

MEDICAL AND SURGICAL TOURISM: The new world of health care globalization and what it means for the practicing surgeon

by James A. Unti, MD, FACS

In this issue of the *Bulletin*, the leadership of the American College of Surgeons has published a Statement on Medical and Surgical Tourism (see page 26). The statement addresses a number of concerns about this new industry and some of the safety and quality issues that patients may encounter if they seek health care services outside of the U.S. On June 16, 2008, the American Medical Association adopted its own first set of guidelines on medical tourism to help ensure the safety of patients who are considering traveling abroad for medical care.¹ The American College of Surgeons' statement and the American Medical Association's guidelines together provide an important set of principles for consideration by patients, employers, insurers, and other third-party groups responsible for coordinating such travel outside of the country.

Medical tourism is a rapidly growing, worldwide industry, and its continued expansion could have significant implications for health care delivery in the U.S.² It is important to distinguish medical tourism today from the traditional model of international patient travel. In the traditional model, patients generally journeyed from less developed nations to major medical centers in more highly developed countries. They would do so to receive services that were not typically available in their own communities. Wealthy individuals and dignitaries have often traveled great distances to seek out the best treatments, frequently coming to the U.S. for

care that for many years was perceived to be second to none. Individuals in upper social classes have a long history of traveling abroad, seeking spas, mineral baths, innovative therapies, and fair climates such as those of the Mediterranean with the hope of improving their health.³ Individuals lacking health insurance coverage and individuals with insurance seeking services that weren't covered by their payor plans have crossed borders for care that was simply more affordable. Typically, the services sought were of limited medical complexity. Common examples include elective, cosmetic surgical procedures and various types of dental care. Still others

have traveled for reasons of privacy, to circumvent delays associated with long waiting lists, to obtain services for which access was restricted, or because the desired care was illegal in their homeland country.^{4,5}

Worldwide shortages of donor organs for transplant have created global commercial opportunities in the international organ trade. Often referred to as “transplant tourism,” this form of medical tourism has little in common with the emerging industry that is being broadly promoted today. In transplant tourism, patients travel on their own to obtain organs through the organ trade or through other means that contravene the regulatory framework of their countries of origin.⁶ Many clinical and bioethical concerns surround this trade, and the unavailability of sufficient amounts of verifiable data has led to numerous superficial and often inadequate assessments of this exceedingly complex issue.⁷

Reproductive outsourcing is another specialized form of medical tourism. Legal and policy limitations in many countries have created a global environment where, in a rising number of instances, individuals and couples must travel elsewhere to procure fertility procedures that are unavailable back home.⁸ Sometimes referred to as “reproductive tourism,” circumstances are created in which pregnancy is initiated in one location using the services of a fertility doctor, and parturition occurs at another (typically back home). The jargon term “procreation vacation” has been used, and certainly, assisted conception is one of the most contentious areas of present-day medicine. Such services have many associated bioethical, legal, and other safety issues and these matters become even more complicated when travel to foreign lands is involved.⁹ Pregnancy termination presents another area with many concerns. Like transplant tourism, determining both the demands and the outcomes for these services is complicated by virtually nonexistent domestic record keeping and an unclear understanding of the size and scope of the industry.

*It is highly recommended that the reader take a moment to access the Internet and perform a simple search of just a few of the innumerable medical tourism Web sites to obtain a full appreciation of what is being marketed to the health care consumer today.

The new model of medical tourism

The newer, more popularized concept of medical tourism refers to the model in which patients not only travel across national borders to receive health care services, but they typically travel from more highly economically developed countries to less developed ones. In this circumstance, the term provides neither an accurate reflection of the reality of the patient’s situation nor characterizes the types of advanced medical care that is being delivered in the countries of destination.¹⁰ The image of the typical medical tourist in the new model is one of an individual who jets around the world to a foreign land to receive complex, sophisticated, and often serious medical or surgical care.

Because so much of the care that is actually provided is of a procedural or surgical nature, the term “surgical tourism” may be more accurate in many cases. Imagine a patient leaving the U.S. along with a family member or other companion and flying off to some exotic locale halfway around the world to receive a needed surgical treatment. Following treatment, the “tourist” experiences personal medical attention in a luxurious setting with first-class accommodations and subsequently has the chance to enjoy a vacation for a short while before returning home. Figure 1 (pages 20–21) provides a list of some of the more common surgical procedures that are being promoted by the medical tourism industry.*

At first glance, the imagery being promoted by the industry seems very enticing, and it may be compatible with the delivery of certain procedures that are not associated with serious or potentially life-threatening medical conditions. Add to this imagery the fact that all of the costs for both the tourist and the companion—the medical and surgical care, the airfare, the accommodations, and the extra time for the vacation—are covered by the tourist’s employer-sponsored health insurance. Why? The real answer has nothing to do with improved quality, greater safety, or better clinical outcomes. It simply has to do with costs.

