costs for rare diseases remain high. Sometimes, in certain countries, the procedures themselves or for certain group of people are not allowed due to cultural factors, as abortion, IVF or surrogacy, and thus some people reach for this kind of treatments available through medical tourism. Moreover, there is a controversy related to the transplantations of the organs and the completely new market developed for these procedures. Besides that, in poor countries, there is a risk of organ trafficking.

Different types of demands in medical tourism market and different laws applied in different countries create an environment of too many information, fear and uncertainty especially in relation to the aftermath, which is reasonable to expect to happen in some of the situations. Thus, the reasons why patients make the decision to use medical tourism is very important, especially for studying the possible implications related to [7].

Today, the market of medical tourism is valued at hundreds of billions of USD and is constantly rising, thus presenting multi-way matter of subject. In some countries the health systems are losing patients because of high prices which make the patients to go to other, nearby countries, and in some cases insurance system do not allow patients to use any non-conventional approach in their therapies and healing process [8]. In this case, patients often use all the procedures covered by their insurance and at the same time, they pay for different approach as well. Here we can say – the system (the government system) is losing again.

Medical tourism brings many advantages to patients, countries and governments, but also many negative consequences that affect the individual and public

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system. Obviously, the lack of internationally accepted official definition of medical tourism, of agreed definitions, of databases that record the total number of patients traveling abroad, of the procedures they undergo and of their outcome, is causing more problems as the time pass.

Without systematic monitoring and collecting data, it will be impossible to do the comparison of the quality of implemented services of medical tourism between countries and institutions. We believe that organized approach to this hot topic of medical tourism and implemented standards and measures through the health systems and services will not provide benefits only for the end-consumers, but also for the countries, governments and their economics as well.

2. Services

Medical services used by traveling patients are often elective interventions, complex surgery, procedures in the field of plastic surgery, dental medicine, as well as all other forms of medical care. Recently, there is a huge increase in search of second opinion outside of the country of residence and many internationally recognized clinics and hospitals see it as a lucrative side service.

However, the reasons that are behind the patients' engagement in medical tourism are complex. They include unmet care, the nature of services they are trying to find (including dental care), the manner by which the treatment is accessed (mainly dependable on resident's country healthcare system), available properly educated staff and waiting time related to the service to be done in the resident country.

2.1 Unmet care

Inadequate healthcare access and unmet care in their native countries has led to a significant increase in the number of people using medical services outside the borders of their country. For example, in all European countries, most of the population in 2018 reported that they had no unmet care needs for financial reasons, geographic reasons or waiting times (**Figure 1**).

