# International Healthcare Policy and Medical Tourism

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The healthcare system in the United States presents inequalities amongst its citizens. High costs make it impossible for some individuals to ever experience the benefits of state-of-the-art medical facilities and advanced technology. Rising costs of medical services in the U.S., long waiting lists, and insufficient technology in other countries have created an industry of medical tourism. Individuals choose to leave their resident country to have procedures done such as cardiac surgery, cosmetic surgery, and hip replacement because they are more economically feasible elsewhere. In efforts to improve the inequalities in the U.S. healthcare system, the Patient Protection and Affordable Care Act was passed and will be fully implemented by 2014. If it solves some of the unequal treatment and provides more individuals with access to healthcare, the medical tourism industry may decrease significantly.

Key Words: Medical tourism; affordable care act; healthcare; international healthcare; healthcare models

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## Introduction

Americans are not satisfied with the rising cost of healthcare. Facing the crisis of paying for a major healthcare procedure is not an easy task. What would you do if your loved one needed a bypass surgery and could not afford to pay the 50% that their insurance could not pick up? Would you consider traveling to Mexico, where it is more than $50,000 less than what you would pay in the US? Individuals are concerned with their economic and health security as well as confused by changes from recent reforms and policies (Lynch & Gollust, 2011). Those who are uninsured or underinsured either simply do not see a doctor or find alternate routes to manage their well-being. This paper will discuss the recent healthcare reform not only in the United States, but international reforms to current healthcare plans around the world. In having a perspective on what other countries are providing their citizens, it will be easier to understand why some are said to have "better healthcare opportunities" and how this leads to medical tourism. Why do individuals resort to medical tourism and how might that change with recent healthcare reform in the United States?

Medical tourism is "the movement of individuals abroad primarily to seek biomedical services" (Smith, 2012, p. 2), which includes elective treatment (Boultbee, 2012), preventative care, complimentary medical care, and dental care (Eissler & Casken, 2013). Similar terminology associated with the same concept are: medical travel, health travel, and health tourism (Boultbee, 2012). In 2006, this market produced $60 billion worldwide and was expected to see a 40% increase by 2012 (Evans, 2008). On a national level, the United States sent nearly 2 million citizens abroad to improve their health in 2008 (Bauer, 2009).

### Should the Government or the Private Market Supply Health Insurance?

A nation's history, politics, economy, and overall values have a direct impact on how its health care system is organized and maintained (Reid, 2009). Public norms, beliefs and opinions have an effect on each nation's healthcare policy (Lynch & Gollust, 2011). Developments such as various public policies and strikes have occurred around the world providing a significant increase in individuals' right to health information (Gross, 2013). Once a citizen becomes

aware of his/her rights and the opportunities available, having a procedure done in his/her country of residence may not be the most desirable. An individual may not have access to healthcare because of the high cost or lack of available resources. As a result, medical tourism is an alternative providing individuals with more cost effective healthcare.

Four basic models exist that can describe how or if the government is involved with healthcare and whether or not there is a private sector (Reid, 2009). The chart below gives a quick overlook of the countries involved and what each model is. They are important to medical tourism because the way in which the healthcare sector is setup allows the prices to be more affordable for some procedures as they are funded differently.

| Model Name | Countries involved | Description |
| --- | --- | --- |
| **Bismark** | Germany, Japan, France, Switzerland, Belgium, parts of Latin America | Health care providers and payers separate |
| **Beveridge** | Spain, Italy, Scandinavia, Great Britain, Cuba | Financed through taxes |
| **National Health Insurance** | Canada, Taiwan, South Korea | Mixture between Bismark and Beveridge models |
| **Out-Of-Pocket** | Cambodia, India, Egypt | Financed solely by payer |
| **Mixed Model** | United States, Malawi | Government financed and third payer private insurers |

The first model is the Bismark model, where both health care providers and payers are separate entities. Like the U.S. healthcare is financed jointly by employees and employers, yet their insurance plan is different because they cover everyone without making a profit (Reid, 2009). The key difference from the U.S. is that the insurance companies' pay for their citizens' healthcare rather than focus on providing a return to investors. As a result they cannot deny any claim, there are no deductibles, and they do not discriminate based on preexisting conditions.

