

Research article

Medical tourism: Sea, sun, sand and ... surgery

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Abstract

Medical tourism, where patients travel overseas for operations, has grown rapidly in the past decade, especially for cosmetic surgery. High costs and long waiting lists at home, new technology and skills in destination countries alongside reduced transport costs and Internet marketing have all played a role. Several Asian countries are dominant, but most countries have sought to enter the market. Conventional tourism has been a by-product of this growth, despite its tourist packaging, and overall benefits to the travel industry have been considerable. The rise of medical tourism emphasises the privatisation of health care, the growing dependence on technology, uneven access to health resources and the accelerated globalisation of both health care and tourism.

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As health care costs skyrocket, patients in the developed world are looking overseas for medical treatment. India is capitalizing on its low costs and highly trained doctors to appeal to these “medical tourists.” Even with airfare, the cost of going to India for surgery can be markedly cheaper, and the quality of services is often better than that found in the United States and UK. Indeed, many patients are pleased at the prospect of combining their tummy tucks with a trip to the Taj Mahal.

Yale Global (www.medical-tourism.us)

1. Introduction

It is a truism that tourism is supposed to be about relaxation, pleasure and an increase in well being and even health. Even with the rise in cultural tourism and notions of tourism also being a learning experience, such learning too is expected to be relaxing and quite different from classroom memories. Tourists need not necessarily be hedonists, but they anticipate a beneficial outcome. In the past decade the attempt to achieve better health while on holiday, through relaxation, exercise or visits to spas, has

been taken to a new level with the emergence of a new and distinct niche in the tourist industry: medical tourism. This paper seeks to provide a first assessment of this emerging phenomenon.

Some of the earliest forms of tourism were directly aimed at increased health and well being: for example, the numerous spas that remain in many parts of Europe and elsewhere, which in some cases represented the effective start of local tourism, when ‘taking the waters’ became common by the 18th century. By the 19th century they were evident even in such remote colonies as the French Pacific territory of New Caledonia, while the emergence of hill stations virtually throughout the tropics further emphasised the apparent curative properties of tourism and recreation in appropriate, often distant, therapeutic places (Smyth, 2005). Somewhat later, recreation and tourism shifted seawards in developed countries, and extended from elites towards the working classes, and sea bathing became a healthy form of recreation (e.g. Gilbert, 1954). Other sports, such as golf, cycling, walking and mountaineering, similarly became part of the tourist experience and were supposedly pleasurable ways of combining tourism and well being. Even more recently tourists have travelled in search of yoga and meditation. The legacy of all this is the continued presence of ‘health

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tourism' where people visit health spas, for example in Kyrgyzstan (Schofield, 2004), with the primary purpose of beneficial health outcomes.

With the partial exception of some spas, none of this has involved actual medical treatment, but merely assumed incidental benefits in amenable, relaxing contexts. This paper is a preliminary attempt to examine a contemporary elaboration of this—the rise of 'medical tourism', where tourism is deliberately linked to direct medical intervention, and outcomes are expected to be substantial and long term. A distinct tourism niche has emerged, satisfying the needs of a growing number of people, mainly in developed countries, benefiting both themselves and a growing number of destinations, principally in developing countries.

2. A new form of niche tourism

In the last decade, and primarily in the present century the notion of well being has gone further than ever before. No longer is improved health on holiday merely an anticipated consequence of escape from the arduous drudgery of work and the movement to a place with a cleaner (or warmer) climate, or the outcome of 'taking the waters', but in some circumstances—the rise of medical tourism—it has become the central theme of tourism in an active rather than a passive sense. A new niche has emerged in the tourist industry. While some writers have continued to use the phrase 'health tourism' to cover all forms of health-related tourism (e.g. Garcia-Altes, 2005), it seems more useful to distinguish 'medical tourism' as one involving specific medical interventions.

