

## COMMENTS

# Bioethics and transnational medical travel: India, “medical tourism”, and the globalisation of healthcare

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### Abstract

*Health-related travel, also referred to as “medical tourism”, is historically well-known. Its emerging contemporary form suggests the development of a form of globalised for-profit healthcare. Medical tourism to India, the focus of a recent conference in Canada, provides an example of the globalisation of healthcare. By positioning itself as a low-cost, high-tech, fast-access and high-quality healthcare destination country, India offers healthcare to medical travellers who are frustrated with waiting lists and the limited availability of some procedures in Canada. Although patients have the right to travel and seek care at international medical facilities, there are a number of dimensions of medical tourism that are disturbing. The diversion of public investments in healthcare to the private sector, in order to serve medical travellers, perversely transfers public resources to international patients at a time when the Indian public healthcare system fails to provide primary healthcare to its own citizens. Further, little is known about patient safety and quality care in transnational medical travel. Countries that are departure points as well as destination countries need to carefully explore the ethical, social, cultural, and economic consequences of the growing phenomenon of for-profit international medical travel.*

As health researchers with backgrounds in bioethics and global health equity, in late November 2009 we attended the conference and exhibition: “India Medical Tourism Destination 2009: Healthcare without borders” (1). Held in Toronto, Ontario, Canada, the event promoted health-related travel to India. Amid the exhibition booths, marketing pitches, patient testimonials, and repeated criticisms of Canada’s publicly funded healthcare system, it was possible to discern the emerging outlines of a global marketplace in health services. Healthcare increasingly spans national borders (2). Transnational medical travel, more popularly known as “medical tourism”, is not a recent development (3). While most health problems are addressed in local communities, there is also a long history of ailing persons making pilgrimages to healing shrines or sacred sites and travelling to internationally renowned medical centres. Though reliable quantitative data are sparse, despite dramatic claims about millions of patients crossing borders in search of healthcare, there appear to be increasing numbers of individuals from Australia, Canada, the United Kingdom, the United States, and elsewhere, who purchase healthcare in

such destinations as India, Indonesia, Malaysia, the Philippines, Thailand, and Singapore (4).

One of many countries promoting medical tourism, India is positioning itself as a low-cost, high tech, high-quality healthcare destination (5). Healthcare facilitators in India typically advertise prices that are lower than the cost of medical procedures in “competitor” nations. Private for-profit hospitals, which are growing rapidly in number, cater to India’s expanding middle class as well as to international patients (6). But the corporate sector is not the only promoter of Indian medical tourism: among the conference exhibitors and sponsors were the Government of India’s Ministry of Tourism and the Consulate General of India, Toronto. Government agencies see “medical tourism” as part of a larger strategy to build regional “bio-economies”, attract tourists, and promote foreign investment.

Just as destination hospitals and government bodies try to attract international patients to India, medical tourism companies also play an important role in helping patients navigate the complex global health services marketplace (7). These companies advertise a smooth and seamless experience from the date of departure to the return journey following treatment. Travel facilitators, or medical tourism agents, organize appointments with surgeons, internists, and other healthcare providers; identify treatment alternatives at internationally accredited medical facilities; provide different “price points” or “price bands” to potential customers; sell insurance products designed for medical travellers; offer financing for treatment, and market low-cost, expedited access to care. Travel packages are commonly marketed with the promise that patients will receive “VIP treatment”. Medical tourism, customers are told, puts the “hospital back in hospitality”, and makes the deluxe care found at “five star hotels” available within healthcare settings. Marketing succeeds in blurring standard distinctions between hospitals and hotels.

Accompanying the corporate exhibits we visited were presentations justifying why Canadians should consider arranging healthcare in India. A health economist from The Fraser Institute reviewed wait times in Canada and stated that public healthcare in Canada lags behind medical care in comparable OECD nations, fails Canadian patients, and does not control the rising cost of care. Another speaker drew

upon interviews with patients who identified their suffering as being the result of lengthy treatment delays or lack of care in Canada. Canadians who had arranged medical care in India offered "testimonials" describing the high quality of care and ready availability of treatment there, and criticised delays in receiving treatment in Canada. In general, presentations at the conference condemned treatment delays in Canada and promoted India as a nation where it is possible to receive timely, high-quality, affordable medical care.

Acknowledging the human right to travel and recognizing that some individuals have good reasons to consider arranging care at international medical facilities, there are nonetheless worrisome dimensions to "medical tourism". These problematic features of the globalisation of health services need to be identified and publicly debated.

