Abstract
Health has always been a concern for human beings throughout the centuries. Travelling across the places in search of being treated has always been the tendency of the humans and it has been found so in across cultures and time. But the notion of medical tourism in itself is a different phenomenon at all. Medical tourism is also defined as health tourism at large though there is little demarcation between the two accepted notions by some scholars only. In the paper here medical tourism as well as health tourism would be taken one and the same. Medical tourism is a form of travel to different destinations due to health reasons but because of different causes. The paper here tries to find out the broader definition of what constitutes the notion of medical tourism and looks at the various reasons of what so ever that has led to the emergence of this concept on the whole. The paper will also try to look at bigger notion of globalisation of health as a market phenomenon and change of person from patient to the consumer. The paper will also try to delineate the fallout that is supposedly going to occur because of the booming medical tourism. Attempt has been also made in the paper to find out the consequences of the growing medical tourism in the Indian health sector as such and how it is going to further globalise the health sector.

1. Introduction
Tourism word as such seems to be sort of luxury of which rich and elite are bestowed upon but once medical word is attached to it, one gets astonished. Why not one will get of course puzzled a lot because medical always is something where in a person assumes the role of a patient and how come then he can be a tourist. But the fact of the matter is that it is a sort of marketing of patients just like as tourists by the travel agencies.
Medical tourism is not entirely new. Bartha knoppers and Sonia LeBris coined the term ‘procreative tourism’ in 1991 to describe the practice of patients exercising their personal reproductive choices in other less restrictive states (cortez, 2008). “We define health care tourism as the attempt on the part of a tourist facility (e.g hotel) or destination (e.g baden, Switzerland) to attract tourists by deliberately promoting its health care services and facilities in addition to its regular tourist amenities. (E.Goodrich, 1997). Loverseed (1998), states that, “health tourism encompasses those products and services that are designed to promote and enable their customers to improve and maintain their health through a combination of leisure, recreation and educational activities in location removed from the distractions of work and home (cited in Dharmesh, 2008). Thus from all these definitions it becomes clear that medical tourism involves the cross border movement of an individual for the purpose of being getting treated along with the other facilities provided thereafter. Medical tourism has exploded in recent years, aided by globalisation in the health services industry. Now there are thriving international markets for health care professionals, medical technology and drugs. Earlier globalisation had taken clinical trials and diagnostic test interpretations across borders. The latest and perhaps most important segment to succumb to globalisation is the market for patients.

2. Debate Over The Use Of The Terms Like Medical Tourism, Reproductive Tourism

In recent times the debate has been growing over the use of the term tourism with the medical per se. many argue that this terminology in itself raises many questions on the ethics of the language. Matorras, (2005) argues, “the term reproductive tourism is both inaccurate and in appropriate. It is inaccurate because tourism means travelling by pleasure and by no means do infertile couples travel by pleasure. It is inappropriate because it trivialises infertility problems. Infact the term could seem frivolous and offensive for couples seeking reproductive assistance and also for professionals involved in assisted reproductive techniques. I would prefer to use reproductive exile than reproductive tourism.” Pennings (2005) argues, “the term reproductive exile proposed by Prof. Matorras is interesting but over emphasises the opposite position: People are sent or forced into exile as a form of punishment. While this could be correct it depends on the interpretation. I propose to replace term reproductive tourism by cross border reproductive care and I feel it avoids the negative connotations of tourism.” Thus it seems quite clear that the whole terminology of medical tourism has a question mark to it. I believe that tourism is a derogatory term when used in medical context. The origin of term medical tourism was used when people went on a vacation to exotic places and took advantage of the opportunity to obtain some medical treatment. Tourism was their primary motive. However, this clearly has changed in recent years. Travelling is now mainly motivated by medical treatment; the exotic and recreational aspect is thrown in as a nice extra. Hence just cross border health care should be used as pointed out by commission on European communities (2004).
3. FACTORS LEADING TO EMERGENCE OF MEDICAL TOURISM

Health care is one of the most rapidly growing markets in the world. As we already know that pharmaceutical market has cast a different image on the global level and same trend is now being followed by the medical tourism. ‘In 2006 medical industry grossed about $60 billion worldwide. Mckinsey and Company estimates this total will rise to $100 billion by 2012 and Indian medical tourism alone will grow to $2.3 billion by 2012’ (Herrick, 2007).

Several theoretical explanations have been put forth to explain the conceptual framework of medical tourism. One of the mostly widely accepted theories is the push and pull factor theory. The pull and push factor concept was introduced by Dann in 1977 in tourism and same is now used in medical tourism. Push is the reason to travel while pull is the attraction of the destination (Doshi, 2008). Medical tourism has grown dramatically in recent years primarily because of the high costs of treatment in developed western countries especially America, long waiting lists, the relative affordability of international air travel and favourable economic exchange rates. It has been argued that the most important reason why patients travel across borders for getting treated is the financial one. In a recent nationwide survey in America, the willingness of patients to travel abroad for medical care because of financial reasons has been found out.