Medical tourism as a niche has emerged from the rapid growth of what has become an industry, where people travel often long distances to overseas countries to obtain medical, dental and surgical care while simultaneously being holidaymakers, in a more conventional sense. It has grown dramatically in recent years primarily because of the high costs of treatment in rich world countries, long waiting lists (for what is not always seen institutionally as priority surgery), the relative affordability of international air travel and favourable economic exchange rates, and the ageing of the often affluent post-war baby-boom generation. It has thus largely reversed an earlier pattern of wealthy patients travelling to rich world centres, such as Harley Street in London (but where tourism was not involved). Growth has been facilitated by the rise of the Internet, and the emergence of new companies, that are not health specialists, but brokers between international patients and hospital networks. It has also grown because of rapidly improving health care systems in some key countries, where new technologies have been adopted. Above all it has followed the deliberate marketing of health care (in association with tourism) as medical care has gradually moved away from the public sector to the private sector, ensuring that a growing majority of people, especially in the richest countries, and particularly in the

United States, must pay—often considerably—for health care. Finally, growing interest in cosmetic surgery, involving such elective procedures as rhinoplasty, liposuction, breast enhancement or reduction, LASIK eye surgery and so on, or more simply the removal of tattoos, have created new demands. Various forms of dental surgery, especially cosmetic dental surgery, are not covered by insurance in countries like the UK and Australia; hence dental tourism has become particularly common. In Asia these trends are 'the unlikely child of new global realities: the fallout of terrorism, the Asian economic downturn, internet access to price information, and the globalisation of health services' (Levett, 2005, p. 27).

The biggest hurdle that medical tourism has had to face, and continues to face, is the challenge of convincing distant potential visitors that medical care in relatively poor countries is comparable with that available at home, in outcome, safety and even in dealing with pain thresholds. This has been especially so when medical care systems, in countries such as India, have been conventionally regarded in the west as inadequate, 'even' for India itself. As the German radio station, Deutsche Welle, has pointed out 'India is not exactly known for health and hygiene' yet it nonetheless anticipates a major market in Germany (*Deutsche Welle*, 22 March 2005). Attached to that is the parallel perception that 'you get what you pay for', hence cheap medical care may well be inferior. While such situations have now radically changed the perception of inadequacy remains.

Advertisements for medical tourism therefore invariably stress technology, quality reliability, and overseas training. Advertising in 'Air Mauritius in-flight magazine the Challenge' Hair Paris hair grafting clinic provides 'before and after' photographs of European clients and stresses:

One of the five most advanced clinics in the world is located in Mauritius. The international medical team consists of one Plastic Surgeon, a Laureate winning doctor from the faculty of Paris and an anesthetist, all members of the Medical council... This clinic, set up to European standards and approved by the Ministry of Health is equipped with state of art technology (*Islander*, 38, December 2004).

Cuba emphasises that the quality of its professionals in plastic surgery and dentistry is 'unquestionable as shown by the health indices given by the World Health Organization' (www.cubanhealth.com). In all these countries, and across them, new companies have sprung up, to link patients, hospitals, potential medical tourists and destinations, many with names that either attest to these linkages, such as Surgeon and Safari (South Africa), and Antigua Smiles, that hints at the pleasures associated with both cosmetic dentistry and visiting the Caribbean. In source countries too new companies are emerging, such as Gorgeous Getaways in Australia that specialises in cosmetic surgery in Thailand and Malaysia.

3. The rise of medical tourism in Asia

Medical tourism has grown in a number of countries, such as India, Singapore and Thailand, many of which have deliberately linked medical care to tourism, and thus boost the attractions of nearby beaches etc. But medical tourism has also developed in South Africa and in countries not hitherto associated with significant levels of western tourism such as Belarus, Latvia, Lithuania and Costa Rica. Hungary, for example, declared 2003 to be the Year of Health Tourism. Eastern European countries have become important for dental care and plastic surgery. Jordan serves patients from some parts of the Middle East while Israel caters both to Jewish patients and others from nearby countries, through specialising in female infertility, in vitro fertilisation and high-risk pregnancies.