The Beveridge model describes countries where healthcare is fully financed through tax payments. Most Americans refer to this method as "socialized medicine", where medical treatment is a public service and many hospitals and clinics are owned by the government (Reid, 2009). As a result of the government being in control, doctors or hospitals do not have a say in what services they provide or how much they charge for them (uhcforward.org, 2011).

The National Health Insurance Model is a mixture between the Bismark and Beveridge models, such as in Canada where healthcare is financed through taxes and delivered by private providers (Shi & Singh, 2010). "Care must be (1) available to all eligible residents of Canada, (2) comprehensive in coverage, (3) accessible without financial and other barrier, (4) portable within the country and while traveling abroad, and (5) publicly administered" (Shi & Singh, 2010,

p. 18). The negative side to National Health Insurance is the lengthy waiting lists which could prolong an individual's disease or health problem. The positive aspect is that in this model, healthcare is considered a human right, which is desired by many U.S. citizens (Lynch & Gollust, 2011).

The unfortunate ideology in regards to the out-of-pocket system is that in some, mostly poor countries, no organizational system exists and payment out-of-pocket is the only option. As a result, the rich can afford health care and the poor cannot (Reid, 2009). This type of system prevents hundreds of millions of individuals from having access to care and further expands the impoverished population (uhcforward.org, 2011). In countries such as India, citizens must all pay for their own healthcare. They have considerably lower costs in clinical procedures compared to the U.S., however the majority of their citizens cannot afford healthcare (Reid, 2009). India is a hot spot, as a result, for citizens to travel for cheaper procedures, especially from the U.S.

**Healthcare in the United States**

The flawed United States health care system does not fall into one specific model. Citizens of the U.S. rely heavily on for-profit private insurance companies to be the third party payer in many cases, however there are aspects that are paid for by the government such as Medicare, Medicaid, and services provided to Veterans Affairs (Reid, 2009). There are citizens that do not fully understand the system or even the functionality of their own insurance provider (Reid, 2009). This confusion arises especially when there is a noticeable policy change such as the Affordable Care Act, which will be further explained in this paper. When consumers and providers are required to rapidly change the way they seek and provide healthcare, the chance of confusion and unhappiness increases (Gold, 1999). Confusion and third party representation causes inefficiency in the U.S. healthcare system (Reid, 2009).

Patients themselves also add to the inequalities of the system. They do so by overusing health care because their insurance plan is excessive, by making irrational choices, and also having a lack of knowledge to compare various healthcare services such as providers and insurance (Kellis & Rumberger, 2010). Lynch & Gollust (2011) found that Americans believe inequalities in access of healthcare and quality of care have more of an impact on the decision to engage in medical tourism than unequal outcomes of health. Citizens are more concerned with equal opportunity for healthcare than equal outcomes. “More than 70% of Americans think inequalities in quality of care or access to care are fundamentally unfair, regardless of the social group affected by these inequalities” (Lynch & Gollust, 2011, p. 870). Every ethnic group and social class are impacted by the unequal U.S. healthcare system.

**Medical Tourism Development**

Individuals have varying reasons behind their desire to travel overseas to seek medical treatments. The two common themes found are long waiting lists and high costs that cause patients to go abroad (Smith, 2012; Eissler & Casken, 2013; Boultbee, 2012). Other reasons include procedure legality, availability of complementary and alternative medicine, an opportunity to travel (Smith, 2012; Eissler & Casken, 2013), and availability of experimental treatments (Eissler & Casken, 2013). Over the past 20 years, privatization and marketisation of healthcare have increased dramatically in developing

countries. It is driven by the basic economic supply and demand principle which points to "high demand and cost of treatment in the West and the low cost and high quality of care in a number of developing countries" (Smith, 2012, p. 1).

