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Public-Private Partnerships for Inclusive Development: Role of Private Corporate Sector in Provision of Healthcare Services

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Abstract

Travelling abroad for medical treatment, also known as healthcare tourism is a growing phenomenon. Medical tourism is a provision of cost effective private medical care by corporate hospitals such as Apollo and Fortis, in partnership with the government, medical and the tourism industry to foreign patients needing elective, diagnostic, cosmetic surgery and alternative therapies who are travelling to India in search of value. The Minister of Finance, in the 10th 2003-2007 budget speech, called for India to become a world class “Global Health Destination” and attracting foreign direct investment as a pathway for economic development. Thus on one hand, India is providing first world quality of medical treatment to foreign patients and on the other hand, is struggling to provide equitable access to primary healthcare and infrastructure for millions living in poverty. The aim of this paper is to critically examine the sustainable and inclusive (pro-poor) development of healthcare services by the private corporate sector, in public-private partnership (PPP) with the government.

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1. Introduction

Travelling abroad for medical treatment has grown phenomenally in the twenty first century and is one of the fastest growing exports of trade in healthcare services by the private corporate hospitals (Chanda, 2002 and 2007; Chee, 2007; Arunanondchai and Fink, 2007; Bookman and Bookman, 2007; Chinai and Goswami, 2007; Cattaneo, 2009;

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Smith and Puczko, 2009; Smith et al., 2009; Turner, 2010; Hopkins *et al.*, 2010; Lunt et al., 2010; Medhekar and Ali, 2012). There has been increasing cross border trade and travel for health care services to countries such as: India, Thailand, Malaysia, Singapore, Indonesia and Mexico from patients from developed and developing countries for diagnostic, surgical, non-surgical treatment and alternative therapies in search of value for money. The key motivation for medical travel to an overseas country is low cost of surgery, less or no waiting time, state-of-the-art medical technology and facilities, quality of healthcare, highly qualified medical staff, privacy, confidentiality, along with having a holiday (Connell, 2006; Carrera and Bridges, 2006; Bookman and Bookman, 2007; Deloitte, 2008; Turner, 2007; Bies and Zacharia, 2007; Douglas, 2007; Horowitz and Rosensweig, 2007; MacReady, 2007; Ye *et al.*, 2008; Singh, 2012; Hopkins *et al.*, 2010; Lunt *et al.*, 2010; Lunt and Carrera, 2010; Brotman, 2010; Ali, 2012; JCI, 2013; Medhekar and Ali, 2012; Taleghani, *et al.* 2011). Besides medical cost, other factors that make India an attractive destination are: cost of surgery inclusive of travel and accommodation, tourism, English language, personalised service, convenience, and cultural sensitivity.

According to United Nation Development Programme (2006, p. 367) report, India is the second most populated country in the world after China. It constitutes 17% of the world population and accounts for 35% of the world's poor and 40 % of the world's illiteracy rate (p.367). The economic and social impact of the development and growth of medical tourism industry for developing countries like India in particular, is highly significant in generating employment opportunities (Bookman and Bookman, 2007) and having a multiplier effect on the various sectors of the economy such as: healthcare sector, medical industry, tourism industry, allied healthcare services, hospitality, marketing, food and beverage, transportation and infrastructure development needed to attract foreign tourists. Further, educational institutions also play a major role in human capital development needed for this industry, and influence policy to have universal and inclusive healthcare reforms.

Medical tourism industry can be seen as an innovation in healthcare and economic development. Thus PPP approach for sustainable development of India's healthcare system should be adopted to earn foreign exchange on one hand (Medhekar, 2011 & 2012), but also to provide "universal healthcare in India by 2020" (Reddy *et al.*, 2011, p. 760) on the other hand. Thus, pro-poor macroeconomic policy development and reform of the healthcare sector in the domestic economy was stressed by the 11th five year plan (Planning Commission, 2006) and the 12th 5 year plan (2012-17) 'Towards Faster, Sustainable and More Inclusive Growth' (Planning Commission, 2011). The World Development Report (World Bank, 2009) also focusses on the policy response for mobilising the resources such as labour to ensure inclusive development and poverty reduction. The foreign exchange revenue from medical tourism can be used to provide a better medical services to the poor Indians living in poverty (Medhekar, 2012) and will also provide over 40 million jobs to Indians (Deloitte, 2008), besides, development of state-of-the-art health sector, tourism and infrastructure facilities which will benefit the country at large.