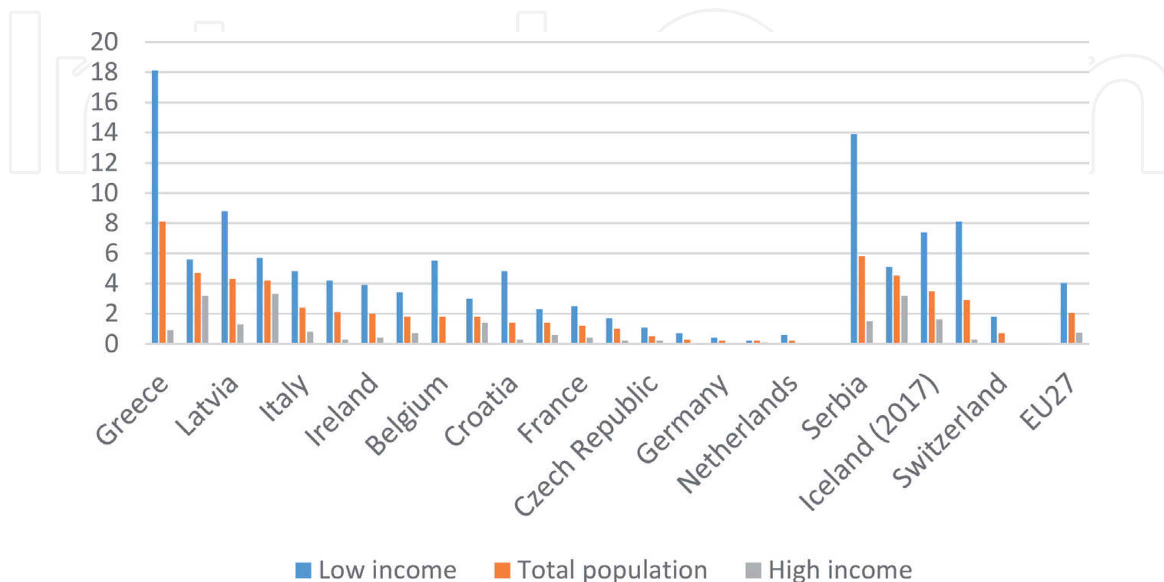

Figure 1.
Unmet need for medical examination due to financial, geographic or waiting time reasons, 2018. Source: This chart is made by authors by using data from Eurostat Database [9], (online data code: HLTH_SILC_08$DV_361; sdg_03_60; tsdph270) and OECD data.

However, in Estonia and Greece for example, at least 8% of the population reported some unmet needs for health care, with the burden falling mostly on people from low-income households, particularly in Greece. Nearly one in five Greek people in the lowest income quintile reported going without some medical care when they needed it and these unmet needs were mainly for financial reasons. In Estonia, long waiting times are the main reason for people to report unmet care needs, which are partly explained by the limited volume of some services (such as specialist consultations) fully reimbursed by public health insurance [9].

The gap in unmet medical and dental care needs between poor people and rich people remains large: on average across EU countries, people in the lowest income quintile are still four times more likely to report unmet medical care needs than those in the highest quintile, and six times more likely to report unmet dental care needs [9].

2.2 Staff shortage

The characteristics of national health care system will certainly define the overall demand for medical tourism in each country. In addition, the impact of medical tourism on national care system will depend on those characteristics as well. This double relation between medical tourism and health care system will finally affect the policy in this area.

Moreover, it is important to mention staff shortages especially in certain medical specializations or geographic areas [10]. In the coming decades, aged population is expected to be one of the major challenges for the health sector [11, 12]. The demand for healthcare will probably increase substantially in elderly population, particularly in the US and EU, and at the same time the proportion of the people in work will probably decline. In 2018, just over two fifths of all doctors in the EU were aged 55 years and over. According to the European Commission's Directorate-General for Health and Food Safety, more than 60 000 doctors (or 3.2% of the workforce) were expected to leave the profession each year during the period 2018–2020. There are countries more affected - in 2018, more than half of all physicians in Italy and Bulgaria were aged 55 years and over [13].

Proper health care access requires a sufficient number of doctors, with a proper mix of general practitioners and specialists and a proper geographic distribution to serve the population in the whole country. There were many concerns in the late 2000s about projected shortages of doctors arising from population aging and the aging of the medical workforce [9]. These concerns prompted many EU countries to take actions to anticipate the retirement of a large number of doctors, notably by increasing the number of medical students, to replace those retiring [9]. Several countries also took actions to postpone the retirement of current doctors and recruited more doctors from abroad [9].

In many countries, the main concern has been about growing shortages of general practitioners, particularly in rural and remote regions. Whereas the overall number of doctors per capita has increased in nearly all countries (**Figure 2**), the share of general practitioners (GPs) has come down in most countries.

In many countries, it remains a challenge to attract a sufficient number of medical students to fill the available training places for general practitioners. The uneven geographic distribution of doctors and difficulties in recruiting and retaining doctors in remote and sparsely populated areas is another persisting challenge in many European countries. In all countries, the density of physicians is generally greater in urban regions, reflecting the concentration of specialized services such as surgery in urban centers as well as physicians' preferences to live and practice in cities [9].