South Africa has grown in prominence in recent years, especially for cosmetic surgery, since its costs are less than half those of the United States, from where most of its patients come. Argentina is also noted for plastic surgery. The Caribbean has found it more difficult to enter the medical tourism market since, despite its proximity to the United States, its prices cannot compete with those in Latin America (Huff-Rousselle, Shepherd, Cushman, Imrie, & Lalta, 1995). Some Caribbean states have sought to get around this by specialisation, hence Cuba specialises in skin diseases and Antigua in dentistry. In the Pacific Guam has become a regional dental centre for Palau, the Federated States of Micronesia and also Japan (*Pacific*, June 2005, p. 23).

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. Branding is seen as important; ‘it remains to be seen if DHCC will attract people...if there is a single hospital that had one or two good brands that would be good if there was a Cleveland Clinic or a Guy’s or Thomas’s Hospital’ (*Gulfnews.com*, 23 May 2005). Saudi Arabia has sought to link medical tourism, and especially cosmetic surgery and dentistry, with pilgrimage (Hajji) visits to the country, with most patients being from other Gulf countries (*Arab News*, 27 July 2005), and the Health Minister of Iran has claimed that ‘No Middle East country can compete with Iran in terms of medical expertise and costs’, comparing the cost of open heart surgery at US\$18,000 in Turkey, \$40,000 in UK and \$10,000 in Iran so that patients ‘can afford the rest on touring the country’ (*Persian Journal*, 22 August 2004). In 2005 relatively low cost Jordan remained the main medical tourism destination in the Middle East.

As medical tourism has grown in Asia rich world countries have also sought involvement. Thus the Bavaria Medical Group (BMG) has developed links with Qatar Airways and the Sultanate of Oman that have taken patients from Oman to Germany and also resulted in specialist BMG doctors visiting Oman (*Times of Oman*, 24 May 2005). However, rich countries can rarely compete, and restore the old order, as medical tourism has reversed direction. In a very short time period the global structure of health tourism has become highly complex.

The main region for medical tourism is Asia. Thailand became known as a destination for medical tourism as early as the 1970s because it specialised in sex change operations, and later moved into cosmetic surgery. Malaysia became involved after 1998 in the wake of the Asian economic crisis and the need for economic diversification, as did many Thai hospitals, when local patients were no longer able to afford private health care. Singapore has belatedly sought to compete with Malaysia and Thailand, deliberately set rates just below those in Thailand and even set up a stand at the airport with fliers, information and advice for transit passengers.

India is usually regarded as the contemporary global centre for medical tourism, and it advertises itself as offering everything from alternative Ayurvedic therapy to coronary bypasses and cosmetic surgery. To become the most important global destination it has upgraded technology, absorbed western medical protocols and emphasised low cost and prompt attention. Since economic liberalisation in the mid-1990s private hospitals have expanded and found it easier to import technology and other medical goods, thus bringing infrastructure in the best hospitals to western levels. The links to India’s highly successful IT industry are also advertised as important. Moreover, as hospitals improved and specific salaries increased, so doctors returned from overseas. Many had international qualifications and western experience that could be advertised to make potential tourists more comfortable. The same liberalisation brought new structures of corporatisation that streamlined India’s notorious bureaucracy and significantly improved administration. The principal corporate hospital chains employ teams of interpreters, though India has benefited because of its widespread English speaking ability. (Thailand’s Phuket Hospital provides interpreters in 15 languages and receives about 20,000 international patients a year, while the now famous Bumrungrad International Hospital in Bangkok claims to employ 70 interpreters, all its staff speak English, and it has 200 surgeons certified in the United States). While technology has become much the same as in the west, and doctors are experienced in western procedures, most labour costs remain very low and insurance is less costly. Success rates, even for procedures that can have high infection rates, such as heart operations, bone marrow transplants and kidney transplants, are comparable to those at some of the world’s best hospitals. India has an annual Medical Tourism Expo and it has been predicted

that medical tourism will earn India as much as US\$2 billion by 2012.