Trade in healthcare services is a billion dollar profitable industry for India in the 21st century (RNCOS, 2010). Bookman and Bookman (2007) reported that approximately 272,000 medical tourist visited India for medical tourism, worth US\$ 656 million in foreign exchange. It was estimated that India's medical tourism market was worth \$ US2.5 billion in foreign exchange in 2012 (Deloitte, 2008). In 2009, a developing emerging economy India was ranked second after Thailand as a world class medical destination (Nagaraj, 2009) for complex specialised surgeries due to low cost of complex surgery and number of medical tourists (IMT, 2009; Healy, 2009), however it spent only 4.6% of GDP in 2001-02, (Planning Commission, 2006) on total health expenditure, resulting in inequality of access to its own poor population. According to Neelankhantan (2003), 150,000 foreign medical tourists visited India in 2002 and almost half of them came from the Middle Eastern Arab countries. In 2005, nearly 150,000 medical tourist visited India, and by 2012, it grew annually at the rate of 30% (CII and McKinsey, 2002). Federation of Indian Chambers of Commerce and industry (FICCI, 2008) study also projected that the healthcare and insurance market was expected to grow by \$ 2.2 billion by 2012.

Several State Governments in India such as Andhra Pradesh, Kerala, Gujarat and Maharashtra in partnership with private corporate hospitals have been promoting and attracting foreign medical tourists (Medhekar, 2013a) for highly complex surgeries such as hip and knee replacements, eye, cancer, dental procedures, reproductive, surrogacy and organ transplant. For example in 2006, 'Year of Medical Tourism' was announced by the Government of Kerala State (Marcelo, 2003) and in 2013 Confederation of Indian Industry (CII) in PPP with Government of Kerala will organise the fourth Kerala Health Tourism Conference which aims to promote Kerala as a Medical Tourism destination to the world (Bus-India, 2013). The key corporate hospitals providing medical treatment to foreign

patients are Apollo Hospital Group, Wockhardt, Fortis Healthcare, Max India, India Institute for Medical Sciences, Birla Heart Research Centre, Christian Medical College, Tata Memorial Hospital, Sancheti, Jaslok Hospital, Asian Heart Institute, Kokilaben Hospital which receives patients from developing countries like Mauritius, Seychelles, Maldives, Bangladesh Sri Lanka, Bhutan, Nepal, Oman, UAE, Bahrain, Qatar, Saudi Arabia Africa and developed countries of UK, USA, Canada and Australia. Further, Apollo Hospital Group has also established branches in Sri Lanka, Bangladesh, Ghana, Mauritius, Kenya, Nigeria, Oman, Qatar and Kuwait (Medindia, 2006; Herrick, 2007; AMTA, 2010) to provide first world care to foreign patients in their home countries, without having to travel to India.

After the privatisation, liberalisation and private finance initiatives during the 1990's and the New Economic Policy reform initiatives of the 10th five year plan; healthcare provision was opened to private corporate sector, attracting foreign direct investment. World Health Organisation's macroeconomic health strategy of investment in health, as a pathway for economic development was adopted by developing countries (WHO, 2000) and the Indian Minister of Finance, in the 10th five year plan 2003-2007 budget speech, called for India to become a world class "Global Health Destination" (MOT, 2012; GOI, 2003, 2008a), thus supporting trade in healthcare services. On one hand, India is providing world class quality of medical treatment in state-of-the-art facilities to foreign patients and on the other hand, is struggling to provide equitable access to health infrastructure and basic primary healthcare for millions living in poverty (Gupta, 2008; Tattara, 2010; Medhekar, 2013a & 2013b). Capital cities attracted most of the private corporate investment in healthcare. However, backward states were left out in health, education, and other infrastructure facilities needed to support inclusive development. It is thus important to have a PPP approach in the social sector (GOI, 2003; Medhekar, 2012) for an inclusive development strategy to not only treat foreign patients who bring in much needed foreign exchange revenue, but also to ensure that the poor or disadvantaged population have access to first world quality of healthcare facilities and medical treatment at a free or subsidised cost, by the private sector hospitals. These private hospitals on one hand are making profits by treating foreign patients, but also reaping the benefits of subsidies from the government. The aim of this paper is to examine the sustainable and inclusive development of medical tourism industry by the corporate private sector in partnership with the government. The introductory section of the paper provides a background to the importance of trade in healthcare services by medical tourism industry provided by the corporate sector. Section two puts forward a brief literature review on medical tourism. Section three critically examines the government policy initiatives to support the sustainable development of medical tourism industry and public-private partnerships required for inclusive and sustainable development. Section four provides discussion and policy implications, followed by conclusions.

