4 Medical Value Travel in India: Prospects and Challenges

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INTRODUCTION

In recent years, several medical tourism hubs have emerged in different parts of the world. This is because familiarity with countries which share similar languages, social customs, and cultural mores makes it easier for foreign patients to access treatment in another country.[1] Some of these countries have become leading providers in specific health services such as cardiac, cosmetic, or dental surgery. The Asian region constitutes an important medical tourism market. It was estimated that medical tourism in Asia generated US$1.3 billion a few years ago and is projected to reach US$4.4 billion by 2012 (United Nations Economic and Social Commission for Asia and the Pacific, 2009, p. 9). India, along with Thailand, has established itself as a recognized hub for medical value travellers in the Asian region. Although reliable country specific estimates are not available to gauge the size of the medical value travel industry in different countries, it is estimated that India in 2004 had 150,000 medical tourists and US$333 million in medical tourism revenues, and has the potential to realize US$2.3 billion from medical tourism by 2012 (Confederation of Indian Industry (CII) and McKinsey and Company, 2002; Federation of Indian Chambers of Commerce (FICCI) & Industry and Ernst and Young, 2007; Tourism Research And Marketing, 2006; Chinai & Goswami, 2007).

This chapter discusses India's prospects for and challenges to medical tourism. Section 2 briefly highlights the salient characteristics of India's healthcare sector (for medical value travel) and then outlines recent trends in India's exports of medical tourism, how it compares with other countries with respect to arrivals and expenditures by foreign patients, and some of its key markets. Sections 3 and 4, respectively, discuss the facilitators and constraints to India's medical tourism exports. Section 5 presents the benefits and concerns that have been voiced in India regarding medical value travel exports and situates this discussion within the wider debate on the pros and cons of trade in health services. Section 6 concludes by outlining positive steps

for India domestically, as well as internationally, in order to facilitate its medical tourism exports.

OVERVIEW OF INDIA'S MEDICAL VALUE TRAVEL EXPORTS[2]

India's healthcare sector is estimated at US$50 billion and is expected to reach US$75 billion in 2012, with an annual growth rate of 18 percent. The sector's contribution to gross domestic product (GDP) has remained virtually stagnant throughout the past decade and stood at 4.2 percent in 2009. It is expected to increase to 8.5 percent by 2017 (Cygnus Business Consulting and Research, 2010).

Key features of India's healthcare sector

There are several noteworthy features of India's healthcare sector, many of which are pertinent to a discussion on the prospects for medical tourism exports from India and the associated issues and concerns. The most striking feature of India's healthcare sector is the dominance of the private healthcare segment, which accounted for around two-thirds of total expenditure and for around 80 percent of the 16,386 hospitals in the country in 2009 (Cygnus Business Consulting and Research, 2010). The share of public spending in India is much lower than in comparable developing countries such as Brazil, China, and South Africa, where the public sector accounts for around 40 to 50 percent of total healthcare expenditures. Moreover, tertiary care constitutes a significant 15 to 20 percent share of India's healthcare spending and is expected to grow steadily due to the growth in specialized hospital care, which is noteworthy given the country's poor basic health indicators. There is a stark urban-rural and rich-poor divide in availability of healthcare, with private hospitals mostly catering to the urban and affluent sections of society, and rural and poor sections depending mainly on the public healthcare system. Such features not only indicate the growing importance of private players in healthcare delivery but also the low priority and inadequate resources devoted to the public sector by the Government of India.

Table 4.1 Status of Human Resources in Healthcare in South Asia and Other Regions

	Health Workforce										Hospital beds (per 10,000 persons)
	Physicians		Nursing and midwifery personnel		Dentistry personnel		Community health workers		Other health service providers		
	No.	Density	No.	Density	No.	Density	No.	Density	No.	Density	
	2000-07		**2000-07**		**2000-07**		**2000-07**		**2000-07**		**2000-07**
Global Avg	8404351	13	17651585	28	1854512	3	…	…	14631863	24	25
Global median	5201	11	12746	29	900	2	548	2	2767	5	25
Southeast Asia Avg	849324	5	1955203	12	92759	1	132612	1	2002575	12	9
India	645825	6	1372059	13	61424	1	50393	1	1752027	16	7
Brazil	198153	12	659111	38	190448	11	…	…	499592	29	24
China	1862630	14	1259240	10	136520	1	…	…	1724620	13	22
Malaysia	17020	7	43380	18	2160	1	…	…	2880	1	18
Singapore	6380	15	18710	44	1190	3	…	…	1280	3	32
South Africa	34829	8	184459	41	5995	1	…	…	71850	16	28
Thailand	22435	4	172477	28	10459	2	…	…	71528	12	22