Historically, the motivator for medical tourism has been the quality of care, health specialists, and innovative technology (Boultbee, 2012). Hence, patients were known to travel from underdeveloped countries to countries that have advanced medical technology and state of the art doctors (Smith, 2012). Currently over 30 countries including the U.S. are offering medical services to international patients (Eissler & Casken, 2013). The main countries mentioned that attract medical tourists while reviewing various literature are India, Thailand, Malaysia (Smith, 2012; Boultbee, 2012; Eissler & Casken, 2013; Kumar, Breuing, & Chahal, 2012), and Mexico (Artecona, 2012). In the past, the United States was a destination that attracted many individuals internationally for health care procedures and now the tables have turned as the costs have risen beyond citizens' budgets.

Now that developing countries are improving their medical technology and educating more medical professionals, they have the resources and provide healthcare procedures at a much lower cost than the U.S. (Boultbee, 2012). India is the most popular county in the medical tourism market for many services such as heart, cosmetic, and joint surgery; it also exhibits the most highly privatized healthcare system in the world (Smith, 2012). For instance, in the U.S. a heart valve replacement costs $150,000 whereas in India it is only $10,000 (Carabello, 2008). Also, in Mexico it costs $3,250 to have a heart bypass procedure, which is $113,000 in the U.S. These comparisons demonstrate that it is worth the cost of travel and hotel accommodations to have a procedure done abroad. The table below demonstrates why medical tourism is advertised with the slogan "first world treatment at third world prices" (Smith, 2012).

**Average Costs of Procedures**

| Surgery | U.S | India | Thailand | Singapore | Malaysia | Mexico |
|---|---|---|---|---|---|---|
| **Heart Bypass (CABG)** | 113,000 | 10,000 | 11,000 | 18,500 | 9,000 | 3,250 |
| **Heart valve replacement** | 150,000 | 9,000 | 10,000 | 12,5000 | 9,000 | ________ |
| **Hip Replacement** | 47,000 | 8,500 | 12,000 | 12,000 | 10,000 | 17,300 |
| **Total knee replacement** | 48,000 | 8,500 | 10,000 | 13,000 | 8,000 | 14,650 |
| **Gastric Bypass** | 25,000 | 6,000 | NR | 26,000 | ______ | 8,000 |
| **Angioplasty** | 47,000 | 9,000 | 13,000 | 13,000 | 11,000 | ______ |
| **Hip resurfacing** | 47,000 | 8,250 | 10,000 | 12,000 | ______ | _______ |

Adapted by Author Source: Medical Tourism International, 2007 as cited by (Carabello, 2008).

In order to put price comparisons into perspective, three fictional examples of U.S. citizens can be examined. Beginning with person A, who has insurance through their employer and recently was told by their doctor that they are in need of a heart valve replacement because they are at risk of major heart complications. Person B is an elderly individual who is insured through Medicare and needs a total knee replacement. Person C is a young college student that does not have insurance at all and is in need of a gastric bypass surgery because they are chronically obese and unable to lose weight using other methods. How could each of their lives be changed by medical tourism?

Person A was informed by their insurance company that they will only be covered for 50% of a heart valve replacement. As a result, the procedure will cost this individual approximately $75,000 out-of-pocket, yet India will provide the same procedure for approximately $9,000 (Carabello, 2008). When looking at the cost of travel, a flight from Chicago, IL to Mumbai, India for two weeks will cost close to $915 (kayak.com, 2014). If family members travel with the individual and they need a hotel for the duration of two weeks at a price of $87 per night, it would total to $1,218 for hotel accommodations (kayak.com, 2014). Looking at the overall price, the cost of the procedure in India, $9,000 + $918 (flight) + $1,218 (hotel for 2 weeks) = $11,136. The difference then between the two costs would be $75,000-$11,136= $63,864. Traveling to India for this procedure seems more financially reasonable due to major price differences and their insurance coverage.

Person B was given the unfortunate news that Medicare is refusing to cover them for a knee replacement due to their age. Therefore, the cost they would have to pay out-of-pocket would be approximately $48,000 while Malaysia will provide the same procedure for $8,000 (Carabello, 2008). When looking at the cost of a flight from New York City to Penang, Malaysia it would cost approximately $1,300 (kayak.com, 2014). When adding the cost of the procedure in Malaysia, $8,000, with the cost of the flight, $1,300, it would cost individual B $9,300 to engage in medical tourism. Although this number does not include the cost of hotel accommodations, the individual will be saving $48,000-$9,300= $38,700. In some locations, the hospital will provide patients a stay long enough for them to recover from surgery, not requiring them to pay for a hotel stay (Artecona, 2012).