For patients with sufficient financial resources, cross-border medical travel provides a way to avoid waiting lists or obtain treatment that may not be offered in Canada. However, it is important to note what promoters of medical travel often fail to address. The high-tech, fast access health services available to Canadian, US, and other international medical travellers are unavailable to the majority of citizens of India. There is limited private health insurance and no universal health insurance for Indian citizens. The care advertised to Canadian and other international patients conceals the extreme poverty, health inequalities, and widespread lack of access to care in India's urban slums and neglected, underserved rural communities. While wealthy and middle-class citizens are capable of purchasing insurance and healthcare, India fails to address the primary healthcare needs of the population. Basic health indicators are disturbing: the under-5 mortality rate was 72 per 1,000 in 2007. Only 43% of births are attended by skilled health staff -- an important indicator of inadequate access to primary healthcare. These figures reveal the need to place much greater emphasis on health equity in India. In 2007, the total expenditure on health in India was 4.1% as a percentage of gross domestic product (GDP), with public expenditure on health at 1.1% of GDP, and 26.2% of total health expenditure (8). India's healthcare sector is described as falling "well below international benchmarks for physical infrastructure and manpower, and even falls below the standards existing in comparable developing countries"(9). India's "medical tourism" strategy ensures that international medical travellers receive prompt access to advanced biomedical therapies, while local citizens are often unable to obtain access to basic medical services.

In the context of the Indian public healthcare system, in which public funds are used to educate physicians and other health professionals and also subsidise construction of for-profit hospitals, the transfer of public funds to private healthcare constitutes what is commonly described as a "perverse subsidy". Public funds are not only placed at the service of private for-profit hospitals but also serve international patients. This arrangement effectively transfers funds intended for the benefit of the Indian population into the hands of comparatively

wealthy foreign patients. Persistent and profound under-resourcing of India's public healthcare system raises troubling questions about why government ministries are using public funds to promote private care for international patients, rather than using them to improve health equity for citizens. Though some hospitals in India claim that payments from international patients subsidise the care of local patients, there is little evidence available to suggest that private, for-profit hospitals are using cross-subsidisation to improve health equity (10). Rather, claims about cross-subsidisation are used to promote "medical tourism" while few actual benefits appear to flow toward low-income citizens of India. In addition, there is reason to fear that the proliferation of private, for-profit hospitals in India will result in an "internal" national brain drain of healthcare providers from the public to the private sector. Such a development will exacerbate existing health inequalities and further undermine efforts by non-government organisations and citizens' coalitions to promote greater health equity.

Researchers investigating contemporary international travel of patients to countries such as India also raise troubling but important questions about quality of care at destination medical facilities, reliability of international hospital accreditation, adequacy of information, disclosure and informed consent in the sale of procedures to "medical tourists", legal rights of international travellers when malpractice occurs, and costs to domestic public healthcare systems when patients return home with serious complications needing treatment (11). All of these topics require careful scholarly analysis. In addition, health researchers investigating the emergence of a global marketplace in health services need to better understand how patient flows from countries such as Canada and the United States to countries such as India and Thailand could make access to healthcare even more difficult to obtain for citizens of these latter countries (12).

Liberalised trade in goods and services is purported to generate numerous benefits: the globalization of health services may also generate economic and clinical benefits. However, significant harms can result from efforts promoting transnational medical travel. The health equity effects and implications of an emerging global marketplace in health services are not adequately addressed by corporate proponents of a highly commodified, for-profit, privatised international healthcare bazaar. The potentially harmful consequences of international medical travel need to be explored and addressed by healthcare providers, patients, citizens, and policy makers in countries that are departure points for medical travel, as well as in destination countries. "Medical tourism" must cease to be a topic dominated by marketing hyperbole. The subject deserves careful, critical scrutiny from scholars in such disciplines as bioethics, public health, medical anthropology, medical sociology, and medical geography. It is time to move beyond glib remarks about "putting the hospital back in hospitality" and better understand the local, regional, and transnational consequences of promoting a global marketplace in health services. At present, there are grounds for concern that personal and collective benefits of transnational medical travel are

routinely exaggerated and possible harms are minimised. More empirically grounded and theoretically informed ethical, social, and economic analyses of medical travel are greatly needed.