Source: Based on data from WHO Statistical Information System (WHOSIS) http://www.who.int/whosis/indicators/en/ (accessed May 25, 2012)

Although there has been growing demand for both physical and human infrastructure, availability has not kept pace. As per the WHO guidelines, there is a gap of around 1.4 million doctors and 2.8 million nurses worldwide.[3] According to a Confederation of Indian Industries (CII) and McKinsey and Company study, between 2002 and 2012, there was a projected requirement of 750,000 additional hospital beds to meet the growing demand for in-patient services and to reach a hospital bed to population ratio of 1.9:1000 by 2012, with an estimated investment requirement of US$24 to US$34 billion to set up the required infrastructure (CII & McKinsey and Company, 2002). Table 4.1 highlights the status of human resources and physical infrastructure in India's healthcare sector compared to other developing countries. It shows that India compares poorly on these indicators not only relative to these other countries but also relative to the global average.

Table 4.2 captures the predominance of the private sector in healthcare expenditures in India and also shows that the bulk of private spending on healthcare is out-of-pocket, indicating the very low levels of public and private insurance penetration in this region. Access to healthcare is thus largely a function of ability to pay, i.e., income level and economic background, with implications for equity and human development outcomes.

Table 4.2 Characteristics of Healthcare Expenditures in India and Other Countries

	Public-Private Composition of Health Care Expenditure (percent)						**Out of pocket in private health expenditure (percent)**		**Share of external resources in health expenditure (percent)**	
Country/ Region	**2000**		**2003**		**2006**		**2000**	**2006**	**2000**	**2006**
	Public	**Private**	**Public**	**Private**	**Public**	**Private**				
India	22.2	77.8	18.5	81.5	19.6	80.4	92.1	94	0.6	0.7
Brazil	40	60	41.3	58.7	47.9	52.1	62.7	64	0.5	0.1
China	38.3	61.7	36.2	63.8	42	58	95.6	92.9	0.1	0.1
Malaysia	52.4	47.6	56.4	43.6	45.2	54.8	75.4	73.3	0.6	0
Singapore	36.8	63.2	34	66	33.6	66.4	97	94	0	0
South Africa	42.4	57.6	40.1	59.9	41.9	58.1	18.9	17.5	0.3	0.8
Thailand	56.1	43.9	66.6	33.4	64.4	35.6	76.9	76.6	0	0.3

Source: Based on data from WHO Statistical Information System (WHOSIS) http://www.who.int/whosis/indicators/en/ (accessed May 25, 2012)

This dependence on private out-of-pocket spending when placed against the poor performance on social and physical infrastructure parameters such as availability of healthcare personnel or number of hospital beds (as highlighted in Table 4.1), is also indicative of this inequitable distribution of healthcare availability and quality of services.

India's medical tourism segment in the global context

Against this backdrop of private sector-led healthcare, with imbalances in availability and quality of healthcare delivery, India's medical tourism segment has been growing rapidly, in line with global trends. International arrivals and associated revenues have increased considerably in recent years. According to CII and McKinsey and Company (2002), India's medical tourism revenues were estimated at US$300 million in 2002 and were projected to reach US$2.2 billion by 2012, with an estimated year on year increase of 25 percent in foreign patient arrivals between 2002 and 2012. More recent data from Euromonitor International[4] on international arrivals and medical value travel expenditures for selected countries suggest that the CII estimates may be optimistic, although there has been an increase in the number of foreign patients seeking treatment in India and in the value of medical tourism exports from India (Euromonitor International, 2011).

India faces competition from several countries, mainly within Asia but also globally as a destination for medical value travel. The main competing destination is Thailand, in terms of price and quality, owing to its image as a tourism destination and its efforts in accrediting hospitals. Other notable competitors include Singapore due to the latter's modern healthcare infrastructure, Malaysia for its price competitiveness and government efforts to attract foreign patients from the region, and the Philippines given recent government initiatives in that country to boost its medical tourism industry. Globally, countries such as Mexico, Costa Rica, and Panama in Central America and Jordan and the UAE in the Middle East are competing destinations for foreign patients from the US, Canada, and Europe.