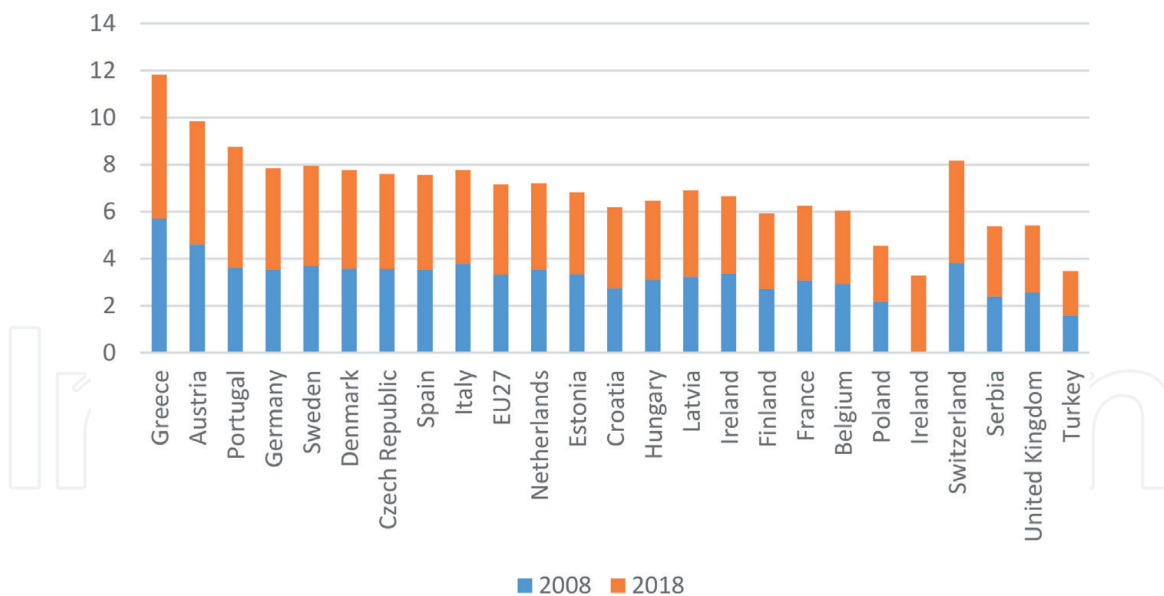

Figure 2.
Practising doctors per 1 000 population, 2008 and 2018 (or nearest year). Source: This chart is made by authors by using data from Eurostat Database [9], (online data code: hlth_rs_prs) and OECD data.

2.3 Waiting time

Some services in the international medical tourism are in more demand than others are. Services with long waiting lists are particularly influencing this demand. Moreover, long waiting lists for elective (non-urgent) surgery have been a longstanding issue in many European countries as they generate dissatisfaction in patients because the expected benefits of treatments are postponed. The COVID-19 pandemic will likely increase waiting lists for many elective surgeries, at least temporarily, as non-urgent interventions have often been postponed during the peak of the epidemic.

The median waiting time for people who received a cataract surgery in 2019 (or 2018) varied from about 30 days in Italy, Hungary and Denmark, to about 150 days in Estonia and 250 days in Poland. For hip replacement [5], the median waiting time ranged from 35 to 50 days in Denmark, Hungary and Italy, to 180 days in Poland and 250 days in Estonia. The pattern is generally the same for knee replacement, although in most countries the waiting time is slightly longer than for hip replacement [9].

2.4 Oral health

Oral health is an important, although often neglected public health issue. The global burden of dental diseases is mostly seen in caries and periodontal diseases being major public health problems in industrialized countries among children and adults [14].

The economic burden of oral diseases is substantial. With dental costs on the rise, a vast number of people across Europe and the USA are finding it difficult to afford proper dental care, especially when it comes to procedures that are more complex. This is the main reason people are deciding to spend their holidays in destinations that offer them the same quality of dental services at lower price rates. This cost-effectiveness principle is often the main principle in managing the choice of medical service and country of destination. There are different reasons why the prices in some countries are lower than in the other, but in most of the popular dental tourism destinations, it is due to lower labor and real estate costs. Dentists in these countries can afford themselves to have lower prices than their colleagues in big centers of

Europe and USA, while providing the same quality of dental work. Oral diseases account for more than 5% of total health spending on average across EU countries, and productivity losses due to oral diseases have been estimated at around EUR 57 billion a year [15]. The extent of public coverage for dental care costs can also partly explain some of the cross-country variations in the number of dentist consultations. In Romania for example, only 6% of dental care spending is publicly funded. By contrast, in Germany, more than 60% of dental spending is publicly covered [9].

The cost for non-medical dental treatment, esthetic ones, are much higher. This is specially related to the fact that there is no country with the public health coverage for esthetic dental treatments – those are covered mainly in children and for the visible teeth, if they are at all.

2.5 Healthcare access

Healthcare access mirroring the state organization and social sensitivity. Still, it is usually related to money and availability of services. Nevertheless, there are concerns that low- and middle-income countries will suffer the inequity and worse accessibility to healthcare if the medical tourism prevail [16]. The reasons, as elaborated in earlier paragraphs, are numerous: staff shortage or drain to the private sector [10], long waiting time, higher prices. However, healthcare access does not show only the shortcomings in countries where medical tourism applies [2]. There are benefits related to the growing medical tourism in such countries: money obtained from medical tourism services often spills to the secondary and tertiary sectors thus producing economic expansion. Even though, we need to be conscious on different aspects of medical tourism' impact on healthcare access [2].