2. Literature Review

2.1. Medical Tourism

Medical tourism is an example of international trade in healthcare services which has grown dramatically in this century mainly because of low cost, no waiting period for surgery, qualified professional medical staff, affordable and ease of travel and Joint Commission International (JCI) quality of healthcare (Connell, 2006; Milstein and Smith, 2006; Bookman and Bookman, 2007; Keckley, 2008; Woodman, 2008; Smith et al., 2009; Medhekar, 2013b). According to General Agreement on Trade in Services (GATS), it is the second mode of trade in healthcare services (Chanda; 2002). World Trade Organization classification of international trade in services, GATS defines four modes of supply through which services can be traded (WTO, 1991). This can be applied to medical tourism. Mode 1, relates to the supply of medical equipment from developed to developing nations. Medical tourism falls under Mode 2 of GATS, which involves the movement of medical patients to a country where healthcare services are provided to foreign patients. The "destination country" is, therefore, the "exporter" while the patient's "home country" becomes the "importer" of the service. Mode-3, relates to where the highly qualified and experienced medical professionals move between countries and mode-4 is about attracting foreign direct investment in healthcare and medical hospitals infrastructure facilities and public-private partnership (PPP) needed for its sustainability (Medhekar and Ali, 2012). This growth of trade in health care services through the medical tourism industry has led to global outsourcing of healthcare and surgery to affordable destinations in Asia, where first world medical care at third world prices, is provided to foreign patients who are in search of value (Baliga, 2006; Turner, 2007; Bies and Zacharia, 2007; Smith and Forgiione, 2007; Deloitte, 2008). Table-1 shows clearly that India has a cost

advantage for complex surgeries between the popular medical tourism destinations.

Table 1: Cost Comparison for Selected Surgeries

Countries	Heart By Pass	Hip Replace - ment	Knee Replac -ement	Hysterectomy
Australia	\$33,340	\$23,800	\$20,089	\$7,113
USA (US\$)	\$130,000	\$43,000	\$40,000	\$20,000
India (US\$)	\$9,300	\$9,000	\$8,500	\$3,000
Thailand (US\$)	\$11,000	\$12,000	\$10,000	\$4,500
Singapore	\$18,500	\$12,000	\$13,000	\$6,000
Malaysia (US\$)	\$9000	\$10,000	\$8000	\$3000
Korea (US\$)	\$34,150	\$11,400	\$24,100	\$12,700

Source: Compiled from American Medical Association (2008) American Medical Association and Medi-bank Private (figures from 2006 / 2007 financial year prices) and Josef Woodman (2012).

The academic literature on travelling aboard for medical treatment can be reviewed from different angles such as; cosmetic surgery, dental, reproductive, surrogacy, various models of medical tourism, legal, ethical health insurance, accreditation and quality, health economic policy, equity in access to medical treatment but not much on inclusive economic development and growth by private hospitals and PPP. The main purpose of a medical tourist is to travel aboard for diagnostic and complex surgeries as seen from Table-1, to improve their health and wellbeing. Smith and Forgione (2007) have identified economic, political, and regulatory factors influencing the patient's choice of a specific country and that choice of international medical facility is impacted by costs, quality of care, physicians training and accreditation.

Bookman and Bookman (2007) have studied demand and supply factors for developing countries and have classified three forms of medical tourism: invasive, diagnostic, and lifestyle and defined medical tourism, "as travel with the aim of improving one's health, medical tourism is an economic activity that entails trade in services and represents the splicing of at least two sectors: medicine and tourism" (p. 1). Caballero-Danell and Mugomba (2007) have described a distribution channel and marketing model for medical tourism industry by identifying the key stakeholders. Their model identified nine factors: social issues, communication channels, product, target market, infrastructure, legal framework, branding, operators, and customer benefit. Motivations to travel to Hong Kong for medical treatment were studied by Ye, et al. (2008). Further, Heung, Kucukusta, and Song (2010) have proposed an integrated demand and supply model of medical tourism. Internet is also a driving factor in disseminating information, outsourcing healthcare services and making medical travel a global phenomenon, whereby potential patients gain access to global healthcare information and promotion, along with the choice of destination, cost of surgery, waiting time, quality, tourist attractions, social, economic and political conditions within a country before they make a decision to travel abroad for medical treatment (Karuppan, 2009; Lunt et al., 2010; Cormany and Baloglu, 2011; Medhekar and Newby, 2013).