Table 4.3 highlights India's comparative performance in medical tourism by showing the trends in international arrivals for medical treatments and in medical tourism expenditures for India and other selected Asian countries for the 2007-10 period.

Table 4.3 International Arrivals for Medical Treatments and Medical Tourism Spending for Thailand, India, Singapore and Malaysia, 2007-2010

Country	No. of foreign patients ('000s) and Expenditure (US $mn)							
	2007		2008		2009		2010	
	Patients	Expenditure	Patients	Expenditure	Patients	Expenditure	Patients	Expenditure
Thailand	1325	294.2	1360	390.2	1260	487.2	1580	635
India	450	186.9	530	200.7	609	202	731	253.4
Singapore	571	238.6	646	274.5	665	275	725	206.4
Malaysia	341	83.8	370	102.8	425	116.8	489	157.3

Source: Adapted from Euromonitor International Reports by author

The data indicate that India compares favourably with other leading destinations for medical value travellers in Asia, such as Thailand and Singapore. The number of foreign patients has increased around one and a half times between 2007 and 2010 although per head expenditure remains at about US$40,000, and total earnings from medical tourism remain at less than US$300 million (Euromonitor International, 2011). Thailand is clearly the leader in this region, with more than twice the number of medical tourists than India in 2010. The data also indicate that India has caught up with Singapore as the second most preferred destination for medical value travellers within Southeast and South Asia.

India's medical tourism exports in the regional context

India attracts medical tourists from various geographies and for various reasons. Foreign patients receiving treatment in India include the Indian diaspora who prefer to come to their home country for personal and social reasons, patients from countries with rationed healthcare where waiting periods can be long, such as the UK and Canada, patients from uninsured in markets such as the US who prefer low cost and high quality treatment in India, and patients

from developing countries in Africa and South Asia where healthcare facilities are lacking or are of poor quality (Oberholzer-Gee, Khanna and Knoop, 2007).

There is a strong regional dimension to India's medical tourism exports. Within South Asia, India is a medical tourism hub. It is an attractive destination for patients from neighbouring countries such as Nepal, Bangladesh, Bhutan, and the Maldives given the latter's relatively underdeveloped facilities and the lack of specialized treatments in these markets. Patients from other South Asian countries find medical care in India attractive due to cost, quality, and cultural and geographic considerations.

Discussions with several leading corporate hospitals indicate the importance of the regional market as a source for foreign patients (Chanda, 2011a).[5] For instance, the Manipal Hospital in Bangalore receives patients from Sri Lanka, Bangladesh, Nepal, and Pakistan. The Apollo Gleneagles Hospital in Kolkata receives patients from Nepal and Bangladesh and the Apollo Chennai Hospital receives patients from Sri Lanka. Pakistan is seen as a potential source market for patients seeking high-end treatments at a reasonable cost. There have been several high profile cases of Pakistani children seeking specialized cardiac treatment at Indian hospitals (Chanda, 2011a). The Bhutanese government sends patients to Kolkata and Delhi and pays for their treatment. In view of the promising regional market for medical tourism, the Bangalore-based Narayana Hrudayalaya Hospital targets patients from South Asia and other regional markets. Some of the Narayana Group's hospitals have already established referral arrangements with hospitals and agents in source countries and joined up with travel operators to provide an integrated set of services to medical tourists.

Medical tourism opportunities have also led to investment initiatives by leading Indian hospitals in other South Asian countries, through joint ventures, wholly owned subsidiaries, and management contracts, in order to cater to patients in the regional market. For example, Apollo Hospitals has taken on an operations management contract for a 330-bed tertiary care hospital in Dhaka. It has entered into a joint venture with its Bangladeshi partner, STS Holdings, Dhaka. The objective of this project is to cater to the large number of patients coming to India and other neighbouring countries for treatment. According to newspaper reports, Indian hospitals are increasingly looking at entering Bangladesh through joint ventures and standalone