#### References

1. India medical tourism destination 2009: healthcare without borders. The first ever medical tourism exhibition and conference in Canada [Internet]. Toronto: IMTD; 2009 [cited 2010 Nov 30]. Available from: <http://www.imtd2009.com/>
2. Ramirez de Arellano AB. Patients without borders: the emergence of medical tourism. *Int J Health Serv*. 2007;37(1):193-8.
3. Jensen J. Silver City health tourism in the early twentieth century: a case study. *N M Hist Rev*. 2009;84:321-61.
4. Eggertson L. Wait-list weary Canadians seek treatment abroad. *CMAJ*. 2006 Apr 25; 174(9):1247.
5. Mudur G. Hospitals in India woo foreign patients. *BMJ*. 2004 Jun 5;328 (7452):1338.
6. Bagchi S. Growth generates health care challenges in booming India. *CMAJ*. 2008 Apr 8;178(8):981-3.
7. Turner L. 'First World health care at third world prices': globalization, bioethics and medical tourism. *BioSocieties*. 2007;2:303-25.
8. The World Bank. HNP Stats- health financing [Internet]. The World Bank;(c)2010 [cited 2010 Nov 30]. Available from: [http://go.worldbank.org/3KMGKYPN90\[S2\]](http://go.worldbank.org/3KMGKYPN90[S2])
9. Chanda R. *Foreign investment in hospitals in India: status and implications* [Internet]. New Delhi:WHO; [date unknown, cited 2010 Nov 30]. Available from: [http://whoindia.org/LinkFiles/Trade\\_Agreement\\_Foreign\\_investment-full\\_text.pdf](http://whoindia.org/LinkFiles/Trade_Agreement_Foreign_investment-full_text.pdf)
10. Thomas G., Krishnan S. Effective public-private partnership in healthcare: Apollo as a cautionary tale. *Indian J Med Ethics*. 2010 Jan-Mar;7(1):2-4.
11. Cortez N. Patients without borders: the emerging global market for patients and the evolution of modern health care. *Indiana Law J*. 2008;83:71-132.
12. Chanda R. Trade in health services. *Bull World Health Organ*. 2002 Feb;80(2):158-63.

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## GRADE the evidence before using the results in clinical practice

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### Abstract

*Reports of clinical trials that do not describe the methods used to minimise the risk of bias, and reports that do not present results in a comprehensible and accurate manner, are unethical as they could lead to misleading conclusions, adverse health outcomes, and the inappropriate use of healthcare resources. The Grading of Recommendations: Assessment, Development, and Evaluation (GRADE) approach to framing healthcare recommendations provides a pragmatic approach to making summary evidence profiles of outcome-specific evaluations regarding the magnitude and precision of estimates of benefit and harms, and the overall quality of evidence from comparisons of healthcare interventions. In addition, contextual factors such as the balance between benefits, harms, and resource costs; baseline risks in different groups; inconveniences; varying values and preferences; and competing priorities and options, should ideally be extrapolated from these evidence profiles and other sources of evidence to determine the strength of recommendations regarding the use of an intervention.*

### Science and ethics: mutually inseparable

Selvan et al (1) attempt to demonstrate that the use of appropriate statistics in research reports of clinical trials could improve the understanding of clinicians and lay people of the clinical implications of research evidence, and accelerate their incorporation into clinical practice. Submitting their article to an ethics journal is appropriate because clinical trials, even those that are conducted according to the highest ethical standards, are unethical and wasteful if they do not yield results that are accurate and understandable, and can be trusted (2).

It is therefore necessary for ethicists and those who espouse the ethical conduct of clinical research to understand the importance of evaluating whether trial results are credible and clinically important before they are used.

### Estimation of treatment effects: relative versus absolute effects

Selvan and colleagues rightly emphasise the importance of looking beyond p values in evaluating the significance of differences in outcomes between interventions in a clinical trial. P values are traditionally used to assess if the results are statistically significant. They tell us if the observed difference in the outcomes of interventions in clinical trials excludes the possibility of this being due to chance (or random error) by more than 95%, if the p value is less than 0.05. P values do not indicate if the observed difference in outcome is clinically important. Even if the difference is clinically important, they do not indicate how important this might be. Selvan et al ignore p values altogether and discuss, instead, the use of relative risks (RR) and relative risk reduction (RRR). These measure the relative magnitude of efficacy of one intervention over the other. More important, they can be used to derive the absolute risk reduction (ARR) and the numbers need to treat to benefit (NNTB) or harm (NNTH), measures of the actual numbers of people likely to benefit or be harmed by the intervention.

### Uncertainties in effect estimates

These effect estimates would need to be presented with their 95% confidence intervals. The confidence interval (CI) is an estimate of uncertainty; it depicts the range of values for the RR,