Halal medical tourism is growing globally. India has many Muslim patients travelling from countries of South Asia, Africa and Middle East for medical treatment. It faces competition from Malaysia and Dubai. Global Health City was established in Chennai in 2012, as the first Halal Friendly Medical Tourism Hospital. It is certified by Halal India and International Halal Integrity Alliance Malaysia; which is a partner of Islamic Chamber of Commerce and Industry Saudi-Arabia, providing customised medical treatment to foreign Muslim patients along with halal certified food, medicine, and prayer-room. Based on this emerging halal healthcare market Medhekar and Haq (2010) proposed a culturally sensitive Muslim typology to market Indian medical tourism to Muslim patients. Turner (2010) has proposed quality and ethical standards for regulating the global medical tourism industry at national and international level, to protect the patients when they travel abroad for medical treatment. With the globalisation of healthcare services, health literacy is a key factor. Medhekar and Ferdous (2012) thus adopted the 4

types of health literacy from National Network of Libraries of Medicine and developed culturally competent health literacy for medical tourists and medical tourism service providers; to understand and interpret visual information related to medical data and graphs (visual literacy); evaluate and apply health information (information literacy); operate, and research relevant information from the internet (computer literacy); and to calculate and understand data related to medical tourists health reports (numerical literacy).

Medhekar and Newby (2013) proposed an Information Search Model of Medical Treatment Abroad. Their empirical findings concluded that potential medical patients make an informed decision and search for internal (personal experience) and external (internet, print, media, family, friends, doctor, medical tours operator, and health insurance provider) information before making the decision to travel abroad for treatment. Ethical and equity issues related to private corporate sector and medical tourism are raised, where millions of poor from do not have access to affordable first world quality of health care and surgery; and developing nations are treating patients from developed countries of USA, UK, Canada, Europe and Australia (Fleck, 2002; Sengupta and Nundy, 2005; Turner, 2007 & 2010; Varman and Vikas, 2007; Singh, 2008; Vijaya, 2010; Pocock and Phua, 2011; Meghani, 2011; Medhekar, 2013b).

3. Government Policy Initiatives

Government of India took the initiative to promote India as a 'Global Healthcare Destination' (GOI, 2003, 2008a & 2010) to the world and introduced Medical-Visa (M-Visa) in 2003, which is valid for a year and Medical Escort Visa (MX) for accompanying family and friends (Chinai and Goswami 2007). Further, to reduce bureaucratic delays and expedite visas on arrival (VoA) scheme for medical tourists was introduced in 2010 (The Hindu, 2012). National Accreditation Board for Hospitals (NABH) certification body, of the Indian Government has been approved by the International Society of Quality in Health Care (ISQUAH), to promote a uniform regulation at state and central level, of quality of healthcare facilities and treatment, ethical standards and equal access to healthcare for treating foreign as well as domestic patients (Anon, 2009). National Association of Health Tourism also took the responsibility of promotion of alternative medicine through overseas Indian high commissions and medical tourism trade fairs to build brand –India. Foreign patients look for international accreditation for quality of healthcare facilities and services and so, USA based accreditation body, Joint Commission International (JCI), has also accredited 17 hospitals and 3 medical facilities in India (JCI, 2013).

The Prime Minister's advisory council on Trade and Industry, states that... 'the treatment of foreign patients is legally an 'export' and the same is eligible for all fiscal incentives extended to export earnings...' (GOI, 2003). For example, import duties on medical technology, life-saving medical equipment and machinery was reduced and government also provided 100% foreign direct investment incentives for development of medical infrastructure, research and development initiatives. Further, depreciation rates of used medical equipment were increased from 25% to 40%. Prime land was provided at a subsidised rate to build hospitals and health infrastructure to corporate private hospitals engaged in the business of medical tourism (Gupta, 2008); with the promise of providing free health care for certain number of poor patients. However whether this promise and commitment by the private hospitals to treat the poor, in return of all the subsidies and support for the development of medical tourism industry, is still debatable. Government also organises medical tourism trade fairs, exhibitions, and conferences in developed and developing countries in partnership with private corporate hospitals and foreign governments, medical tour operators to promote medical tourism to India. Based on this, foreign direct investment (FDI) was encouraged to develop first world medical facilities and infrastructure, import medical equipment and technology, by reducing import duties, approve low interest rate loans, build hotels and accommodation, roads and international quality of airport facilities to ease the arrival and departure of medical tourists from aboard (GOI, 2008a; BMHRC, 2009; Chinai and Goswami, 2007; Chanda, 2007). Government has taken all the policy incentives to support trade in medical tourism, but it has not made it mandatory on corporate hospitals to treat a quota of local poor as their corporate social responsibility, to achieve one of the key objective of the 12th five year (2012-2017) plan, 'Towards Faster, Sustainable and More Inclusive Growth', in improving the health of the local poor population.

