Medical Tourism

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Evolution of Medical Tourism

• Until mid-1990s: affluent consumers from developing countries travel to industrialized countries for medical treatment

• Early 1990s-about 2001: Consumers travel to countries such as Argentina, Brazil, and Israel for cheap cosmetic procedures

• Post-2001: Wealthy from the Middle East, SE. Asia and S. Asia seek treatment in Asia
  – Emergence of medical tourism in Thailand, Malaysia, Singapore, and India

• Emerging Trends: Medical Outsourcing
  – Un- and underinsured consumers from industrialized countries seek 1st world care and quality at developing country prices
Drivers

I. Rapidly increasing healthcare costs
   – System level: rationing and queuing (UK/Canada)
   – Individual: increasing numbers of un- and underinsured (US)

II. Geopolitical events
   – Post 9/11 immigration controls

III. Greater availability of information
Drivers

IV. Emergence of assurance and reputational mechanisms

1. Accreditation. JCI (Joint Commission International), ISO etc.
2. Partnerships and managerial oversight from leading medical providers and accreditation agencies
   - Mayo Clinic/Cleveland Clinic/Harvard Medical School affiliations in UAE
   - India’s National Accreditation Board for Hospitals and Healthcare Providers affiliation with Australian Council on Healthcare Standards
3. Familiarity and comfort with diasporic healthcare providers at home
   - e.g. Indian origin health professionals in N. America and U.K
4. Diasporas seek treatment and engage in word of mouth advertising in country of origin
Drivers

V. Cost Differences

Expected facility and professional fees comparison for elective coronary artery bypass graft surgery (JCI and/or ISO accredited foreign hospitals)

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Location</th>
<th>Price ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apollo</td>
<td>India</td>
<td>6,500</td>
</tr>
<tr>
<td>Wockhardt</td>
<td>India</td>
<td>10,000</td>
</tr>
<tr>
<td>Bumrungrad</td>
<td>Thailand</td>
<td>15,500</td>
</tr>
<tr>
<td>Angeles</td>
<td>Mexico</td>
<td>25,000</td>
</tr>
<tr>
<td>California</td>
<td>(Avg of 2 hospitals)</td>
<td>60,400</td>
</tr>
</tbody>
</table>

Source: Milstein, Arnold. “American Surgical Emigration is a Treatable Symptom.” U.S. Senate Special Committee on Aging: June 27, 2006.
Challenges

1. Only a small percentage of medical procedures can be outsourced
   - Currently about 2% of healthcare spending in the US (approximately $40 b)
   - In UK, a medical procedure requiring more than three hours of travel will not be covered by NHS

2. Liability and insurance
   - US insurance provider wariness to underdeveloped malpractice and liability mechanisms abroad

3. Aftercare: who will provide post operative care once the patient returns home?
   - Insurance mechanisms to cover treatment for complications?
## Indian Healthcare

<table>
<thead>
<tr>
<th></th>
<th>2005</th>
<th>2015 (estimate)</th>
<th>2025 (estimate)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total household consumption</td>
<td>82</td>
<td>140</td>
<td>248</td>
</tr>
<tr>
<td>Healthcare consumption</td>
<td>7</td>
<td>9</td>
<td>13</td>
</tr>
</tbody>
</table>

*Source: MGI Consumer Demand Model, v1.0*
## Indian Healthcare

### Share of Healthcare Spending

<table>
<thead>
<tr>
<th>Year</th>
<th>Type</th>
<th>Hospitalization</th>
<th>Non-Hospitalization</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Rural</td>
<td>Urban</td>
</tr>
<tr>
<td>1986-87</td>
<td>Public</td>
<td>60</td>
<td>40</td>
</tr>
<tr>
<td></td>
<td>Private</td>
<td>40</td>
<td>40</td>
</tr>
<tr>
<td>2004</td>
<td>Public</td>
<td>42</td>
<td>38</td>
</tr>
<tr>
<td></td>
<td>Private</td>
<td>58</td>
<td>62</td>
</tr>
</tbody>
</table>
## Medical Tourism Market in India

<table>
<thead>
<tr>
<th>Year</th>
<th>Market Size</th>
<th>Patients</th>
</tr>
</thead>
</table>
| 2006 | 0.5 billion | 200,000  
(≈ 5% from US) |
| 2012 | 2-3 billion | 500,000  
(≈ 20% from US) |
Effects on Indian Healthcare

Will medical tourism complement or substitute for domestic healthcare?

Benefits

• Contributes to broad economic growth, especially for the health sector
• May stem “brain drain” and NRIs may return as they find medical sector in India more lucrative than before
• Foments technology and improved facility acquisition
• Greater competition from private sector may force changes in moribund public sector health systems
Effects

Concerns

• Increases inequalities in healthcare access between private and public systems

• Domestic brain drain from public to private sector

• Indian government’s campaign to make India a primary medical tourism destination may divert attention from primary healthcare and other sectors
Policy Implications

• Will medical tourism increase “dualism” in healthcare in India?
  – And if so, will it be at the expense of the treatment of communicable diseases (AIDS, tuberculosis, malaria, etc.) which still run rampant?

• About half (but declining) of the disease burden in India is infectious diseases
  – This portion will not benefit from medical tourism and may be adversely affected because talent and resources will chase profits not patients

• Emphasizes the need for reorganizing public healthcare systems in India