Lastly, person C with no insurance needs a gastric bypass surgery done, costing $25,000 in the US and $8,000 in Mexico. This individual can fly to Mexico for 2 weeks from Atlanta, GA to Mexico City, Mexico at an approximate cost of $460 (kayak.com, 2014). The total cost for travel and procedure in Mexico would be $8,000 + $460= $8,460. The difference of the cost from the U.S.to Mexico is $25,000-$8,460= $16,540 (33.84% savings). Overall, in all three of these fictional situations, the individuals would be saving a significant amount of money on major procedures by engaging in medical tourism.

**Why Choose Medical Tourism?**

In Alaska, researchers Eissler and Casken (2013) conducted a study to evaluate the perspective of patients who traveled internationally for either medical or dental care. In their study, 15 individuals were interviewed to discuss their experiences. The Alaskan residents expressed that they traveled elsewhere for healthcare because they had unmet healthcare needs,

displeasure with the U.S. healthcare system, and desire a functional healthcare reform (Eissler & Casken, 2013). The participants felt well informed on the decision they had made to seek medical treatment by researching options in the international healthcare market (Eissler & Casken, 2013).

Individuals that engage in medical tourism are able to maximize their short-term goals of improving their health status while spending less than they would in their resident country (Lynch & Gollust, 2011). There are many clear benefits including affordability and avoidance of long waiting lists (Smith, 2012). The opportunities are becoming more well-known as websites advertise internationally and promote hotel style accommodation in hospitals (Boultbee, 2012; Smith, 2012). Surprisingly, there are even employers in the U.S. that include medical tourism as part of their health benefits package (Boultbee, 2012). Packages offered include medical services, air travel, and hotel stay, some of which offer kitchenettes, adjoining bedrooms, gymnasiums, swimming pools and wide screen televisions (Smith, 2012). Medical tourism can also aid in improving the job market in destination countries, develop linkages for international marketing, and improve knowledge of medical technology and practices outside the country (Artecona, 2012).

To ensure safety and consistency, the majority of hospitals used for medical tourism have gone through a process to be accredited by the Joint Commission of International Accreditation (JCI) (Artecona, 2012). Its mission is "to continuously improve the safety and quality of care in the international community through the provision of education and advisory services and international accreditation and certification" (jointinternational,org, 2013). Based out of the United States, professionals from the organization ensure that each hospital is safe to improve the confidence of the patients who travel to seek medical services. In 2009, the JCI had accredited over 400 facilities in 39 countries (Artecona, 2012).

With the implementation of the earlier described healthcare reform in the U.S., the demand for medical tourism is expected to increase (McIntosh, 2012). Some services provided by Medicare will no longer be fully funded, decreasing access for these individuals. As people become more informed about this option, via word of mouth or internet services such as medicaltourism.com; it will provide them with an affordable option to improve their well-being (McIntosh, 2012).

**Concerns**

There are concerns that are associated with the idea of medical tourism. Those discussed in the reviewed literature are: global healthcare economics, medical ethics, patient safety and follow-up care upon return to residency, and the impact on destination countries (Eissler & Casken, 2013). When imagining the aftercare involved following a quadruple bypass surgery, most individuals will need extensive rest as well as to be monitored by a knowledgeable doctor. It is difficult to find a medical professional that is willing to accept the risks involved in providing follow up care for a procedure that was done outside of the country. Kumar, Brueing, & Chahal (2012) state that there is not sufficient information available to tourists, especially those who are underinsured or uninsured, in regards to the risks involved in the procedures.

Another concern with medical tourism is the overuse of medical personnel on foreigners instead of residents. Medical tourism has exacerbated this phenomenon, which is called internal brain drain, the relocation of doctors to other countries or sectors of healthcare (Chen & Flood, 2013). Though it has influenced more medical professionals to remain in their home country, they now lean towards working in urban centered private sectors and specializing in a service provided to foreigners. This creates more opportunity for the medical professionals to capitalize on the wealth of medical tourists, yet does nothing to improve the inequalities faced by poor nations, such as India (Chen & Flood, 2013).