4. Public -Private Partnerships (PPP) for Inclusive Development

In the pursuit of economic development and growth, government adopted various alternative measures to provide and finance new economic and social infrastructure by corporatisation, deregulation, privatisation,

commercialisation, commodification of all public services including healthcare. After the 1990 Indian financial crisis, various sectors were opened to free market reform by the Rao government. Deregulation, corporatisation and privatisation initiatives (Labonte, 2003; Coburn, 2003) were adopted under the new economic policy reform initiatives to finance many infrastructure projects. Public Finance Initiatives (PFI) or Public-Private Partnerships (PPP), initiatives of the Thatcher and the Reagan government in UK and USA (Augustyn and Knowles, 2000; Montanheiro, Kuznik *et al.*, 2003) was adopted by the Indian government (Planning Commission, 2007; Basu and Nundy, 2008). Schaeffer and Loveridge, (2002) define Public-Private Partnerships (PPPs) as “arrangements between government and private sector entities for the purpose of providing public infrastructure, community facilities and related services. Such partnerships are characterised by the sharing of investment, risk, responsibility and reward between the partners” (p.170).

This paper suggests that PPP defines cooperation between the government ministries of health, tourism, social welfare, transport and health infrastructure, education, public hospitals and health care services on one hand, and the corporate private sector hospitals on the other hand, which will not only enhances the competitive advantage of medical tourism industry between the various stake holders: such as central and state government and its departments, corporate private hospitals and other business involved in supporting the medical tourism industry, but will also lead to inclusive development if appropriate policies and regulations are developed for implementing and improving the access to healthcare facilities and treatment to the local poor population of developing countries like India and Thailand. Rauniyar and Kanbur (2010), reviewed and synthesised Asian Development Bank (ADB) literature on inclusive growth and inclusive development and summarised that it should involve a combination of mutually reinforcing measures to reduce poverty such as (i) promoting pro-poor sustainable economic growth, (ii) ensuring level playing political field or good governance (iii) social safety nets for inclusive social development. Under the poverty reduction strategy, of ADB, emphasised that “economic growth can effectively reduce poverty, only when accompanied by a comprehensive program for human capital development, social capital development, gender and development, and social protection” (Rauniyar and Kanbur, 2010, p. 456).

Table 2: Public-Private Partnership Model for Inclusive Development in HealthCare Provision



Source: Developed for this paper.

With the growing global demand for healthcare and medical services, PPP between the key stake holders governments, ADB, NGO, private sector is essential to plan, implement and deliver education, medical, health and tourism related infrastructure facilities for inclusive development (GOI, 2003; Ali, 2007; Nag, 2007; Fernando, 2008; GOI, 2008b; Planning Commission, 2011; Medhekar, 2012 and 2013b), as well as to guarantee quality of medical service, infrastructure needs, price, accreditation and handling of any legal disputes equally for local disadvantaged domestic poor and foreign patients. Thus central and state governments in India should not only regulate, but also facilitate with private corporate hospitals and form PPP with various stake holders (domestic and foreign) for inclusive development of the healthcare sector, so that pro-poor macro-policies are developed and disadvantaged local population also benefits from access to first world healthcare provided by the corporate private hospitals such as: Apollo, Sancheti, Wockhardt, Kokilaben Dhirubhai Ambani Hospital and Medical Research and Fortis. This will support the achievement of macroeconomic growth and equity objectives simultaneously by the nation in healthcare development, which is of good quality, affordable, universally inclusive (pro-poor), equal and

ethical. All key stake holders in the healthcare industry need to work together in partnership for efficient, effective and equitable provision and delivery of cost effective, innovative healthcare solutions to all Indians first and secondly to foreigners; as seen from Table-2, which can be applied to any developing country, for the successful implementation of the common goal of inclusive development and access to healthcare facilities and treatment for the poor disadvantaged domestic population and not just the local rich and foreign patients.

