

# Medical tourism – new growing industry on a concealed market

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## Abstract

**Background.** Travel for health reasons is not new. 'Taking the waters' has long been a pursuit of those who could afford the travel to spa destinations, often crossing borders to do so. There are numerous 18th century accounts of wealthy Europeans traveling to famous French spas or to the medicinal waters for treatments.

**Aim.** This study aims to analyze the industry within medical tourism as literal sea change has been occurring in recent years.

**Results.** Growing technological sophistication and low labour costs in developing countries, combined with cheap airfares and a growing global demand for healthcare services, has created a burgeoning new entrepreneurial sector: medical tourism. The industry is said to reach over US\$100 billion in 2012.

## Key words:

destination, medical  
tourist, health, medical  
tourism, industry

## Introduction

Individuals have travelled abroad for health benefits since ancient times, and during the 19th Century in Europe for example there was a fashion for the growing middle-classes to travel to spa towns to “take the waters”, which were believed to have health-enhancing qualities. During the 20th Century, wealthy people from less developed areas of the world travelled to developed nations to access better facilities and highly trained medics. Medical travel (MT) is not new, but the global nature of the cross-border medical care industry has developed rapidly since the late 1990s with thousands of patients moving to countries such as India, Thailand and Mexico, in search of medical care usually deemed too expensive, inadequate or unavailable at home. Ironically the first account of what has become a phenomenon imbued with capitalism, entitlement, individualism and self-fulfilment was of Cuba (Goodrich, Goodrich, 1987). High costs, lack of insurance, under-insured, long waiting-times, and domestically unavailable treatments are some of the causes to go abroad to seek medical services. Moreover, increasing globalization, intensifying competition, and advancing transportation, communication, and information technologies have also been responsible for the phenomenal growth of cross border health care services. As a manifestation of globalization and privatization, the MT industry has grown in recent years especially in Asian countries like India, Thailand, Singapore, and Malaysia. High velocity growth has also shown up in countries like the United States, Canada, Brazil, South Africa, Indonesia, Mexico, Cuba, and the Philippines (Crooks et al., 2010).

The key features of the new 21st century style of medical tourism are summarized below:

- the large numbers of people travelling for treatment;
- the shift towards patients from richer, more developed nations travelling to less developed countries to access health services, largely driven by the low-cost treatments and helped by cheap flights and internet sources of information;

- “new” enabling infrastructure – affordable, accessible travel and readily available information over the internet;
- industry development: both the private business sector and national governments in both developed and developing nations have been instrumental in promoting medical tourism as a potentially lucrative source of foreign revenue.

In this paper, an overview is given of the short history and rapid rise of medical tourism, current knowledge and analysis of the industry.

## The market for medical tourism

Some places may be simultaneously acting as countries of origin and destination in the medical tourism marketplace. The global medical tourism industry is estimated to generate around US\$20 billion of dollars per year. Medical tourists not surprisingly are mainly from rich world countries where the costs of medical care may be very high, but where the ability to pay for alternatives is also high. Most are from North America, Western Europe and the Middle East. In India a majority are part of the Indian Diaspora in the United States, Britain and elsewhere. Medical tourism has grown in a number of countries, such as India, Singapore and Thailand – the three major worldwide medical tourism destinations, ([www.discovermedicaltourism.com](http://www.discovermedicaltourism.com)) many of which have deliberately linked medical care to tourism, and thus boost the attractions of nearby beaches etc. The three hubs are estimated to account for 90 percent of all medical tourism within the Asia. But medical tourism has also developed in South Africa and in countries not associated with significant levels of western tourism such as Hungary, Latvia, Lithuania, Poland (Tucki, Hadzik, 2013).

From marketing materials (both newspaper and web-based sites) it is apparent that the range of treatments available overseas include: Cosmetic surgery (breast, face, liposuction), Dentistry (cosmetic, reconstruction), Cardiology/cardiac surgery (by-pass, valve emplacement), Orthopaedic surgery (hip

replacement, resurfacing, knee replacement, joint surgery), Bariatric surgery (gastric by-pass, gastric banding), IVF/reproductive system (IVF, gender re-assignment), Organ and tissue transplantation (organ transplantation; stem cell), Eye surgery, Diagnostics.