**Affordable Care Act and Its Effect on Medical Tourism**

In an effort to minimize healthcare inefficiencies and decrease the number of uninsured individuals, President Obama signed the Patient Protection and Affordable Care Act (ACA) into law on March 23, 2010 (Winkler, 2013). This is important to the topic of medical tourism because it can change U.S. citizens' ability to use the healthcare system as well as their attitude towards it. "The Patient and Affordable Care Act has 3 main objectives: (1) to reform the private insurance market- especially for individuals and small-group purchasers, (2) to expand Medicaid to the working poor with income up to 133% of the federal poverty level and, (3) to change the way that medical decisions are made" (Silvers, 2013, p. 402). The requirement of this act is for Americans to maintain minimum essential health insurance coverage either through their employer or a private insurance company (Winkler, 2013; Silvers, 2013). It also requires private insurance companies to become competitive by offering comparable policies of the same rates to all of their clients and they will no longer be able to deny anyone due to a preexisting condition (Silvers, 2013).

The ACA has clearly reformed the health system in the U.S., yet it is not certain how much of an impact it will have on diminishing the overall costs of health care (Kellis & Rumberger, 2010). As costs of healthcare rise, the financial deficit becomes unsustainable for employers and employees alike. This demonstrates yet another inequality of accessibility that will hopefully be corrected with the full implementation of ACA, also creating a possibility for change in the frequency of medical tourism.

While healthcare costs in the U.S. continue to increase dramatically, quality remains stagnant. The fact is that individuals simply cannot afford pricey procedures they need even with access to health insurance (Kellis & Rumberger, 2010). Now the question is how much of a role should the government have in providing and controlling U.S. citizens' access to healthcare (Lynch & Gollust, 2011)? Because of the mixed private competition/governmental model that is used in the United States, much of the health system's costs are incurred from inefficiencies (Kellis & Rumberger, 2010). With higher costs and the same coverage through insurance, individuals may be encouraged to leave the country to seek cheaper care. This idea suggests that with a single payer or universal healthcare system, the U.S would become less wasteful with finances (Kellis & Rumberger, 2010).

The Affordable Care Act will clearly impact how the healthcare industry in the U.S. does business and could have a significant effect on the potential of medical tourism. Peters and Sauer (2011) found that over half of the respondents to a survey of medical tourism service providers believe the implementation

of ACA will have a significant positive impact on the number of individuals interested in medical tourism. Comparatively, individuals who are uninsured are more likely than those who are insured to engage in medical tourism because it saves them money on major procedures (Artecona, 2012). This was demonstrated by the three scenarios previously mentioned. The example of the uninsured individual traveling to Mexico would be saving close to 34% by traveling for a major procedure, such as a gastric bypass surgery. Therefore, if the ACA insures more people, there is a possibility that the medical tourism industry will decrease in its participants from the U.S. (Gan & Frederick, 2013).

## Conclusion

Medical tourism provides an opportunity for individuals to seek healthcare outside of their own country due to lack of access or affordability. The Affordable Care Act has been put in place to decrease inefficiencies and decrease overall costs in the U.S. healthcare sector. If this objective is not met, the U.S. will continue to lose revenue to foreign healthcare providers with medical tourism (Kumar, Breuing, & Chahal, 2012). Especially with new policy changes within individuals' insurances, they will be driven to seek other options of healthcare if they are dissatisfied. High costs in the U.S. for certain procedures will drive citizens away. Medical tourism dates back to the 18th century (Pickert, 2008); however it is becoming more popular as individuals are realizing how much money they can save. Known motivators of this procedure are to avoid high prices, long waiting lists, or to have a procedure done that does not exist in the patient's residing country. Recalling the significant potential cost savings to the individuals in the three fictional case studies earlier in this paper, the price differences were enormous. These scenarios only represented a single procedure. The costs are exacerbated when considering chronic illnesses or patients requiring multiple hospitalizations. Medical tourism is seemingly impossible to be rid of completely as it becomes the most financially feasible option in some cases. The benefits outweigh the risks in many situations because individuals are able to save thousands of dollars.

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