Measures of the flows of medical tourists vary enormously, partly because this defies easy categorisation (either in terms of patients and/or accompanying family members etc.) and partly because no statistics distinguish it. The only specific survey undertaken appears to have been in Costa Rica where a 1991 university study found that 14 percent of all visitors to Costa Rica came to receive some sort of medical care, usually cosmetic surgery and dental work (www.infocostarica.com/news/20-Jun-2005.html). In terms of origin it has been estimated that about 50,000 people left the UK in 2003 as medical tourists (*Guardian*, 11 May 2004). Thailand claims to have the largest number of medical tourists, with a million patients from Japan in 2003 and a 20 percent increase in 2004 (www.expresshealthcaremgmt.com/20050315/interview01.shtml), and has been credited by Singapore with having 800,000 overseas patients in 2003 (Ai-Lien, 2005) but there are no reliable data to demonstrate this. It has also been reported that in 2004 some 247,238 Japanese, 118,701 American, 95,941 UK and 35,092 Australian patients were treated in Thai hospitals, though this includes locally based expatriates and other injured and sick tourists (Levett, 2005). One estimate for India was of 150,000 medical tourists visiting in 2002, almost half of whom came from the Middle East (Neelankantan, 2003), but it has been estimated that the number will reach about 500,000 in 2005. Another recent estimate for 2004 put the annual inflow to India between 10,000 and 20,000 foreign patients (*Indian Express* www.expresstravelandtourism.com), and another repeated the 150,000 figure (ABC, 8 November 2005). At the end of the last century the number of foreign patients seeking medical treatment in Malaysia was estimated to have been around 400,000 over a two-year period (Chaynee, 2003); this is likely to be an overestimate, as some 150,000 were reported in 2004 (Chong, Boey, & Vathsala, 2005). Singapore claimed an annual 150,000 international patients in 2003, was reported as having 230,000 foreigners seeking medical care in 2003 (Ai-Lien, 2005) and was recently said to have an annual 200,000 medical tourists (*Gulfnews.com*, 14 February 2005). Certainly numbers are steadily rising in most destinations, but there are no reliable national figures for any country.

4. Tourists—the economic rationale?

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, but include elites from a range of countries, including several African states, but there has been a gradual shift to a more diverse patient population. One Chennai (Madras) hospital has claimed patients from

Oman, UAE, Bahrain, Qatar, Saudi Arabia, Mauritius, Seychelles, Maldives, Sri Lanka, Bhutan, Nepal, East Africa, Germany, Australia, Canada and the UK (*Times of Oman*, 11 June 2005). European patients favour India, Thailand and Malaysia. Early on, Malaysia primarily focused on the Middle East, stressing its Islamic credentials, including the presence of halal food and Islamic practices in hospitals. The manager of one group of Malaysian hospitals has said ‘since 9/11 people started looking to the Eastern world for holidays and we are trying to capture a fraction of these people. The Middle East is a huge market for us. Abu Dhabi Company for Onshore Oil Operations sends its 36,000 employees to us for check-ups’ (*Gulfnews.com*, 14 February 2005). Since 9/11 Thailand has gained contracts from the UAE’s police department and the Oman Government, both of which were formerly linked to Europe (Levett, 2005). Malaysia has also organised trade missions to such south east Asian countries as Myanmar and Vietnam, where there is a small potential elite market (and there are few high-quality medical facilities), and it receives a large number of medical visitors from Indonesia (Chaynee, 2003). However, 70 percent of those people from UAE who travel overseas for health treatment are said to go to Singapore (*Gulfnews.com*, 14 February 2005) and India is said to be the preferred destination of Omanis (*Times of Oman*, 11 June 2005). Many patients in both Malaysia and Singapore are Europeans and Americans resident in Asia. Singapore has seen a shift of its market from Indonesia to the Middle East, alongside ethnic Chinese from a diversity of sources. Rich Japanese tend to fly to Singapore, and Sumatrans go by ferry to Malaysia (M. Wang, Pers. commun., 4 October 2005). Thailand has deliberately sought a Japanese market, since many doctors have been trained in Japan, and nurses and other staff have been taught to speak Japanese; Thailand mainly has patients from Japan, Brunei, Singapore, Taiwan, Pakistan, China and Bangladesh. Cuba has a primarily Latin American market with Argentina, Ecuador and also the Dominican Republic as the main sources of medical tourists (Huff-Rousselle et al., 1995, p. 10). The global migration of doctors, especially from India to Europe and North America has meant growing familiarity with being treated by Indians and Filipinos.