Detailed characteristics in materials shows, that the medical tourism industry consists of three primary actors (Labonte et al. 2013): *patients* seeking healthcare outside their country, *providers* in destination countries willing to offer it and medical *brokers/facilitators* linking the two. A fourth is often complicit, although not always central to the process, the travelling patient's personal physician who may provide the detailed medical history often required or accommodation and sightseeing/shopping sites when staying longer or is a package tour (Fig. 1).

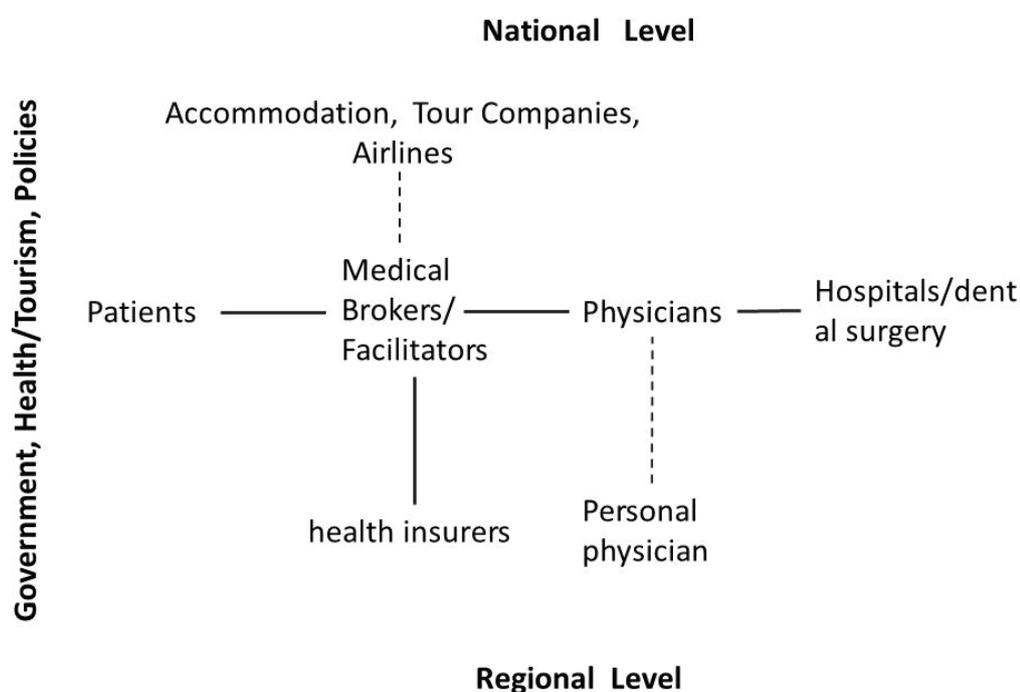
There are several secondary actors: governments, marketing organisations in destination countries who view the industry as a source of foreign revenue often offering generous subsidies as incentives; private and some public health insurers with interests in lowering costs (cheaper services abroad, minimizing complications on a patient's return); and the tourism industry in destination countries/regions that increasingly partners with providers to create attractive

package deals. ITC (websites) and industry conferences/fairs become important marketing tools that let the two meet together.

Lower labor and living costs, the availability of inexpensive pharmaceuticals, and the low cost or absence of malpractice insurance allow many developing countries to offer some procedures at 10 per cent of the cost in the United States, inclusive of travel and accommodation (tab. 1).

A recent study looking at possible bi-lateral medical tourism trade in Europe, between the UK and India demonstrated substantial savings could accrue to the UK NHS from sending its patients to India. If one takes a selected number of procedures suitable for medical tourism, and compares the cost of sending those patients to India, with the costs of getting treatment in the UK, the savings would be of the order of up to 56% (Table 2).