entities, given that country's growing market and affluent population, and economic stability and the large number of Bangladeshi medical tourists who are at present seeking treatment in other countries such as Thailand (Oberholzer-Gee, Khanna & Knoop, 2007, p.6).[6] Likewise, Kolkata's BM Birla Heart Research Centre is interested in establishing its presence in Chittagong and Dhaka. It is setting up a hospital in Dhaka and will be undertaking the management of another hospital in Chittagong. AMRI Hospitals (a private hospital chain) is similarly considering setting up a branch in Bangladesh. These hospitals are interested in tapping the patient base in Bangladesh travelling to Kolkata and other cities in India for treatment. Cultural and linguistic similarities and geographic proximity make Bangladesh an attractive market for overseas ventures for Indian hospitals in the Eastern part of the country. The BM Birla Group is considering setting up a hospital in Bhutan given the country's need for state-of-the-art facilities in healthcare. Thus, opportunities for medical tourism have given rise to other commercial opportunities and private sector players in India are leveraging the linkages that exist between medical tourism and other modes of trade in health services, such as commercial presence and telemedicine in the regional context.

FACILITATING FACTORS

There are several factors that have contributed to India's competitiveness as a medical tourism destination. As highlighted in the following discussion, these factors relate to intrinsic advantages such as the presence of a low cost, skilled health workforce and a large diaspora population. Pro-active efforts and initiatives that promote growth in private healthcare are also factors.

Cost advantage

One of the most important drivers has been India's cost advantage. Data on relative costs for different medical procedures shows India's cost competitiveness in a wide range of treatments, such as transplants, cardiac surgeries, and orthopaedic treatments. India compares favourably with developing country destinations and is one-fourth to as much as one-tenth cheaper than developed countries such as the US for common procedures such as organ

transplants, orthopaedic surgeries, and heart bypass surgery (excluding travel and accommodation related costs). Table 2.1 in Chapter 2 of this volume demonstrates these cost advantages.

With respect to both physician and clinical expenditures, for a variety of medical procedures, India has a significant cost advantage over the US. However, it is also worth noting that if one were to add costs of travel and stay to the cost of medical procedures, India's cost advantage may be considerably eroded when compared with cost competitive destinations such as Mexico or Costa Rica which can cater to patients travelling from the US.

Role of the private sector

The emergence of a vibrant, rapidly growing private corporate sector hospital with state-of-the-art facilities, upgraded technologies, super-specialty care, and standards comparable to those of developed country hospitals, has played a very important role in shaping India's medical tourism exports. Privately owned corporate hospitals such as Apollo, Fortis, Max Healthcare, and Columbia Asia are the main destinations for foreign patients seeking treatment in India. Several of these hospitals have established a reputation in specific areas such as cardiac surgery and joint replacement (Arellano, 2007). Many have partnered with international insurance and tourism companies as well as with hospitals and practitioners abroad to facilitate the medical tourism business. Health cities have also emerged where major corporate hospitals provide an integrated set of services, including hotels, residential, recreational, and transport facilities. The private sector hospitals have also entered into agreements with wellness and holistic centres in their efforts to provide a comprehensive approach to healthcare.[7]

An important driver behind the growing presence of private hospitals in India's medical tourism exports has been international accreditation. Over 10 Indian hospitals, such as Apollo Hospitals (Bangalore, Chennai, Hyderabad, Chennai), Apollo Gleneagles Hospital Kolkata, Indraprastha Apollo Hospital Delhi, Asian Heart Institute, and Fortis, among others have received JCI accreditation. International accreditation has helped raise the standards of healthcare delivery in India and improved India's visibility as a medical tourism destination.

The private sector has also played an important role through associations such as the CII and the Federation of Indian Chambers of Commerce and Industries (FICCI). These

associations have helped in raising awareness about issues of standards and accreditation in the country and have actively lobbied the government on issues such as taxes, infrastructure, financing, medical technologies, and insurance. All have a bearing on the industry's overall cost competitiveness and quality assurance, with implications for India's prospects in medical tourism. Industry associations have also helped in marketing efforts, such as by organizing an annual health conference, with a section on medical tourism and by organizing visits by delegations from the Indian hospital industry and from overseas bodies such as the NHS in the UK to promote the medical tourism industry and highlight barriers affecting such exports from India.

Government policies

Around the world, many countries have promoted the medical tourism segment through aggressive marketing efforts, pro-active policies such as special facilities and incentives for medical tourists, facilitation of investments in multi-specialty corporate hospitals, expedited visa procedures, and integration of healthcare and tourist facilities. For instance, Singapore has a multi-agency initiative through trade exhibitions, investments, and focus on niche treatment areas to promote itself as a medical tourism destination. Thai consuls provide price guidelines for selected treatments available at Thai hospitals (Wibulpolprasert et al, 2004). Many countries have also undertaken targeted initiatives, including efforts to promote themselves as regional hubs.