Japan has always been unwilling to accept immigration hence has a health care system that is under considerable pressure, especially as its population ages, without access to migrant health workers as in most other developed countries. Consequently Japan has taken particular advantage of the notion of medical tourism. Many Japanese companies even send their employees to Thailand and Singapore for annual physical examinations, as the savings on medical fees and high-quality medical care make the airfare inconsequential. For provincial Japanese companies the cost is little more than that of travelling to Tokyo, reports are done in Japanese and images sent electronically to Japan (M. Wang, Pers. commun., 2005). Moreover at

least one Bangkok hospital has an exclusively Japanese wing and there are many Japanese nursing homes in Bangkok.

Economics effectively calibrates the rise of medical tourism. Price differentials between most Asian states and more developed countries are considerable and are presently diverging even further. This may be accentuated or influenced by long waiting lists. For complex surgery the differences are considerable. In 2003 a small child in the United States with a hole in her heart was faced with a bill of around \$70,000 there, but the operation was carried out in Bangalore, India at a cost of \$4400 (Neelankantan, 2003). Open heart surgery may cost about \$70,000 in Britain and up to \$150,000 in the United States but in India's best hospitals it costs between \$3000 and \$10,000 depending on how complicated it is. Dental, eye and cosmetic surgery costs about a quarter of that in western countries (Neelankantan, 2003). The price differentials for cosmetic surgery are particularly significant since cosmetic procedures are not covered by insurance. A face-lift in Costa Rica costs about a third of that in the United States, and rather less in South Africa. However, any complications and post-operative costs may have to be met in the patient's home country, hence disparaging comments that this is 'fly in fly out' or 'itinerant surgery'. Patients in a sense are outsourcing themselves.

Currency fluctuations can be a significant influence. When the South African Rand rose significantly in value against the US dollar in 2004, one company went from about 30 patients a month in 2003 to none in 2005 (J. Mortensen, Pers. commun., June 2005).

India has cornered a substantial part of the market because its fees are significantly below those of other possible destinations. Thus bypass operations in India are about a sixth of the cost in Malaysia. Nonetheless, price differentials between all Asian countries and the west remain considerable: Thailand can offer liposuction and breast enhancement surgery for a fifth of the rate this would cost in Germany, hence it has focused on this particular European market. Singapore has sought to compete on quality rather than price and stresses its superior technology, and that Singapore doctors had carried out the first Asian separation of Siamese twins and the first South East Asian heart transplant, amongst other similar 'firsts'.

While economic benefits are central to medical tourism they are not the only factors. Waiting lists for non-essential surgery such as knee reconstructions may be as long as 18 months in the UK. In India the whole procedure can be done in under a week and patients sent home after a further 10 days. Some surgery, such as this, regarded as non-essential or low priority in the western world, may be necessary for certain forms of employment, and hence worth travelling for. Similarly, in the UK, waiting times for fertility treatments may be very long, and at an important period in couples' lives, hence many 'fertility tourists' have gone overseas (Graham, 2005).

Distance offers anonymity. Some medical procedures, such as sex changes, have become small but significant parts of medical tourism, especially in Thailand, where recuperation and the consolidation of a new identity may be better experienced at a distance from standard daily life. Similarly cosmetic surgery patients may prefer recuperation in a relatively alien environment.

For many, what makes medical tourism so appealing is that no one need know there was anything medical about the trip. [A couple from the United States] visited South Africa a year ago for tummy tucks, liposuction and eyelifts. Back from South Africa they threw a SuperBowl party "Friends kept saying we looked fantastic". Funny how a good vacation can be such an uplifting experience (Andrews, 2004).