From their viewpoint, domestic payors see savings that are significant enough to justify their actions. They believe that they are con-

tributing positively to our nation's health care system by making overall care more affordable and accessible.

The Table on page 22 provides some examples of cost comparisons that have been promoted throughout the medical tourism industry. Prices for medical services in countries like India may be as low as 10 percent of the corresponding prices in the U.S., and obtaining such services in other countries like Thailand and Singapore could result in cost-savings of as much as 80 percent.^{2,11-13} Medical centers in developing countries are able to provide services at such reduced pricing largely because of their lower economic status. Significantly lower fixed costs, pharmaceuticals, employee wages, and administrative expenses—and the virtual absence of litigious medicolegal climates in these countries—allow them to have substantial advantages. For example, the professional liability insurance premium for a surgeon in India has been estimated to be only 4 percent of the premium for a similarly practicing surgeon in New York.¹⁴

Figure 2 on page 23 lists many of the countries that are involved in the medical tourism industry outside of the U.S. Increasing numbers of facilities, agencies, and even countries are marketing their advantages. Tourist destinations in a number of highly developed nations—such as Belgium, Canada, Germany, Israel, and Italy—are trying to attract foreign patients, claiming to offer modern care that is more attentive to patient preference, service, and satisfaction.

Figure 1. Common surgical treatments promoted by medical tourism agencies

Specialty	Procedure
Cardiac and vascular surgery	Aortic aneurysm repair Atrial septic defect repair Cardiac valve replacements: aortic and mitral Carotid endarterectomy Coronary artery bypass grafting Femoropopliteal bypass surgery Varicose vein treatments
Cosmetic and plastic surgery	Abdominoplasty Blepharoplasty Breast augmentation/reduction Cosmetic skin refinishing and body contouring Face lifts and implant surgery Liposuction Rhinoplasty
Dentistry and oral surgery	Bridges and implants General dentistry procedures Orthodontic procedures Endodontic procedures; root canal surgery Tooth veneers
Ear, nose, and throat surgery	Bronchoscopy Cochlear implants Nasal septoplasty and reconstruction Sinus surgery Tonsillectomy and adenoidectomy Tympanoplasty and tube insertion
General, colorectal, and oncologic surgery	Bariatric surgery: banding and bypass Bowel surgery: colectomy and other procedures Breast surgery: biopsy, lumpectomy, mastectomy Cholecystectomy Gastrointestinal endoscopy: upper and lower Hemorrhoidectomy Herniorrhaphy Laparoscopic surgery

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Establishing legitimacy

To address potential quality and safety concerns, facilities in underdeveloped countries have sought to improve their reputations by becoming recognized through accreditation. The Joint

Figure 1 (continued). Common surgical treatments promoted by medical tourism agencies

Specialty	Procedure
Neurosurgery	Treatment of brain tumors Treatment of spine disorders Skull base surgery
Obstetrics and gynecology	Gynecologic laparoscopy Hysterectomy: abdominal and vaginal In vitro fertilization and intrauterine insemination Tubal ligation and reversal
Ophthalmologic surgery	Cataract surgery Cornea alteration procedures Glaucoma treatments
Orthopaedic surgery	Ankle fusion Arthroscopic and arthroplasty procedures Carpal tunnel release Back procedures: discectomy, laminectomy, spinal fusion Hip replacement and resurfacing Knee replacement Shoulder surgery
Transplant surgery	Organ transplantation: heart, kidney, liver, lung
Urologic surgery	Cystoscopy Genitourinary prosthetic implant surgery Prostatectomy Testicular cancer surgery

Commission—through its international arm, the Joint Commission International (JCI)—and the Trent International Accreditation Scheme in the U.K. have responded to these needs and have already accredited a number of centers around the world. The International Society for Quality in Health Care in Ireland (formerly headquartered in Australia), another organization whose mission is to drive continual improvement in health care quality worldwide, actually accredited JCI's own standards in August.¹⁵ A recent review of the JCI's Web site reveals 219 organizations in 35 countries that have received accreditation to date.¹⁶ In addition to accreditation, many of the tourist agencies that cater to this market make

declarations about the certifications and training of their associated physicians. Many claim that their physicians have either received training in the U.S. or maintain U.S. board certification.

It must be pointed out that the accrediting guidelines applied internationally are not necessarily equivalent to those used to evaluate programs in the U.S. Many of the guidelines have been developed to complement the differing legal, cultural, and religious climates of the various countries involved. In some instances, they may defer to local laws and customs, and this deference makes it difficult to fairly compare hospitals in different countries or regions with each other.

