

NUFFIELD
COUNCIL^{ON}
BIOETHICS

BACKGROUND PAPER

Medical Tourism and Cross-border Care

*Dr Dominique McMahon, Munk School of Global Affairs,
University of Toronto*

**Forward Look
7-8 May 2013**

Note

The author was commissioned by the Nuffield Council on Bioethics to write this paper in order to inform the Council's discussions about possible future work on this topic. The paper is intended to provide an overview of key clinical, ethical, social, legal and policy issues, but is not intended to offer any conclusions or recommendations regarding future policy and practice. Any views expressed in the paper are the author's own and not those of the Nuffield Council on Bioethics.

**Nuffield Council on Bioethics
Forward Look
7-8 May 2013**

**Medical Tourism and Cross-border Care
Background paper**

**Dr Dominique McMahon, Munk School of Global Affairs,
University of Toronto**

Summary

1. This paper presents an overview of medical tourism and cross-border care, and outlines the major ethical and policy issues these activities present.

Background

Defining medical tourism and cross-border care

2. Medical tourism and cross-border care are defined as the movement of patients across national boundaries for the expressed purpose of seeking out medical care. While these terms and others are, at times, used interchangeably,¹ they are often distinguishable. Medical tourism here refers to medical care sought by individuals and accessed through their own volition, even without or against the recommendation of their local health care provider. Care is typically paid out of pocket, and is in some cases combined with additional leisure or culture-related activities. Cross-border care instead refers to care that is facilitated or referred by a local health provider or institution, often by pre-established arrangements or agreements.² Cross-border care is typically sought in countries within the same region, and is often reimbursable or paid directly by the responsible party. This would include, for example, patients accessing care within EU countries through their rights as EU citizens, agreements to outsource

¹ Pennings G, De Wert G, Shenfield F *et al.* (2008) ESHRE task force on ethics and law 15: cross-border reproductive care *Human Reproduction* **23(10)**: 2182-4; Samir N, and Karim S (2011) An Insight: Medical Tourism, Local and International Perspective *Oman Medical Journal* **26(4)**: 215-8; Smith K (2012) The problematization of medical tourism: a critique of neoliberalism *Developing World Bioethics* **12(1)**: 1-8.

² Lunt N, and Carrera P (2010) Medical tourism: assessing the evidence on treatment abroad *Maturitas* **66(1)**: 27-32; Lunt N, Smith R, Exworthy M *et al.* (2011) *Medical tourism: treatments, markets and health system implications - a scoping review*, available at: <http://www.oecd.org/els/health-systems/internationaltradeinhealthservices.htm>; Snyder J, Dharamsi S, and Crooks VA (2011) Fly-by medical care: conceptualizing the global and local social responsibilities of medical tourists and physician voluntourists *Globalization and Health* **7**: 6; Johnston R, Crooks VA, and Snyder J (2012) "I didn't even know what I was looking for": a qualitative study of the decision-making processes of Canadian medical tourists *Global Health* **8(1)**: 23.

public UK orthopaedic patients to France, Germany and Belgium, or cross-border insurance contracts between the US and Mexico.³

3. The term medical tourism is used here due to its extensive use in the literature, despite criticism by some authors that it is inappropriate and dismissive of the suffering endured by patients seeking care abroad, particularly as much medical tourism does not include the leisure elements implied by the term.⁴ Solely for the purpose of simplicity, both medical tourism and cross-border care are referred to herein as medical travel.⁵

Size and characteristics of medical travel

4. Advances in transportation, rapid information exchange and globalisation have facilitated the global movement of patients seeking medical treatment options outside of their own countries. Medical travel has quickly transformed medical services into an internationally tradable commodity, with many countries vying for a share of the growing industry. Trade agreements, including the General Agreement of Trade in Services (GATS), may further liberalise the international trade of medical services.⁶
5. Cross-border care is an important and growing activity between neighbouring countries and countries within the same region, including within the EU. In addition to specific bilateral agreements and referrals between specific countries or facilities, citizens within the EU have the right to access medical care from any country within the region, according to Regulation 883/2004 (previously Regulation 1408/71).⁷ Originally for

³ Glinos IA, Baeten R, Helble M, and Maarse H (2010) A typology of cross-border patient mobility *Health & place* **16**: 1145-55.

⁴ Whittaker A (2008) Pleasure and pain: medical travel in Asia *Global Public Health* **3(3)**: 271-90; Kangas B (2010) Traveling for medical care in a global world *Medical Anthropology* **29(4)**: 344-62; Snyder J, Dharamsi S, and Crooks VA (2011) Fly-by medical care: conceptualizing the global and local social responsibilities of medical tourists and physician voluntourists *Globalization and Health* **7**: 6; Smith K (2012) The problematization of medical tourism: a critique of neoliberalism *Developing world bioethics* **12**: 1-8.