Even where privacy may not necessarily seem to be crucial to the operation, that it parallels exclusivity can be important. Thus the Mauritius hair grafting clinic, whose name suggests an elite Parisian connection, argues 'situated not far from most exclusive hotels, the clinic receives patients from around the world. Many stars and persons of international fame, who naturally require the utmost discretion, owe the restoration of their hair to this clinic' (*Islander*, 38, December 2004).

Distance also offers alternatives. Certain operations may not be available in origin countries. Abortions are banned in several countries or are restricted to early periods of pregnancy. In Britain, for example, health authorities are usually unwilling to countenance stomach stapling for patients if they are aged less than 18; this is not the case in many medical tourism destinations where the 'customer' is more likely to be right.

The most extreme forms of such travel, where the word tourism fits least easily, are those of patients seeking euthanasia. In recent years this has brought a stream of non-citizens to Switzerland, may have taken 'death tourists' to the Netherlands and for a time in the 1990s took Australians to the Northern Territory (the only part of the country where euthanasia was briefly permissible). A final form is a variant of 'transnational retirement': the establishment of overseas nursing homes, where patients effectively stay permanently, as in Kenya, where converted hotels (as the tourism market declines) have been turned into homes for east African Asians, retiring and returning from the UK, or for Japanese in Thailand and the Philippines.

5. 'It's a fine line between pleasure and pain'. Tourism?

While almost all advertisements for medical tourism stress the links between surgery and tourism, especially during recuperation, the extent to which recuperating patients may be able to benefit from 'normal' elements of tourism may be queried. Is this therefore merely long distance migration for surgery, marketed as an attractive tourist experience, or is there actual tourism? Indeed

describing a medical procedure as part of a tourist experience might seem to be in itself merely cosmetic advertising.

In some destinations, including Hungary and Mauritius, medical tourism possibilities are advertised in in-flight magazines and standard government tourist publications, on the assumption that tourists might avail themselves of small-scale procedures such as dentistry during otherwise standard tourist visits. In Thailand it is argued that the reputation of the country as a tourist destination has boosted medical tourism to the extent that for the Bangkok Dental Spa, which treated about a thousand overseas patients in its first year, '90 percent of patients already know Thailand and love it as a holiday destination' (quoted in Levett, 2005, p. 27). Tourism provides a partial basis for medical tourism.

Marketing naturally stresses the pleasures of the destinations. Some sense of the link between tourism is evident in the website for the Nirmalyam Ayurvedic Retreat and Hotels company in Kerala, which also stresses the possibilities of catamarans and house boats:

The tourists are attracted by Yoga, Ayurveda and Vedic Astrology, the great sciences which grace Indian culture. One of the resorts which supports these sciences is the famous Nirmalyam Ayurvedic Retreat, where many tourists come and stay for Ayurvedic treatment and enjoyment of scenic beauties in God's own country, Guravayur, Kerala. Within a couple of kilometres from Guruvayur, the famous temple city, is the world's largest elephant sanctuary of 58 elephants, which is visited by many a tourist. The Nirmalyam Ayurvedic retreat functions as an Ayurveda centre as well as a three star hotel with state of the art 60 rooms with economical rates (www.eastrovedica.com).

However, this is primarily health rather than medical tourism, involving no more than massage, and tourists who have not experienced invasive procedures may be more easily able to appreciate the delights of elephants and catamarans. One Bombay hospital has considered the slogan 'open your new eyes on the beach at Juha' (some 30 km to the north). Indonesian visitors to Malaysia prefer to be treated in the large cities of Penang and Malacca, both of which have a significant tourism industry.