Although the Indian government has not had a similar pro-active and targeted drive to promote medical tourism, it has indirectly promoted it by considering medical tourism to be a "deemed export" in its National Health Policy of 2002, and thus granting the sector fiscal incentives in the form of lower import duties, providing prime land at subsidized rates, and tax concessions (Burkett, 2007; Garud, 2005; de Arellano, 2007; Sengupta, 2008). However, discussions with government health officials reveal a general reluctance to actively promote medical tourism, mainly due to the many shortcomings in public healthcare delivery and the possible adverse effects on equity that are associated with the commercialization of healthcare through medical tourism.[8] This concern is also reflected in criticisms that have been levelled against the government regarding the provision of fiscal and other incentives to help private

sector players, given the shortage of healthcare facilities and the geographic and economic inequities characterizing healthcare delivery in India.

Other factors

A variety of other factors have helped India's prospects in medical tourism. These include the widespread use of the English language which puts India at an advantage over neighbouring competitors such as Thailand which need translators, its widespread diaspora which provides a market for attracting patients from overseas, and the Indian doctors and nurses who have practiced overseas and are recognized for their skills and competence. Geography, culture and language have also played a role in terms of India's position as a hub for medical tourism within South Asia given the cultural and linguistic affinities between India and other countries in the region.

Another contributing factor is the availability of alternative and traditional systems of medicine, such as ayurvedic, unani, panchkarma, and homeopathy as well as spiritual and rehabilitative forms of treatment such as yoga or siddha, which have been important contributors to India's attractiveness as a medical tourism destination. The latter treatments and therapies, in particular, ayurveda, are distinguishing features of the Indian medical system and are particularly popular among foreigners from Western countries. The Ayur Vaidya Sala at Kottakal in Kerala is popular among German, British, and American tourists, some of whom come to India specifically to avail of these services and for treatment of chronic disorders where allopathic (Western) medicine may fail to deliver (Gupta, Goldar, Mitra, 1998). According to a 2007 report regarding the distribution of Indian doctors by type of medicine, over 50 percent of doctors were practicing alternative medicines, including 36 percent in ayurveda and 16 percent in homeopathy, alongside 43 percent in allopathy (FICCI & Ernst and Young, 2007; CRISIL Research, 2007). Hence, India's niche in alternative therapies is also supported by a sizeable body of practitioners in these other fields of medicine.

CONSTRAINING FACTORS

There are a host of regulatory, infrastructural, quality, and perception related factors which constrain India's prospects for medical tourism exports. These are both domestic and external, some of which may be more difficult to tackle than others. Some of these factors are specific to India while others are constraints inherent to the very nature of the medical tourism industry and healthcare in general (Chanda, 2011a, 2011b).

One major constraint is the lack of insurance portability between important source countries for medical tourists and India. State insurance trusts and private insurance companies do not reimburse for treatment carried out in India. This limits the potential pool of foreign patients mostly to those paying out-of- pocket or to those insured by select companies which have reimbursement or Third Party Arrangements (TPAs) with hospitals catering to foreign patients in India. The absence of reimbursement arrangements with public sector health providers, such as the UK NHS, also limits the scope for attracting patients from countries where the public sector dominates the provision of healthcare and there are generous public health insurance schemes, and where the share of non-insured, out-of-pocket paying patients is low[9]. The dominance of the public sector in healthcare provision and insurance also creates problems of political acceptability for allowing medical value travel to India or for claiming reimbursement from national health insurance trusts in the patient's source country. In the case of some countries, there are restrictions on the reimbursement of patients by national insurance trusts if time spent travelling exceeds a certain amount, which effectively negates the possibility of India as a medical tourism destination. For instance, there is a flight time restriction of 3 hours for patients from the UK for reimbursement from the NHS, which would thus accommodate most European countries where patients can access care, but not countries outside of Europe[10]. There are also restrictions on the reimbursement of alternative medicines and therapies for lack of scientific evidence, registration, and regulation.