- The survey revealed following facts:
- Almost no one would travel a great distance to save $200 or less.
- Fewer than 10% will travel to save $500 or $1000.
- About one quarter of uninsured people, but only 10% of those with health insurance, would travel abroad for care if the savings amounted to $1,000 to $2,400.
For savings exceeding $10,000 about 38% of the uninsured and one quarter of those with insurance would travel abroad for care (Arnold et al, 2007 cited in Herrick, 2007).

The cost factor is a big push factor for so many of the patients that make them to travel to third world countries from the first world one.

(Cited in Herrick, 2007)

From the data above it is clear that India is one of the favourable destination for medical tourism because of the low cost of medical procedures here. The other factor that leads to patients to travel to other countries for medical is the legal factor. Many of the patients do not have access to a particular treatment in their own countries. Many patients from Germany, France or the Netherlands, whose governments impose various restrictions on invitro fertilisation treatments visit to other countries for the same. Every year 7,000 women from Ireland travel to England for abortions because abortion is illegal in Ireland.
(cortez, 2008). Also it is found out that certain procedures may be unavailable in some countries that lack the requisite medical technology expertise or infrastructure e.g. patients from Bolivia, Peru and Ecuador travel to Chile for its superior medical care and similarly patients from Bangladesh come to India for medical care. Thus variations in medical sophistication between countries can encourage medical tourism. It is worthwhile to mention that each medical tourism destination has been found to be favoured by specific group of patients. India as a medical destination has been found to attract patients needing cardiac surgery and angioplasty and Thailand attracts mostly patients needing knee replacement. India also has an added advantage over its rivals Singapore and Thailand as English is widely spoken in India. Long waiting lists are also to enhance medical tourism. It has been argued that in countries where patients have to wait for several months in order to get their surgery done, preferably travel outside to get the treatment. Countries like Canada, Britain were private practice is not allowed have long waiting lists. It has also been found out that even Britain health system makes arrangement for their patients to get treatment in other countries so that rush can be avoided.

Some patients particularly, those undergoing plastic surgery, sex-change procedures, and drug rehabilitation, choose to go to medical tourism destinations because they are more confident that their privacy and confidentiality will be protected in a faraway setting (Horowitz, 2007).

The recent trends that facilitate medical tourism; four broad trends have allowed developing countries to meet the increasing demand by foreign patients. First these countries have dramatically improved the quality of care they can offer, and have become increasingly adept at marketing there services. Second trend is the use of internet by patients, providers and intermediaries. It helps the providers to signal their quality. Third trend is the privatisation of health care sector in developing countries. In developing countries public health entities are gradually reducing their health spending and selling their health care enterprise. Most countries have realised that they need foreign direct investment to modernise their health care infrastructure. India Nepal, Maldives and Thailand have opened their market to foreign investors. Investors are interested because of high rates of return. Public sector spending accounts for less than a quarter of the total health spending in India. Public spending (i.e. expenditure incurred) by the health departments of central and state governments on health gradually accelerated from 0.22% in 1950-51 to 1.05% during the mid-1980’s and stagnated at around 0.9% of the GDP during later years. Thus as countries privatise health care they encourage local hospitals and providers to attract lucrative foreign patients. Fourth trend that aids medical tourism is the globalisation of related industries in health care. Health care is one of the most rapidly growing markets in the world. The rapid growth of other sectors like pharmaceutical, medical technology indirectly aids the medical tourism to a large extent. The global pharmaceutical market has grown between 11-18 % since 2004 in developing countries in Africa, Asia and Latin America (IMS ,2006 cited in (cortez, 2008). The global hospital industry also facilitates medical tourism by creating
international hospital chains, joint ventures are established. The Apollo hospitals group has plans to build hospitals in Nepal, Sri Lanka and Maldives (Chandra, 2007). Also the corporate hospitals in developing world have affiliations with the research institutes in the western countries like wockhardt hospital in India is affiliated with Harvard medical school.

4. REASONS FOR LOW PRICES IN DEVELOPING COUNTRIES LIKE INDIA

It is now clear that one of the prime causes for travel of patients across borders for medical care is the financial one. Therefore it is compulsory to know out what are the drivers that make these developing countries possible to keep their prices low comparatively. Some of the justifications put forth for this are as follows:

**Labour costs:** this is one of the most important factors that determine the cost of the medical procedures. On an average, labour costs equal more than half of hospital operating revenue. Wage rates and other labour costs are very low in developing countries. For example in at Fortis hospital in India; Doctors earn 40% less than comparable physician in USA, Median nurses salaries are one fifth to one twentieth of those in United States, wages of skilled and semiskilled labour like orderlies is far less. (Bruce, 2007).