In some contexts hospital chains have become integrated into the tourist industry. The principal hospital group in Singapore, Raffles, arranges airport transfers, books relatives into hotels and helps to arrange local tours. Hotels in Malaysia have similarly become horizontally integrated with hospitals. In the wake of the December 2004 tsunami, Thai hospitals in Phuket, like nearby hotels, offered special packages (focussed on cosmetic surgery) to revitalise the (medical) tourist industry there. The Phuket Health and Travel website notes 'in addition to scheduling your medical treatment, we also arrange your travel and accommodation, as well as any car hire, cruises, tours or other vacation services. You will fly on a scheduled flight to

Bangkok, then join a connecting flight to Phuket...After your medical procedure we will then arrange for your transfer to the hotel or resort selected by you, for your relaxation and recuperation' (www.phuket-health-travel.com). Tourism is certainly an integral part of medical tourism.

If tourism is about travel and the experience of other cultures then all medical tourism is tourism. Usually it is also rather more than that, if only because medical tourists can only return home when they are, in a sense, well enough to be travellers and therefore tourists. Tourism may involve their relatives rather more than themselves, but most patients are able to sample standard tourist experiences if they wish to. In a few cases patients have chosen holiday destinations with the secondary goal of medical treatment, usually for high-cost low-risk operations such as dentistry.

Californian resident Eva Dang decided to take the 24 h flight over the Pacific Ocean for a dental appointment. "[Singapore] is just as good as America. Doctors are very professional and caring and very attentive". And cheaper too. What is more she can get to relax by the pool in a tropical climate, grab some food at the hawker stalls and catch the sights at the same time (www.CNN.com, 24 February 2005).

Similarly, a cosmetic surgery patient in Jamaica 'recuperated a few hundred yards from the hospital in a villa furnished in wicker and mahogany, with a terrace and a private pool' (Andrews, 2004). However, despite its name, patients of the Surgeon and Safari company in South Africa may be discouraged from going on safari after plastic surgery to ensure proper recovery (Andrews, 2004). Others may prefer to recuperate at length, through tourism, and later see specialists for a final time. Most visitors spend some time shopping, even if no further than hotel stores, and justify this (where they feel it necessary) on the grounds of the money saved through overseas health care.

Ultimately 'tourism' is rather more than just a cosmetic noun for an activity that otherwise has little to do with conventional notions of tourism, since most visitors and certainly those who accompany them, find some time for tourism. Moreover, at the same time, the whole infrastructure of the tourist industry (travel agents, airlines, hotels, taxis etc) all benefit considerably from this new niche. Indeed, since for a significant proportion of patients there may be a lengthy period of recuperation, the rewards to the tourist industry, and especially the hotel sector, are considerable. Such benefits are presently unquantifiable though one estimate is that medical tourists in Thailand spent US\$1.6 billion in 2003 (Taffel, 2004), while medical tourists in South Africa were estimated to spend between US\$30–40 million in the same year (J. Mortensen, Pers. Commun., 2005).

6. Conclusion: ‘first world service at third world cost’?

Medical tourism is likely to increase even faster in the future as medical care continues to be increasingly privatised, and cost differentials remain in place. As the demand for cosmetic surgery (including dentistry) continues to expand so will demand for overseas services, and this will probably replace heart surgery as the core element in medical tourism. Moreover, as successful outcomes become more evident, demand is likely to increase further. Western insurance companies might encourage overseas treatment to reduce their own costs. One Kolkata (Calcutta) hospital has signed an agreement with the British insurance company, BUPA. Similarly, at the start of 2005, the British National Health Service (NHS) was sending patients to Europe to cope with a backlog of cases, but restricting them to places within 3 h flying time (such as France and Spain). Were waiting lists to increase further an extension of this policy might benefit those countries now seeking medical tourists, and the larger Indian companies have been in negotiations with the NHS about outsourcing the treatment of British patients to India.