There are related domestic regulatory issues pertaining to health insurance in India, which are an impediment to insurance portability from source countries to India. Foreign insurance companies face problems with underwriting and premium setting in the absence of a

regulated environment and control over healthcare providers in India and thus bear most of the risk of non-recovery, fraudulent claims, and collusion between clients and providers. Lack of standardization of guidelines and classification of procedures also acts as a deterrent to the growth of the health insurance industry. Absence of a transparent regulatory framework in the Indian insurance sector makes it difficult for Indian healthcare providers to negotiate with foreign insurance companies for insurance portability from the source countries of foreign patients seeking treatment in India.

As healthcare requires a close interface between the doctor and the patient, perceptions play an important role. Concerns regarding India's ability to provide quality healthcare, hygienic conditions, and standards of healthcare are a constraining factor, particularly with regard to patients from developed countries. The latter is not specific to India as concerns about the quality of care received abroad relative to that offered in the home country affects developing country medical tourism destinations more generally. While leading corporate hospitals in India have obtained international accreditation to overcome such perception barriers, the general view of India as a country characterized by poor hygienic conditions and poor infrastructure continues. There are also concerns about lack of follow-up care, possible complications post-surgery which may require treatment back in the home country, and lack of information flow between doctors in the two countries. Again, these are not specific to India and are inherent to most instances of medical value tourism.

Foreign patients and private insurance companies are also concerned about issues such as medical liability and legal settlement (dispute resolution, geographic jurisdiction, and compensation) given the limited malpractice laws in countries like India and Thailand. Absence of mutual recognition agreements between India and key source countries for medical tourists, the still small number of internationally accredited healthcare establishments, and lack of standardized medical and nursing training in the country contribute to this perception barrier and also adversely affect the prospects for insurance portability.

Discussions with leading corporate hospitals also indicate that the rapidly growing domestic healthcare market and the increasingly affluent domestic population within India tend to limit the private sector's focus on medical tourism.[11] Expanding hospital chains and setting up

integrated health cities within India may be a more attractive proposition than catering to medical tourists and undertaking costly initiatives to promote health tourism.

This lack of pro-active and targeted marketing also characterizes the Indian government's approach to medical tourism, particularly in comparison with other competing destinations such as Thailand. Apart from medical tourism being seen as an extension to general tourism campaigns where major hospitals have been linked with tourism, there are no targeted efforts to promote medical tourism or efforts to provide the support infrastructure and facilities in an integrated manner. Even within South Asia, where there are considerable medical tourism opportunities, policies have been lacking. Delays in getting visas and absence of processes for granting expedited medical visas, delays in obtaining approvals for getting overseas treatment, poor airline connectivity, inadequate and poor local support infrastructure constrain the scope for medical tourism within the region (Chanda, 2011a). There are also financing issues, including the lack of insurance portability and absence of regional insurance products, which result in the use of informal channels for payment and constrain medical tourism exports to the region.

POTENTIAL BENEFITS AND CHALLENGES

The debate in India regarding the potential positive and negative fallout of medical tourism echoes the equity-efficiency concerns that have characterized the wider debate on trade in health services (Smith et al, 2009; Chanda, 2002). Proponents of India's medical tourism exports cite resulting benefits in the form of increased foreign exchange earnings, enhanced resources for investment in the sector, increased job creation, and improved standards and accountability in private sector hospitals with spill-over benefits to the wider Indian healthcare system. Proponents also point to the potential for leveraging medical tourism to attract health workers back to India given the growth in job opportunities and more competitive salaries in private hospitals that would result from medical tourism, with additional beneficial effects on quality and perceptions regarding the sector.

On the other hand, numerous concerns have also been voiced about India's engagement in medical tourism exports. Many of these concerns are not specific to India and have been highlighted in earlier studies on health services trade. For instance, there are concerns about the possible creation or worsening of an already existing two-tiered health system where foreign medical patients would have access to state-of-the-art private hospitals while domestic patients are squeezed out from quality care. Should a country that is unable to meet the healthcare needs of its local population devote resources to the treatment of foreign patients? There are concerns about possible internal brain drain, with healthcare professionals leaving the public sector to work in private corporate hospitals where wages and working conditions would improve on account of medical tourism but leave the public system weaker in terms of quality and availability of manpower. It is also feared that medical tourism could divert resources towards investment in urban tertiary care and specialized facilities that cater to foreign patients to the neglect of the needs of the local population. The possible upward pressure on the cost of treatment and medical procedures has also been noted, though there is no hard evidence to suggest that this has indeed happened or any evidence of discriminatory pricing behaviour of healthcare providers who cater to medical tourists.