Study on India's medical tourism sector in 2002, by Confederation of Indian Industry (CII), in collaboration with international management consultants, McKinsey & Company, outlined enormous opportunity and potential growth for this sector. Medical tourism in India grew at the rate of 30 per cent a year and it is projected by the Federation of Indian Chambers of Commerce and Industry (FICCI) that the health-care market in India will be worth around US\$ 2.2 billion year, 5.2% of gross domestic product (GDP) by 2010, to between US\$ 50 billion and US\$ 69 billion, or 6.2% and 8.5% of GDP by 2020 (Chinai and Goswami, 2007; CII and McKinsey, 2002; Ernst and Young, 2006; FICCI, 2008). Further, the leading corporate hospitals such as Fortis and Apollo have partnered with John Hopkins Medicine International medical and teaching facilities in western countries, which are world famous for their quality of treatment. Wockhardt Group is also affiliated with Harvard Medical International, who manages a total of 26 hospitals across the subcontinent and overseas. These hospitals are actively seeking foreign partners to promote medical tourism and collaborate and cooperate with tour operators like Thomas Cook and others in the hospitality resort business (Sengupta and Nundy, 2005; Ernst and Young, 2006; FICCI, 2008; Hopkins *et al.*, 2010; JCI, 2013,) along with sharing medical expertise, knowledge and having international collaboration with the best medical schools and hospitals in the world.

According to Medhekar (2013b), "given the global nature of medical tourism as an export of healthcare services abroad, not only national public-private partnerships but also global GPPP approach is required between all the key demand and supply side stake holders including the domestic local population for the success of this global healthcare industry, and global transferability of health insurance for medical travel related complications, and other legal and ethical issues" (p.15). Any growth initiative which reduces poverty and is pro-poor can be defined as an inclusive development. For example, in case of health sector, the role of corporate private hospitals in the provision of healthcare should not only be focussed on treating foreign patients and affluent Indians, but should also provide access to first world medical facilities and treatment to poor disadvantaged groups. This has given rise to two tiered healthcare system in India one for the foreign patients and local rich Indians and other for the poor disadvantaged group with lack of access to even primary healthcare (Sengupta, 2008; Hopkins *et al.*, 2010; Medhekar, 2013b).

In case of India the public health service is provided by (i) Health sub-centres (ii) Primary health centres, (iii) Community health centres and (iv) District hospitals. The private sector provides range of health infrastructure facilities and healthcare services such as (i) private dispensaries, (ii) hospitals, (iii) medical centres managed by charitable organisations and Non- Government Organisations and (iv) private corporate hospitals which caters to foreign medical tourists and also local rich Indians (Krishnamurthi, 2004). There is also absence of regulation and policies by the government to enforce the private corporate hospitals to earmark a portion of their profits or via taxation of medical tourism profits for equitable and inclusive development and access of world class healthcare for the poor population of India. (Reddy *et al.*, 2011), have proposed healthcare reform initiatives for "universal healthcare in India by 2020", with three goals to ensure excess and quality of healthcare to all Indians, reduce the financial burden of healthcare on individuals; and empower people to take responsibility of their own health and make the healthcare system accountable for their actions (p.760).

5. Discussion and Policy Implications:

How can we have inclusive economic and social development in healthcare sector in India, to reduce the rich and poor divide in provision and access to first world healthcare at a subsidised rate for the poor by the private corporate sector through PPP? This has been discussed in the 12th 5 year plan (2012-2017) "Towards Faster, Sustainable and More Inclusive Growth", that although the total health expenditure was 5.0% of GDP in the 11th plan India has still not closed the health-divide in the areas of empowerment through education, childcare, and strategy for better healthcare for the poor (Planning Commission, 2011). The policy is there, but the problem lies in the lack of focus in the implementation of this strategy for which political will at all levels of government and different ministries is required along with PPP with the corporate private sectors providing health and education mainly to the rich Indians and foreigners who have the ability to pay. Poverty may be declining; however the