The equity could be the main factor for reasonable approach to healthcare access and should be seen from two different angles. Firstly, equity in healthcare access for domestic population, which is not compromised by growing medical tourism while the systems are separate (national vs. private). Secondly, equity, which is compromised by staff or money drain into medical tourism' services which leaves healthcare access for residents inadequate.

The way of access to healthcare in relation to medical tourism is important parameter as well. Healthcare system in many countries allows access to some of these services but all-around world approaches differ. In addition, it differs widely according to healthcare diversity. The countries in which access to healthcare is guaranteed by the national policies will suffer less (or not at all, maybe even benefit) by growing presence of medical tourism. Those countries could experience more well-educated staff, new technologies and treatments present at their market, with no restrictions to use them. Competition could make this healthcare markets even better and more accessible. In countries where no national health insurance policies are present, the growing demand will allow medical tourism to expand, but the outcome could involve equation: more money – more services. Thus, the healthcare access will be as equal insofar as the differences between rich and poor are smaller. This does not necessarily mean that the presence of medical tourism will make more difference between rich and poorer. Maybe will be the reason for more output patients seeking the healthcare outside their country of residence.

Is the presence of medical tourism on healthcare market the reason to look the shortcomings or the benefits of it? Or we just should see the whole picture which shows the fact that medical tourism will not vanish, and the countries should only act in a sense of protecting patients, both incoming and domestic. We believe that healthcare access could greatly benefit by opening this kind of services to wider population while at the same time not endangering patient' safety. Good health insurance policies, certificates and well-defined services could best do this.

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2.5.1 EU cross border healthcare directive 2011/24

Directive No. 2011/24/EU of March 9, 2011 [6] on patients' rights in cross-border healthcare aims to guarantee patient mobility and the free provision of healthcare services. The Directive contains provisions concerning the reimbursement of costs, the responsibilities of the Member States and their cooperation in healthcare. It has been applicable in the European member States since October 25, 2013, and in the European Economic Area* (Iceland, Liechtenstein, and Norway) since August 1st, 2015. However, it does not apply to Switzerland.

The main goal of this Directive is to facilitate access to "safe, high-quality cross-border healthcare and to promote healthcare-related cooperation between EU and EEA (Iceland, Liechtenstein, and Norway) member States, while maintaining each State's independent authority to organize and provide healthcare services".

According to the Directive, the patient is free to choose a healthcare provider or facility in either the public or the private sector, which correspond with the healthcare access, which does not make the difference between them. The patient will be reimbursed by the member State national health insurance, but the amount of money could differ – will be at least the price of the same service in resident county, or sometimes the full amount of the treatment received. If the patients receive the cross-border prescription for medication or medical device, the resident country must provide the follow-up care of same quality. State member is obliged to create National Contact Point responsible to inform patients of all of their rights. Directive also urged creation of updated "e-health" network in each country, which will enable continuity of care and access to high quality healthcare. Network among countries will also promote cooperation between competent centers and authorities, which was visible during COVID-19 pandemic, when EU states worked together and gave money for new treatment solutions (vaccines). Although we have witnessed intensive work on the vaccine in the last year, in previous years member States have also dealt with rare diseases, as one of the common concepts of access to health at European level. We can say Europe is already working on providing patients with "healthcare provider reference networks" and is promoting patient' mobility for expertise.

Directive 2011/24 EU covers all European Union citizens, nationals of the States of the European Economic Area (Iceland, Liechtenstein and Norway), refugees and stateless persons residing in a Member State of the European Union or the European Economic Area, who are or have been subject to the legislation of one or more Member States, as well as their family members and their survivors.

The Directive does not apply to long-term care (home care services), organ donations and public vaccination programs.

There are some good concepts in European' healthcare access policies that should be incorporate in medical tourism worldwide. However, we pointed out this Directive as a new medical tourism booster knowing that it will be difficult to copy-paste it in other continents lacking "Bismarck-like" health insurance model.