The number of countries seeking to develop medical tourism continues to grow rapidly. The success of medical tourism in Asia especially has prompted growing global interest and competition, and optimism is seemingly unbounded. Singapore, for example, though a relatively high-cost destination, is seeking to attract 1 million patients by 2012, which would generate US\$1.8 billion in revenues, create at least 13,000 jobs (Ai-Lien, 2005) and even restore economic growth after the recession in the IT industry at the end of the century. The Philippines has recently declared its interest, based on a new airport and the familiarity that people all over the world have with English speaking Filipino doctors. As a consultant noted ‘there used to be a time gap in terms of medical technology reaching the shores of Manila, but not anymore. Also with every third medical practitioner in the UK or the US known to be of Filipino descent, first-world patients attach a reasonable amount of confidence and comfort in being treated in the Philippines’ (quoted in Kinavanod, 2005). Dubai has built Healthcare City to discourage Middle Eastern tourists from going to Asia. The largest international private medical service group in India, Apollo, had 37 hospitals in India in 2004, partnerships in hospitals in Kuwait, Sri Lanka and Nigeria, and plans for others in Dubai, Bangladesh, Pakistan, Tanzania, Ghana, Singapore, Philippines, London and Chicago as privatised corporations grew and international linkages intensified.

Medical tourism has been particularly attractive to elites, even—perhaps especially—in developing countries; Nigerians for example spend as much as \$20 billion per year on health costs outside Nigeria (Neelankantan, 2003). Despite the presence of traditional therapies within Indian medicine the medical market is now increasingly oriented towards high-end tourism. One outcome has been the more rapid rise of a private health sector in the medical tourism

destinations, as the economic benefits from employment in that sector become even greater. A higher earning capacity plays a small part in reversing the brain drain, a significant issue in such developing countries as India, where many doctors and nurses migrated overseas. Malaysia has actively sought to encourage doctors to return from overseas, firstly, to be involved in medical tourism and, secondly, to provide more equitable health care (Chong et al., 2005). Expansion of the private sector may be at some cost to the public sector, where patients have very limited ability to pay, if skilled health workers move out of that sector. The recent boom in medical tourism has occurred in a context where 40 percent of India’s population live below the poverty line and have no access to basic health care and infant and maternal mortality rates are high. As one health researcher has pointed out:

The poor in India have no access to healthcare because it is either too expensive or not available. We have doctors but they are busy treating the rich in India. Now we have another trend. For years we have been providing doctors to the western world. Now they are coming back and serving foreign patients at home (Ravi Duggal, quoted in Ramesh, 2005).

Ethical issues have therefore become significant (Borman, 2004), both in terms of equity and in the more competitive involvement of the market in medical care. Over the past decade the Indian health system has become ever more dichotomous; Apollo argues that it is setting aside free beds for those who cannot afford to pay, but there is little evidence that these are used (ABC, 8 November 2005), and are pioneering telemedicine in remote parts of India. Apollo argues that ‘India is now ready to heal the world’ but the ABC have noted that ‘the majority of its own people remain at the back of the queue’ (ABC, 8 November 2005). Urban bias in health care delivery has been intensified everywhere. In Malaysia health care delivery is increasingly inequitable (Chong et al., 2005) and in Thailand ‘there is a huge drain on the public health sector. To practise medicine in Thailand you must pass a Thai language examination, so the booming private sector can take staff from only one place’ hence ‘in the past we had a brain drain; doctors wanted to work outside the country to make more money. Now they don’t have to leave the country, the brain drain is another part of our own society’ (Levett, 2005, p. 27). And in source countries: ‘Fertility tourism has always happened and will continue to happen. The real tragedy is that those with money can always go overseas, but the people who haven’t two brass farthings to rub together are always the people who lose out’ (Graham, 2005, p. 9).

In less than a decade the rise of medical tourism has demonstrated that a form of service provision, the provision of health care, so labour intensive that it was assumed to be highly localised can now be globalised like so many other service activities. Japanese export of workers, even for medical examinations and of old people

into nursing homes, has taken this to a contemporary extreme. This process has followed the growing emphasis on technology, private enterprise and the attitude that health care can be bought 'off the shelf'. The trade in health services is expanding, becoming more competitive, and creating new dimensions of globalisation, all elegantly packaged, and sometimes actually functioning, as the new niche of medical tourism.

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