According to a 2008 estimate, the medical tourism business is in operation in 28 countries globally (Discover Medical Tourism 2008). Currently, the most popular destinations for medical tourism are countries once characterized as "third world" such as Thailand, India, Malaysia, Singapore, the Philippines, Jordan (tab. 3).



**Fig. 1.**

The medical tourism industry Source: own collaboration on the basis of Labonte et al. (2013) and Tucki, Hadzik (2013)

**Table 1.**

Prices of selected medical interventions

Procedure	USA	Malaysia	Singapore	Thailand
Heart bypass	130 000	9 000	18 500	11 000
Heart valve replacement	160 000	9 000	12 500	10 000
Hip replacement	43 000	10 000	12 000	12 000
Knee replacement	40 000	8 000	13 000	10 000
Spinal fusion	62 000	6 000	9 000	7 000

Source: Penang Monthly: Statistics-February 2013

**Table 2.**

Cost for one patient travelling to India as medical tourist

Procedure	Cost UK (£)	Cost procedure India (£)	Cost of flight	Total cost India	Total cost saved (£)	
Coronary artery bypass graft (CABG)	8,631	3,413	500	3,913	4,718 (£)	54,7%
Coronary angioplasty	2,269	2,363	500	2,863	-594 (£)	
Total hip replacement	8,811	3,413	500	3,913	4,898 (£)	55,6%
Total knee replacement	6,377	5,145	500	5,645	732 (£)	11,4%
Femoral hernia repair	1,595	819	500	1,319	276 (£)	17,3%
Inguinal hernia repair	1,595	717	500	1,217	378 (£)	23,7%

Source: Lunt et al. 2013

**Table 3.**

Estimated patients treated and money earned in selected countries

Country	Patients treated (year)	Estimated earnings	Services provided
Thailand	1 400 000 (2009)	850 million (2008)	Costmetic surgery, organ trasaplantations, deantal treatment
India	450 000 (2007)	450 million (2005)	Cardiac surgery, joint replacement, eye surgery
Singapore	410 000 (2006)	560 million (2004)	Liver trnnsplants, joint replacements, cardiac surgery
Malaysia	350 000 (2007)	43 million (2005)	Cardiology, cardio-thoracic surgery, comstemic surgery

Source: Hadi (2009); Supakankunti, Herberholz (2012)

Thailand has pioneered medical tourism in its modern form and is still leading in terms of number of patients treated and foreign exchange earnings. The country has the advantage of having a large tourist industry and infrastructure already in place to attract tourists from across the globe. One feature of Thai medical tourism is its flexibility in pricing for services to accommodate the means of its customers (Herrick 2007). Also, Thai international hospitals have adopted a corporate philosophy to promote customer satisfaction. The costs of medical services are often packaged with stays at ocean-front resorts, guided tours and nightclub cabarets in Bangkok to attract international patients (Supakankunti, Herberholz, 2012).

India entered the medical tourism market late but is quickly catching up with other leading countries to become a leading global health care provider (ESCAP 2009). According to one report, Indian hospitals treated approximately 450,000 international patients in 2007 and earned about USD 480 million in 2005. The main strength of the Indian approach is its capacity to provide medical services at the lowest cost among all international health care providers. India has other advantages including a large pool of physicians, many of whom were trained in the UK or USA, English is widely spoken in the country and several hospitals are accredited by the Joint Commission International (JCI) (Herrick 2007).

Singapore has a reputation for high-quality medical facilities and is well known for delivering cutting-edge medical treatment, including surgeries such as liver and heart transplants and complex neurosurgical procedures. It attracted more than 410,000 international patients from 60 countries to generate more than USD 560 million in 2006 (ESCAP 2009).