3. Health insurance

Medical tourism affects each country, but the challenges and advantages will differ based on specific health insurance. Likewise, state, non-state, individual, institutional levels of care and medical tourism market will engage health care system in different ways including profit, autonomy, and ethical aspects. All these relations will then ask for good funding and delivery models, incorporated in good insurance scheme.

Public healthcare systems are even more under the pressure to withstand the new era of globalized medicine [17]. Having in mind, that many countries do, and many do not have public healthcare coverage, the possible model for uniform approach to medical tourism insurances become questionable. In countries without public healthcare insurances, the use of external medical services could become more often but the system will not be burden – while the patients will pay for any consequence, visible after return, related to medical tourism treatment.

But those countries with public healthcare insurances will face another level of problems associated with medical tourism – the cost of all the consequences related to safety and efficacy that will emerge after the patient' return if he/she decided to use the treatment outside the country of residence. Notably, the patients from countries without national healthcare coverage will seek different treatments based on the price and availability [8]. This is something what Europe is prevented by its multilateral agreements on using national health care coverage across the border [6].

Health insurance is a data-driven business, and the more the data are organized and available, the more the insurance will be specific for the treatment. Traditional health insurance product design and pricing rely on gather and analyze the past data (e.g., past claims) of a health care access of certain population. The main question they answer is how many times? So, how many times a year the patient will use access to general practitioner, specialist, and hospital? The second question is how much? How much will each health care access cost? So, if there are not enough and/or reliable information on cross-border healthcare access than the health insurance policy could not be very precise. Then the next question is raised: How much such health insurance cost? Today' insurance companies offer coverage for expenses made due to medical tourism, making efforts to reduce costs, but mainly they do so by their own – no policies or laws almost nowhere are implemented in a way to protect nor the individual nor the system.

While there is difference between countries, the calculation is even more difficult. Today, the cross-border health insurance is typically a more rewarding product than a purely domestic product line. Thus, it is important to understand the local context of the country where the medical treatment is taking place, and to know how the healthcare access in this particular country is organized.

Most health insurance products cover treatment received solely in the customers' main country of residence. Some offer cross-border coverage, like those offered to the expatriate employees of multinational corporations, which give them health care access to the nearest centers of medical excellence in their region.

In time, the patients will increasingly be looking abroad for medical care, as they realize that the quality of treatment (physicians, drugs, devices, etc.) or the lower price, or the quicker access they are looking for is often not available locally (or the waiting list is too long). This also presents opportunities for hospitals, accreditation bodies and funders (e.g., insurance companies).

Safety and efficacy may not be the first parameter for choosing the treatment. Being used to get the appropriate care through the national health care system may make the patients to risk more. Therefore, the risks related to the medical tourism should be anticipated. For example, the entire documentation patient should carry with, the type of insurance, additional costs, post-operative care and complications. This is separate from medical malpractice insurance, which the doctors cover by own insurance - it only covers the consequences of "no fault" complications, not negligence. This will help the overall medical tourism industry to standardize all the elements related to the trip of their patients: travelers' choices, booking, treatments payment, insurance, language, etc.

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A special section represents travel medical insurance. It pays for emergency medical expenses during a trip. If you are traveling and have an unexpected illness, injury or medical condition that is covered by your travel medical insurance, the plan will reimburse you, up to the plan limits. Travel medical insurance pays "reasonable and customary" charges for bills such as: ambulance service, doctor bills, hospital and operating room charges, X-rays, examinations, treatments, lab tests and anesthetics, drugs and medicines. However, this kind of travel insurance does not count as medical tourism as the main trigger for the trip taken was not a medical procedure of any kind.

4. Accreditations and certificates

Healthcare access enhanced and improved by assigned international accreditations and certificates could make a great impact on in- and specially out-patients service satisfaction.

Obviously, the global medical tourism will not affect all national healthcare systems and institutions in the same way, but a possibility of affecting the national healthcare access must be anticipated. Thus, the accreditations and certificates are needed.

There are world organizations referred as examples that publish accreditation. The oldest international accreditation organization is in Canada, accreditations Canada. They made the first accreditation in 1968 for a hospital in Bermuda. In USA operates accreditation body Joint Commission International (JCI), and this organization provides inspections and accreditation to institutions outside the USA since 1999. In United Kingdom (UK) operates Quality Healthcare Advice Trent Accreditation. The Australian Council on Healthcare Standards (ACHS) is a well-known authorized accreditation organization with the Australian Commission on Safety and Quality in Healthcare. The number of internationally accredited medical centres worldwide has witnessed substantial growth, for example, JCI accredits 100 new centres annually and covers 66 countries.