**Out of pocket spending:** The countries where out of pocket spending is more, leads patients to shop like consumers, and hence making market competitive. This further leads to decrease in prices. When patients control more of their own health care spending, providers are more likely to compete for patients based on price. Consequently these countries have more private health care market (cortez, 2008).

**Limited Malpractice Liability:** malpractice costs are lower in developing countries as compared to United States. While American physician in some specialities pay more than $100,000 annually for a liability insurance policy, a physician in Thailand spends about $5,000 per year (Roth, 2006).

![Private Out-of-Pocket Spending on Health Care](image-url)
5. CONCERN FOR DEVELOPING COUNTRIES LIKE INDIA

India being a home to 1.2 billion deserves special attention at present when health care market is globalised. More over the fact of the matter is that India according to world health organisation has the burden of most disease of the world and highest number of infant and maternal mortality in the world. Apart from it the Indian case is more important in the sense that it has one of the world’s largest privatised health sectors even though its population living below poverty line is huge with estimates suggesting around 70%. If speciality corporate hospitals are established using public funds and subsidies, this would divert resources from the public health system and could lead to a two tired health system with a corporate segment and public sector segment. The former concentrating on high level technology and services which do not address broader health needs of the population. Apart from it the worst impact will be in the form of internal brain drain. The better qualified and experienced health professionals will flow from the public sector to the corporate sector with its better pay and superior infrastructure. Also it may even form a sort of association where in the public sector famous health professionals will serve the corporate sector as part time professionals there by further leading the weakening of the public sector as such. “Medical tourism may also cause ‘cream skimming”, where by those who need less but can pay more are served at the expense of the poor and more deserving (Janjaroen et al, 2000 cited in chanda, 2002).

Even though it is argued that medical tourism has lead to coming back of professionals from the western world in their own countries especially in the case of India. But this hardly is going to have some substantial effect on the Indian weak public health system. The concern is also graver regarding the orientation of medical education in India. The immense growth of medical tourism will lead to more focus on post-graduation speciality. As already we are witnessing that most of our medical graduates are going to super specialities, because of lucrative market offers as provided by private sector. Thus in a sense the whole notion of community serving gets eroded away. This effect has already been visible in India as we are facing human resources constraint in primary health care and that too in rural areas. What now the government is doing is just either to make some years or rural service compulsory or they are introducing new course of three years known as Bachelor of rural health services. Is that a solution to this problem only time will tell? The unfortunate episode of the whole phenomenon is that we have been providing health professionals and serving the western world for decades and now when these professionals come back they again serve the same at home. What a tragedy for our poor population who have been waiting since independence for a new sun to rise with easy available public health facilities.

6. CONCLUSION

The phenomenon of medical tourism is trying to gain new heights and scholars are making projections regarding the market value of the medical tourism. It is being projected that by 2012 the market value of medical tourism industry will be around 100 billion US dollars.
Already we know the fallouts of the liberalisation agenda which lead to increase in the privatisation at the cost of public sector. Increase in poverty, widening gap of inequalities, decreasing health status all are the consequences that developing world is facing because of liberalisation agenda. My doubt here is that as medical tourism will continue to grow under the invisible patronage of state, primary health care will meet the most unfortunate tragedy. Since medical tourism will let more and more focus to be delivered towards the tertiary care and hence development of super speciality hospitals. There by the inherent neglect of the primary level care and nothing has to be mentioned about the promotive level health service. Developing countries like India have mostly burden of infectious diseases and most of the population are poverty ridden, therefore what medical tourism is going to offer them is big question in itself. India as we see has one of the largest deaths because of maternal mortality and how that is going to be addressed by medical tourism is worth to be seen. I argue that private sector can nerve be a successful option for providing primary level health care to the vast number of population. This so because the inherent nature or motive behind the private sector is profit making. Thus as our public health system weakens there seems to be no option that our health indicators will improve. More over as has been noticed that associated with health are other factors like housing, water supply, sanitation, food security, hunger and under nutrition and so on. How medical tourism is going to affect all these sectors is an issue that time will make us realise. Profounder of medical tourism argue that medical tourism will lead to growth of employee opportunities in various sectors like tourism hotel industry, transport and so on and thereby increasing income level of populations. But we must have a look at the history of these arguments which run in the trickledown theory, which through the times have been found to be theoretical only and has never possibly happen so. India ranks 171 out of 175 countries in percentage of GDP spent in public sector and stands at 17th in private sector spending (Singh et al, 2005).Thus it is very prerequisite for India to increase public health spending in order to make health status better of its poverty ridden and starved millions. I would also like to throw up some of the issues which medical tourism as a phenomenon rises with itself:

- Does medical tourism improve access to care or does it magnify the income disparities in our health system?
- Should we allow those who not being citizens to buy their health care out of our health system, when our own population is in dire need of medical care?
- How far is it justifiable to exclude local population from the benefits of the care that is being provided in their country to rich strangers even if it allows develop employment in health care sector

7. REFERENCES