trickledown effect is not working in the health sector, where we need to adopt the millennium development goals (MDG) of reducing poverty by 2015. Government policy is geared to attract huge foreign direct investment in the medical tourism sector which is driven by the corporate private sector to promote macroeconomic growth by trade in healthcare services, earn foreign exchange revenues and create employment opportunities; without taking into account the goal of inclusive development in healthcare by corporate sector by adopting Global PPP (GPPP) approach, where world is soon becoming a 'Global Hospital', and where people are making choices in terms of where to travel for surgery based on key factors such as: cost, no waiting time, JCI quality, safety and security, privacy and confidentiality. Unlike Singapore, there is a conflict in India between the policy objectives of four government ministries: trade, tourism, health and family welfare and social services. In order to prevent government failure as well as market failure, India needs to learn from Singapore, a global player and a competitor in the medical tourism industry, regarding the management of providing equity in access and delivery of healthcare to the local poor population, by adopting the 'three M framework' of the Singapore government which funds 32 percent of national healthcare for its own local population: (i) Medfund is a government subsidy scheme for those who cannot afford medical care, (ii) Medisave, is compulsory health saving scheme, covering 85% of the population and (iii) Medishield which is a government funded health insurance scheme (Medhekar, 2013b).

The positive or negative effects or consequences of the development and growth of medical tourism on a developing country such as India are significant, resulting in managerial and policy implications for the healthcare sector. **(i)** Corporate hospitals are catering to foreign patients and the rich in India. This means that public scarce resources are diverted to treat the rich domestic and foreign patients (Varman and Vikas, 2007; Hopkins *et al.*, 2010; Turner, 2007 and 2010), resulting in trade off and opportunity cost, where the local poor patients are deprived of access to healthcare facilities and specialist doctors. The lower middle class and the poor disadvantaged groups cannot pay high price and find corporate private hospitals unaffordable and thus do not have access to world class healthcare facilities and specialist doctors. This has led to growing health-gap between the rich Indians in the urban cities and the urban and rural poor; **(ii)** In India, the best specialist surgeons who are trained at a subsidies rate in the public medical educational institutions which cost the government nearly \$100 million annually (Sengupta and Nundy, 2005; Sengupta, 2011) are changing jobs from public hospitals, to work at the private corporate hospitals like Apollo, Fortis, Jahangir, Sancheti, Ruby Hall and Wockhardt due to higher wages, better working conditions, job satisfaction and world class medical facilities, resulting in internal brain drain which benefits the medical tourism industry. To prevent this migration from public to private government can retain and attract specialists' doctors to the public system by improving the medical facilities and provide better wages and working conditions. There is also evidence of return of medical professionals from developed countries to their country of birth, to work in the private corporate hospitals (Hazarika, 2010). This can result in shortage of skilled and specialist doctors in the public hospitals and long queue for poor patients;

iii) Seeking complex medical treatment in India is a cheaper cost effective attractive option for foreigners and non-resident Indians. However, at the same time it is important to maintain good reputation of the Indian private corporate hospitals, to make sure that Indian legal and medical ethical system, insurance and liability is fairly established to support any medical malpractice cases by foreigners against Indian hospitals and doctors, which includes surgery and post-surgery care; **(iv)** The recent 2012 rape incidents in Delhi, and 2013 case in Mumbai, confirms that safety and security of the locals including foreign medical tourists is very critical, if India wants to reap the benefits and be a global player in this industry. If quality and safety is compromised, it will deter not only tourist but also medical patients from choosing India as a safe destination for tourism and quality of healthcare treatment; **(v)** There are many positive impacts of private provision of healthcare to foreigners by corporate sector as it generates employment opportunities in high skilled areas (Bookman and Bookman, 2007) medical and allied healthcare services, transport, hospitality, tourism services; building medical and other tourism infrastructure facilities; investment in training medical specialist to work in super speciality hospitals; **(vi)** trade in healthcare services/ medical tourism like international education and tourism attracts foreign direct investment and earns foreign exchange, but on the other hand it is subject to exchange rate fluctuations and rising cost of healthcare for local population; **(vii)** It is essential to have dialogue and Global-PPP to discuss various issues (health/medical tourism and non-tourism) at the destination, international and national policy level (health, tourism, social welfare and infrastructure), in context of healthcare and medical tourism such as: regulation, legal, ethical, (Saniotis, 2007; Lum, 2009; Nemie and Kassim, 2009), quality of healthcare, international accreditation, safety and security of the medical tourists, insurance and liability issues, confidentiality and privacy, country infrastructure issues, spread of virus and super bugs (Snyder & Crooks, 2012; JCI, 2013), cleanliness and hygiene of the hospitals and country,

code of conduct by professionals are some very critical issues for sustainable development and growth of medical tourism and healthcare sector in India.