While the above concerns are part of the general debate on commercialization of health services, there are also issues specific to India given the country's prevailing regulatory environment in this sector. For instance, there are ethical concerns surrounding transplant tourism and possible exploitation of local donors in the absence of regulatory mechanisms to check ethical violations. There is also a wider concern that commercialization of health services through medical tourism and other forms could indirectly encourage more unregulated growth of private healthcare providers and also lead to more pressure from this segment for subsidies and other fiscal incentives in the context a lack of a strong regulatory framework to enforce standards and monitor the operations of private healthcare providers.

These concerns are to some extent valid in the Indian context, given the stark inequities in healthcare delivery between the urban and rural population, between the rich and the poor, and between the public and the private segments in terms of availability of physical, human, and financial resources and the quality of these. Medical tourism could aggravate these existing

inequities and imbalances. For example, fiscal incentives offered to private players in the form of subsidized land or reductions in import duties on medical equipment could further encourage the creation of subsidized specialty hospitals which cater to foreign and affluent domestic patients, aggravating the rich-poor divide in this sector. With an estimated shortage of 600,000 doctors and one million nurses, particularly in the public health segment, medical tourism could worsen the resource gap between private and public healthcare by widening existing disparities in wages, facilities, and working conditions (Planning Commission, 2008, p. 111-112).[12] Hence, the potential benefits in the form of resource inflows and upgrading of standards need to be weighed against such negative fallouts, although, as mentioned, it is difficult to ascertain this cost-benefit balance without actual evidence.

POLICY DIRECTIONS

The Indian medical tourism industry has been growing in recent years and has potential for further growth given its comparative cost advantage, competent medical workforce, mix of traditional and alternative systems of medicine, and world class private sector healthcare providers. In light of the shortage of medical manpower and rising healthcare costs plaguing many countries, India's medical tourism prospects are promising. However, there are associated challenges and concerns, particularly given various structural and regulatory shortcomings in India's healthcare sector. The objective therefore has to be to facilitate the growth of medical tourism but with a view to helping the overall healthcare sector and ensuring that the negative consequences are minimized and conditions contributing to these adverse effects are addressed.

The starting point for any policy measures concerning medical tourism is to recognize that the debate surrounding medical tourism needs to be more nuanced than it is been so far and that the root cause of many of the aforementioned challenges lies elsewhere. The Indian healthcare sector is already plagued by a two-tiered system and many imbalances. These problems are not due to medical tourism but are a result of domestic factors such as insufficient funding of public healthcare, inefficiencies in public healthcare establishments, poor

human resource management systems, issues of access and affordability more generally, and inadequacies in the regulatory framework, among others. Therefore, the challenges posed by medical tourism have to be tackled through domestic regulatory and systemic measures, which can reduce these existing imbalances and also enable leveraging of the positives that medical tourism can bring, for the benefit of the wider healthcare system.

Three broad directions for policy action are required. The first involves addressing the structural issues in the healthcare sector. The second pertains to undertaking specific measures to facilitate medical tourism. The third involves looking at ways to derive benefits from medical tourism for the overall healthcare system, with an integrated health sector perspective. A few measures are proposed in the context of each of these areas.

STRUCTURAL ISSUES

Perhaps the most important issue to address in this regard is that of standards and accreditation. The JCI has accredited a number of hospitals in India but all of these are in the private sector. The decline in public sector standards has resulted in declining utilization of government resources in both rural and urban areas. If this gap is to be addressed, then concrete steps have to be taken to improve the standards of public healthcare establishments, improve infrastructure, and to establish a national accreditation body with international recognition in order to ensure a standardized healthcare system. (The latter has been done recently with the introduction of the National Accreditation Board for Hospitals (NABH) and efforts to promote adoption of NABH standards by domestic hospitals.) Improvements in the regulatory framework for both public and private healthcare establishments would ensure greater transparency and accountability. Such efforts would also help India project a positive image to foreign patients as quality of care is among the main concerns for medical tourists.