An important point for all practitioners to understand is that the entire medical tourism phenomenon is being driven purely by economic marketplace forces, and so far its rapid growth has occurred largely outside of the view and control of organized medicine.¹⁰ Equally important is the fact that, to date, no verifiable statistics regarding the true magnitude

of this industry actually exist. Much of what is known consists of information that has been disseminated through news articles published in the lay media and through industry-led marketing on tourism agencies' Web sites.

Healthcare Tourism International was started in 2006 with a declared mission of upholding and improving the reputation of the medical tourism industry. It is headquartered in Los Angeles, CA, but also maintains offices in India, Singapore, and Ecuador. Through its associated not-for-profit service, Healthcare Trip Inc., it has assumed accreditation responsibilities for many of the major groups involved in the trade, including hotels, booking agencies, and other

Table.
Cost comparisons between the U.S. and three tourist destination countries for selected surgical procedures

Procedure	U.S. insurer's cost (\$)	U.S. retail cost (\$)	India (\$)	Thailand (\$)	Singapore (\$)
Angioplasty	25,704–37,128	57,262–82,711	11,000	13,000	13,000
Gastric bypass	27,717–40,035	47,988–69,316	11,000	15,000	15,000
Heart bypass	54,741–79,071	122,424–176,835	10,000	12,000	20,000
Heart-valve replacement	71,401–103,136	159,326–230,138	9,500	10,500	13,000
Hip replacement	18,281–26,407	43,780–63,238	9,000	12,000	12,000
Hysterectomy	9,591–13,854	20,416–29,489	2,900	4,500	—
Knee replacement	17,627–25,462	40,640–58,702	8,500	10,000	13,000
Mastectomy	9,774–14,118	23,709–34,246	7,500	9,000	12,400
Spinal fusion	25,302–36,547	62,778–90,679	5,500	7,000	9,000

Source: See reference 11. (U.S. rates include at least one-day hospitalization.)

nonclinical resource entities.¹⁷ Medical Tourism Association is an independent group established in West Palm Beach, FL, that promotes itself as an objective resource for transparency, communication, and education. This association has offices around the world as well. According to the association's Web site, the founder is an attorney who previously was in charge of United Group Programs Inc., a national third-party administrator for many self-funded employee medical benefits plans.¹⁸

So what significance does this new industry actually have for the practicing surgeon? Perhaps it is best to answer this question at several levels.

The significance for our health care system

For our nation's health care system, the degree to which medical tourism has an impact may be proportional to the extent to which it grows. It essentially is a marketplace reaction to the high costs that are stressing our current system and amounts to the international outsourcing of medi-

cal and surgical care for relief. Advances in communication capabilities, the speed and safety of travel, and medical technology availability around the world have allowed its development. But the tipping point may be the fact that the payors of health care in this country are now beginning to give it greater support. Insurance companies such as Aetna and Blue Cross/Blue Shield of South Carolina, and third-party administrators like United Group Programs Inc., have already begun programs to reimburse some treatments performed outside the U.S.^{13,19} Other insurers either are contemplating or are developing plans as well.

Even more notable is the fact that, in 2006, a bill was introduced for the first time in a U.S. state legislature (H.B. 4359 in West Virginia)²⁰ to allow state employees to go overseas for surgery. A similar bill was introduced in 2007 in the Colorado General Assembly (H.B. 07-1143).²¹ Neither of those legislative proposals passed, but one cannot predict the fates of similar proposals in the future. The U.S. Senate has taken notice of these

Figure 2. Frequently cited countries with medical tourism destinations outside the U.S.

Africa	Asia & the Middle East	Europe	Other
South Africa	China	Belgium	Australia
Tunisia	India	Czech Republic	Barbados
	Israel	Germany	Cuba
The Americas	Jordan	Hungary	Jamaica
Argentina	Malaysia	Italy	
Brazil	Singapore	Latvia	
Canada	South Korea	Lithuania	
Colombia	Philippines	Poland	
Costa Rica	Taiwan	Portugal	
Ecuador	Turkey	Romania	
Mexico	United Arab Emirates	Russia	
		Spain	

Source: Adapted from reference 10.

developments. In June 2006, the Senate Special Committee on Aging held a hearing on the issue of medical tourism and called for a task force of experts to explore the impact and safety of receiving lower-cost health care abroad.²²