(viii) Improving health and education is essential for sustaining inclusive growth in developing countries like India where millions are living in poverty, along with the ageing population which can cause economic, social and political instability as poor and ageing means; poor health and less empowerment; (ix) Inefficiency in healthcare service delivery is due to poor quality of healthcare which is measured by life expectancy, infant and maternal mortality followed by high level of corruption in spending and employee's absenteeism, and increasing use of private healthcare by the people Singh (2008). This can be eliminated only if the private sector and the 3 levels of governments work together to improve on quality, corruption, safety, security, and absenteeism; (x) Governments can pass regulation to earmark all tax revenue earned from the private medical tourism industry, by reinvesting the revenue into the domestic healthcare system and thus providing equal access to medical treatment and facilities for the disadvantaged rural population of India living below the poverty line and enhance local health benefits. (xi) In case of the old and retired people from all sections of the society and particularly middle class and upper middle class families are living alone. The private agencies which provide home-nursing facilities are growing and this is not regulated and accredited by the government. There are many cases where the families and agencies who are caring for the old people in their own home, are taking advantage of their vulnerable age. There is a business opportunity for the major corporate private sector hospitals with partnership with government subsidy to encourage them to build and provide old age nursing homes based on high, medium and low care health facilities as in developed countries, so that old people can be taken care of and not abused by their family members and private carers at home. Medical tourism can act as a driver for improving healthcare facilities and service delivery at a subsidised cost not only to the poor but also to the ageing population by user pay system based on ability to pay principle. This will assure inclusive development and public-private provision of healthcare to all disadvantaged groups in the current context of decentralisation and globalisation of health care delivery; as economic growth and availability of first world healthcare alone does not guarantee inclusive development in access to healthcare.

6. Conclusions

Macroeconomic policy of sustainable and inclusive development and growth is a concern for India because the benefits of equal access to first world healthcare facilities and treatment from the medical tourism industry have not been equitably shared and tricked down to the poorest of poor (people below the poverty line) in urban as well as rural India. Increase in macroeconomic development and growth, which increases inequality, is not inclusive or pro-poor. To meet the objective of the 12th five year plan (2012-2017) as outlined by the Planning Commission (2011), it is necessary to improve the quality of facilities and medical staff at the public hospitals who serve the economically backward and those living below the poverty line, by having a Universal Health Coverage and to improve efficiency, effectiveness and accountability in the delivery of healthcare services to the poor, under the umbrella of National Rural Health Mission. Private corporate hospitals are for the rich Indians and the foreigners. The Indian government may be of the opinion that by supporting the development of medical tourism the market forces will automatically take care of inclusive development and growth, where the benefits from trade in healthcare services will reach the poorest of poor population. In reality, various studies have shown that private hospitals have refused free treatment to poor patients, in return of government measure to support the development and growth of medical tourism (CII and McKinsey, 2002; Smith *et al.*, 2009; Voigt and Laing, 2010; Basu and Nundy, 2008; Gupta, 2008). Further, given the slow growth rate projected in the coming year for the Indian economy for 2013-2014, the rupee has depreciated since August 2013, against US dollar (Das, 2013) and other major currencies. This will make India an attractive low cost destination for medical tourists as well as make import of medical equipment and certain medicine expensive and thus increase the cost of medical treatment for domestic patients.

The new economic policy reform strategy that started in 1990 was oriented towards privatisation, foreign investment and development of industry through free market. However, since the 11th five year (Planning Commission 2007) plan the government is concerned about inclusive development and growth with a human face in all sectors. The corporate sector hospitals need to play a major role by PPP, for making medical tourism pro-poor in providing cost effective, innovative solutions by adopting urban slums and rural villages to ensure inclusive and sustainable development of first world healthcare facilities in regions that are economically underdeveloped and support the idea of universal access to healthcare for the poorest. Further, political commitment is essential between

the key stake holders for providing efficient, effective, equitable and accredited quality of health care for the long term sustainability of the medical tourism industry for the host country, given the increasing competition, as well as to guarantee well developed rural infrastructure facilities such as roads in particular to have easy access to health and educational facilities, quality of service, affordable price, accreditation of public and corporate private hospitals and handling of any legal disputes for all patients (domestic and foreign) to ensure universal access to healthcare. Finally, if the population of the country is in good health, they will generate wealth, and promote sustainable inclusive development and growth for all sectors of the economy.

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