Facilitating Medical Value Travel

Specific steps can be taken to promote medical tourism. For instance, the government and the private healthcare providers could negotiate to remove the flight time restrictions on reimbursement of overseas treatment, as in the case of the NHS. (Efforts in this regard have

proved futile to date, however.) Discussions could also be undertaken with national health insurance trusts to highlight benefits such as reduced costs and waiting time that would accrue to the latter from recognizing and reimbursing treatments received in India. A pilot approach could be taken, such as by selecting certain Indian healthcare establishments for reimbursement, for selected procedures such as cardiac surgeries, joint replacement, or cosmetic surgeries where overseas treatment can be justified easily on grounds of costs or waiting time. Selection could be on the basis of international accreditation coupled with additional audits by the authorities of the concerned governments or insurance companies and third party administrators. There could be an understanding on costs, procedures, and payment arrangements.

There is also scope to negotiate insurance portability with private insurance companies with premiums or co-payments being linked to the place of treatment to account for additional risks along with caps on the maximum reimbursable amount. Trade and industry delegations could negotiate with and incentivize these insurance companies to accept establishments that have international accreditation, coupled with additional audits of facilities (an approach which has worked for Bumrungrad Hospital in Thailand). Thus, sensitization to and promotion of India's potential as a medical tourism destination is required, with information dissemination on India's medical system, procedures, establishments, and advantages, in order to gain visibility.

In the regional context, possible steps to promote medical tourism would include the introduction of a regional insurance product and cross-border payment arrangements through bank-to-bank guarantees in the region. Pilot schemes could be introduced for specialized elective treatments and procedures, which may not be available in the home country of the patient. Some potential segments would be transplant surgery, infertility medicine, joint replacements, and treatments for cardiac, eye, dental, urological, and gastrointestinal problems. The experience of other regional blocs such as in Mercosur, which have entered into regional payment arrangements to promote medical tourism, could be instructive in this regard. In addition, other issues such as visas, transport, supporting logistics in the destination country, and follow-up services would also need to be discussed to promote medical tourism in the region. There is for instance, a need to streamline medical tourism related visas. Follow-up

facilities through bilateral agreements between establishments in the host and home countries and telemedicine could also be explored.

Ensuring Synergies

It is also important to put in place policies that take into account the possible synergies between medical tourism and the rest of the healthcare system. For instance, benefits in the form of improved standards and technologies, increased efficiency, or return migration of health professionals, which are likely to accrue to the private sector could potentially be leveraged for the benefit of the public sector. This can be done through tie-ups and public-private partnerships between public and private healthcare providers in terms of management of healthcare facilities, pooling and exchange of skills and technologies, more inclusive forms of healthcare delivery in the private sector, and requirements such as cross-subsidization of poor patients in corporate sector hospitals against any fiscal concessions and incentives they receive for medical tourism or more generally. Thus measures are required which take an integrated view of the health sector and which link the medical tourism segment and its ensuing benefits to the rest of the healthcare system.

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[1] Most of the patients going to Singapore and Malaysia are from within ASEAN, those going to Jordan are mainly from neighbouring countries in the Middle East and North Africa, and those going to Cuba are mainly from the Caribbean and Central America.

[2] Medical value travel or medical tourism exports is how revenues earned by international patients seeking care in India are described in economic terms.

[3] The minimalist WHO guidelines specify a requirement of 2.28 doctors, nurses, and midwives per thousand population. (See, Milbank Memorial Fund (2011): 1)

[4] Euromonitor publishes reports on industries, consumers and demographics in India and many other countries.

[5] Discussions were carried out by the author with management and practitioners of leading corporate hospitals in India during 2008 and 2009 in the course of her research on prospects for regional integration in services in South Asia.

[6] This business model of expanding facilities to other countries, which in turn may also enhance medical travel to destination country facilities, is also being pursued by South African private hospital and health insurance companies (see the chapter by Crush et al, this volume).

[7] Hospitals have emerged with the inclusion of hotels within hospital facilities, where patients are provided holistic services.

[8] Discussions carried out by the author with health ministry officials in the course of conducting a research study. (See, Chanda 2011b).

[9] Although as other chapters in this book have argued, long wait times in such countries, or non-availability of a desired intervention, still plays an important role in people seeking OOCC.
[10] That this is the case is not surprising either, given recent European court rulings granting patients (with some restrictions) the right to seek reimbursed medical care in any EU member state.
[11] Discussions were held by the author with health industry practitioners and management in 2008 and 2009 in the course of her research work on prospects for regional integration in South Asia. (See Chanda 2011a)
[12] These estimates are based on the benchmark ratios of 1:1000 for doctors, 1:500 for nurses.

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