Unfortunately, there is no organization officially and universally recognized and responsible for such accreditation. Therefore, it is common to see health institutions that are interested in double/multiple accreditations, for US, UK and EU market, to reach patients from different parts of the world. Likewise, there are no necessary demands to obtain accreditation for service of medical tourism providers. This situation affects the consumers to choose the destination and the service without quantitative and/or qualitative information about clinical quality and related outcomes [3].

When a national healthcare system as a whole or an individual health institution is deciding on type of accreditation or certificate, they mostly ask for these main conditions and procedures to be covered by accreditation / certification process is standard of care and patients' safety including:

- ensure safe surgery
- reducing risk of health care-associated infections
- reducing the risk of patient harm resulting from falls
- improving the safety of high-alert medications
- improving effective communication.

However, what most present accreditation and certification organizations do not cover, as there is also no demand from healthcare systems or institutions at this time, is:

- hospital insurance coverage for all of its parts included in medical tourism services provided

- telemedicine, if incorporated in hospital work, should be seen as an advantage that reduce the cost of insurance, especially for post-treatment complications, while will allow doctors to follow-up their patients without additional cost of e.g., prolonged stay

- the number and severity of post-treatment complications tracked

- routine follow-up related to post-treatment care and complications arising from medical procedures performed abroad should be emphasized, identified and addressed

- secured funds that will assure medical tourist that any complication will be promptly covered, no matter insurance reimbursement protocol

- surveillance of contracts with agencies providing medical tourism services (buyers).

International accreditation also could be seen as a great marketing tool for incoming patients. However, problems related to accreditation process involve difference between countries (developed/non-developed), institutions in charge for accreditation (public/private or national/international), and the choice of criteria for accreditation. Good criteria for accreditation in medical tourism will incorporate the healthcare globalization processes preventing at the same time the unwanted consequences of medical tourism.

5. Conclusion

Today the term global health is mostly perceived as a part of public health where all the efforts are made to preserve overall health of the population due to socio-environmental impacts. However, the term reflects the efforts made by the national healthcare systems to protect the health of their citizens especially related to the global burden of disease (GBD). Thus, to understand the difference, it is important to see the medical tourism as a part of globalized medicine. It encompasses individual effort made by the single patient to improve his health. This makes medical tourism an important issue for national healthcare system in relation to in- and out-patients. In addition, it affects global health as well, while global health is easily imbalanced by supply/demand of medical services.

Numerous ethical questions on inequity of healthcare access for local residents could arise: drain of the professionals into private sector, fewer services in national sector, better technologies in private, etc. In vice versa situation, where patients are using medical treatments abroad, the system could easily be burden by costs arising from treating post complications due to medical tourism once they are back home.

However, these processes/challenges can help to facilitate creation of policies. Namely, knowing that different types of healthcare systems will be under the different types of demands for medical tourism could affect health insurance policies specifically.

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Missing unified standards for, both, patients and organizations involved in medical tourism could bring enormous medical, legal and ethical risks in the future. Further on, having no unified terminology, or safety, legal and ethical standards is the reason why related problems remains unsolved. The accelerating growth in medical tourism industry, enhance urgent need for supporting measures that will ensure patient' safety at any level.

To create safe environment for this new, fast-growing industry, globally unified accreditation for all included services/facilities are needed. In order to preserve public safety, availability of health care and to give excellent service, global standardization and accreditation is expected to be most urgent processes that should be done in any country positioning itself as a medical tourism destination. Harmonized propositions for medical tourism industry access covered by both, private and public health insurances, would contribute to service transparency, physician' and management' liability, and patient safety while taking care of moral aspects of such services. Medical tourism without any doubt impacts access to healthcare. Therefore, if consciously incorporated, medical tourism as a part of global healthcare could easily become an efficient and effective additional access to healthcare.

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Conflict of interest

The authors declare no conflict of interest.

Author details

Iskra Alexandra Nola[1] and Zdeslav Radovčić[2]*

1 School of Medicine, Andrija Stampar School of Public Health, University of Zagreb, Zagreb, Croatia

2 Energy Clinic Wellness Academy, Dubrovnik, Croatia

*Address all correspondence to: zdeslav@energyclinic.com

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