Malaysia also began its active role in the medical tourism industry after the financial crisis of 1997 caused a drop in the number of domestic patients visiting private hospitals. These hospitals were forced to search for alternative patients overseas, through government trade missions and other promotional activities. While starting late compared to its regional competitors, Malaysia quickly moved to expand its business and generated about USD 43 million in 2005. It is expected to generate at least USD 55 million in

2010 (ESCAP). Popular treatments that the country offers include cardiac and cardio-thoracic surgeries, radiotherapy and radiology. Most of the international patients it received in 2006 were from Indonesia (72%), Singapore (10%), Japan (5%) and West Asia (2%) (ESCAP 2009).

## National strategies

A range of other national government agencies and policy initiatives have sought to stimulate and promote medical tourism in their countries. Many countries see significant economic development potential in the emergent field of medical tourism. The Asian (Thai, Indian, Singaporean, Malaysian), east-European (Hungarian, Polish) and Middle East governments have all sought to promote their comparative advantage as medical tourism destinations at large international trade fairs, via advertising within the overseas press, and official support for activities as part of their economic development and tourism policy (Chee, 2010, Toyota 2012).

India has introduced a special visa category – an M visa – to cater for the growing number of medical tourists as well as allowing tax breaks to providers. Sen Gupta (2008) notes that medical tourism facilities allow increased rate of depreciation on life saving equipments, and also prime land at subsidised rates.

In Malaysia, the National Committee for Promotion of Medical and Health Tourism was formed by the Ministry of Health in 1998. It developed a strategic plan and networked both domestically and overseas with relevant interests. Tax incentives were provided for buildings, equipment, training, advertising and IT, and providers were encouraged to pursue accreditation with an emphasis on quality (Chee, 2007).

Since 2009, Polish government started promotion of the medical tourism promotion. The Project which was launched on the 29<sup>th</sup> of March 2012, acts as a support tool for companies in creating and implementing a unified concept of the promotion of Polish medical services. The consortium's activities are addressed to potential patients and facilitator, interested in bringing patients from Great Britain, United States, Germany, Norway, Denmark and Sweden to Poland. It

is led by the Ministry of the Economy and has the support of the The Polish Association of Medical Tourism, which promotes the interests of its health-care provider and medical travel facilitator members (Tucki, Hadzik 2013).

Hungary has also sought to harness the opportunities presented by EU accession and develop a medical tourism industry. While many of the clinics offering treatment to medical tourists are undoubtedly private, the role of the Hungarian government should not be overlooked. Terry refers to Hungary as the – dental capital of the world and only a cursory glance at medical tourism sites reveals that a wide range of procedures are being actively marketed to tourists (Lunt et al. 2010).

As one of the main sources of medical tourists, the Middle East—particularly Dubai, but also Bahrain and Lebanon—has recently sought to reverse this flow and develop its own medical tourism industry. Dubai has just built Healthcare City (DHCC) to capture the Middle Eastern market and try and divert it from Asia. Unable to compete on price the Middle East has largely competed on quality, with Dubai bringing in German doctors to guarantee high skill standards, and Lebanon stressing its many doctors trained in Europe and America.

## Conclusions

1. Despite increasing media interest and coverage hard empirical findings pertaining to out-of-pocket medical tourism are rare.
2. Hard data on medical tourism is hard to come by, and the physical scale of the industry is difficult to reach.
3. From marketing materials it is apparent that the range of treatments available overseas include: Cosmetic surgery, Dentistry, Cardiology/cardiac surgery, Orthopaedic and bariatric surgery and reproductive system.
4. Main drivers behind the upsurge of demand for medical health services overseas are: familiarity, availability, cost, quality and bioethical legislation. Elsewhere, drivers of medical tourism include the high costs of treatment at home, the speed of obtaining

treatment and treatments not available in the home country.

5. Many countries participate in medical tourism market as importers or exporters. The main importing countries (country of origin) are in North America and Western Europe, while the main exporting countries (medical tourist destinations) are located across all continents, including Latin America, Eastern Europe, and Asia.
6. Price seems to be the main advantage, choosing abroad treatment abroad when Thailand, India and Malaysia would be the most important destinations; within Europe Hungary and Poland seem to be good choice when regarding costs and quality.

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