Exactly how many Americans are traveling overseas each year for medical treatments is not known, but estimates have ranged from 50,000 to 500,000.²³ One often-cited news article in *India Daily* estimated that as many as 750,000 Americans sought offshore medical care in 2007 and suggested that this number could increase to 6 million in 2010²⁴ (supporting details were not provided). To date, however, the impact on the U.S. health care market has been negligible, accounting for less than 2 percent of spending on noncosmetic health care.²⁵ Other research at the World Bank suggests that the net economic effects of offshore surgery could eventually be impressive. Using recent Medicare payment rates, an international price comparison of 15 surgical procedures showed potential savings of approximately \$1.4 billion annually if even one in 10 U.S. patients chose to

undergo treatment abroad.²⁶

The net effect of these factors is that, in the very near term, medical tourism may not be significantly noticed by our health care system. However, if real cost containment measures are not established, it may, in fact, play a more substantial role in the future.²⁷ Although there are concerns about quality and safety, a telephone survey of a nationally representative sample of 1,003 Americans conducted by International Communications Research revealed that in 20 percent to 40 percent of households with sicker family members, participants said they would agree to obtain major, nonurgent surgery at a very good hospital outside of the U.S. by a good surgeon who was trained here, in England, or in Canada and speaks English (or the patient's language) if offered an incentive of \$10,000.²⁸

In the end, the fact that Americans are traveling out of the country for surgical care is a symptom of, and not a solution to, our health care system's affordability problems. Rather, it is a way to get around the problem without actually fixing it. And longer term, the consequences could be detrimental since actual needed health care dollars are being redirected out of the system itself. The loss of even a small number of profitable insured patients could actually end up endangering the viability of many local programs and institutions that provide necessary services.⁴ Such a circumstance could eventually be devastating to us all.

The significance for the surgeon

For the practicing surgeon, a number of potential issues arise, and the nature of these issues actually depends on the position and the circumstances of the individual surgeon in the marketplace. Many of our own surgical colleagues who are capable, well trained, and respected may be on the receiving end of medical tourist travel.

Some surgeons are becoming licensed in more than one country and they may actually be beneficiaries in this new industry. For surgeons who aren't, however, there may be an initial pushback at the idea of taking care of a patient who has had surgery overseas and returns afterwards for follow-up care. Problems may be encountered with the availability and adequacy of medical records, continuity of care, and the need to deal with potentially serious clinical complications. Questions may arise regarding reimbursement for services, especially in view of the fact that the surgeon performing the follow-up services wasn't the one who performed the original procedure. In some respects, there may be unsettled feelings toward payors that are willing to readily send patients away for care, thus eliminating potentially significant revenue sources for the local surgeon, and then are expecting the surgeon to pick up and deliver care afterwards that may be associated with much lower levels of compensation.

One must remember that although physicians do have rights to decline nonemergent care when other treatments are available, if a patient presents with a problem and the surgeon is competent to diagnose and treat that problem, then he or she should do so irrespective of where the patient may have received prior care. Such care could have just as easily been delivered at a facility down the road, somewhere in a nearby town or city, or at a major referral center within the region. Patients should not be punished for going elsewhere just because they tried to do what they thought was best for their own situation at the time their decision was made.

For our patients, safety, quality, and convenience become greater issues. Most patients would prefer to have major surgery in their local community, near loved ones, or at a regional medical center if it were a feasible or reasonable option. In fact, the vast majority of patients would not likely be able to participate in medical tourism because age and comorbidities would prevent them from doing so. However, there are patients who feel pressed to balance their health needs against other considerations, and at times medical concerns may be subordinated to other issues. These patients may actually access overseas treatments if their payor plans make it more affordable and are able to demonstrate adequate safety and quality.

The problems that can occur do not surface when everything goes right, however. And good, objective data with which to make sound decisions are lacking. Infectious complications with unusual pathogens are possible, the contraction of illnesses because of unsafe blood-banking processes can occur, and circumstances in which records are inadequate or incomplete could be harmful if they are truly needed. A lack of coordination of care could be detrimental if it is not prepared for and arranged ahead of time. Despite what the industry promotes, many of the more serious procedures are not so easy to recover from, and the idea of a vacation on the beach or a sightseeing tour may not be even desirable by many during the immediate postoperative period. Such notions don't seem to be at all compatible with the reality of the situation.

Many other postoperative complications, such as deep vein thrombosis and possible pulmonary emboli, are very real and dangerous, especially because their incidence is enhanced by immobility and prolonged flight travel. And the mechanisms for legal recourse in most underdeveloped countries are almost nonexistent, leaving patients without any ability to take legal actions if the need to do so were to arise. This circumstance would likely be unappreciated until it became too late to make a difference.

The Statement on Medical and Surgical Tourism drafted by the American College of Surgeons was developed with the patient's interests in mind. It is important that individuals considering health care services outside the U.S. become informed of the potential risks and complications as well as the medical, social, cultural, and legal implications of receiving such treatment. It is also important that they are not forced to seek such care by their payor plans and that their right to seek care without restriction be maintained. Surgeons should keep all of these matters in mind as they interact with and provide care to their patients. □

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Dr. Unti is a Medical Associate at the American College of Surgeons’ Nora Institute for Surgical Patient Safety in Chicago, IL.