⁵ The terms medical travel, medical tourism and cross-border care have been used for a variety of practices not included here, including the movement of physicians across borders (unless to accompany a medical tourist) and the out-servicing of secondary medical services such as medical scan interpretation, telehealth services, diagnosis, consultation, and medical transcription. Those who are out of country for holiday or work may seek medical care for emergencies or convenience but are not included in our definition, nor are refugees or long-term residents within the medical destination country. The cross-border purchase of pharmaceuticals, medical equipment and supplies is not included here, nor are "health tourism" services including health, wellness and alternative medicine provided outside of medical clinics and hospitals. While fraudulent access of care abroad to avoid payment does fall under our definition and presents unique ethical and policy issues, it is not a focus of our discussion.

⁶ Timmermans K (2003) Developing countries and trade in health services: which way is forward? *International Journal of Health Services* **34(3)**: 453-66.

⁷ Busse R (2002) Border-crossing patients in the EU *Eurohealth* **8**: 9-11.

emergency or prior authorised care, the 1998 Kohll and Decker rulings broadened access to any medically necessary care, arguing that consumer choice would be otherwise unfairly restricted.⁸ The EU Directive on Cross-border Health care further clarifies the right to cross-border care within the EU.⁹

6. Empirical data on the size of the medical travel industry and the number of travellers are scarce and estimates vary significantly; however, most seem to agree that it is a large and growing. One estimate places the industry as worth 60 billion US dollars and growing at 20 per cent per annum.¹⁰ The number of tourists globally has been much disputed – ranging from 50 million to only 60,000 per year, although some consider the latter to be unrealistically low.¹¹ It is estimated from the UK's *International passenger survey* that around 100,000 residents leave the UK per year for medical treatment,¹² with 52,000 foreigners seeking treatment in the UK.¹³ While estimates again conflict, medical tourism is generally reported to generate about two billion US dollars annual in revenue in India. Thailand is reported to have received 1.25 million medical tourists, generating 860 million US dollars in 2005, and some hospitals in Singapore are reported to make 40 per cent of their revenue from foreign patients.¹⁴ While the medical tourism literature has focused largely on patient movement from high to lower income countries, important movements also occur between developed countries, between developing countries, and from low to high-income countries. Popular destinations for medical travellers depend on the

⁸ Busse R (2002) Border-crossing patients in the EU *Eurohealth* **8**: 9-11; Suñol R, Garel P, and Jacquerye A (2009) Cross-border care and health care quality improvement in Europe: the MARQuIS research project *Quality and Safety in Health Care* **18 (supplement 1)**: i3-i7.

⁹ For example, the directive requires cross-border care to be reimbursed up to the amount that would have been assumed had care been sought in the home country, and allows home country states to implement prior authorization systems to manage patient outflows and to pay for cross-border health services directly. A summary of the provisions within the directive with links to the directive is available at:

http://www.consilium.europa.eu/uedocs/cms_data/docs/pressdata/en/lisa/119514.pdf

¹⁰ MacReady N (2007) Developing countries court medical tourists *The Lancet* **369(9576)**: 1849-50.

¹¹ Youngman, I (2009) Medical tourism statistics: why McKinsey has got it wrong, available at: <http://www.imtjonline.com/articles/2009/mckinsey-wrong-medical-travel/>; Lunt N, Smith R, Exworthy M *et al.* (2011) *Medical tourism: treatments, markets and health system implications - a scoping review*, available at: <http://www.oecd.org/els/health-systems/internationaltradeinhealthservices.htm>.

¹² Youngman, I (2009) *Medical tourism statistics: why McKinsey has got it wrong*, available at: <http://www.imtjonline.com/articles/2009/mckinsey-wrong-medical-travel/>.

¹³ Lunt NT, Mannion R, and Exworthy M (2013) A framework for exploring the policy implications of UK medical tourism and international patient flows *Social Policy & Administration* **47(1)**: 1-25.

¹⁴ Chen H-C, Kuo H-C, Chung K-P *et al.* (2010) Classification and comparison of niche services for developing strategy of medical tourism in Asian countries *International surgery* **95(2)**: 108-16.

treatment sought, the patient's home country and on pre-established agreements.¹⁵

7. The quality of care and facilities available to medical travellers is highly variable and can be difficult to evaluate prior to departure. Patients may consider reputation of the facility, physician qualifications, and patient testimonials.¹⁶ Some facilities may have international accreditation assuring a high standard of care, such as the Joint Commission International (JCI). According to their website, JCI currently has accredited hospitals in 50 countries. Patients may also rely on the services of a medical travel agency to recommend facilities or make care and travel arrangements. One broker site alone lists 1,078 medical tourism facilities and 270 medical tourism agencies that provide "full service" from around the world, as of March 2013.¹⁷

Types of medical travel

8. Medical tourism and cross-border care encompasses an extensive range of medical procedures, each facing unique motivations and risks.
9. Standard medical care sought abroad includes heart surgery, joint surgeries, eye surgery and hip replacements, among others. Lower cost may be an important motivator for the uninsured or underinsured in private health care systems, whereas patients with access to public health care may be motivated by shorter waiting times.
10. Elective treatments, which may include cosmetic surgeries, liposuction, dental work, gender reassignment and bariatric surgery seem primarily motivated by lower cost, as well as the greater anonymity travelling abroad allows. Due to its more elective nature, this category may be more influenced by combined 'tourism' packages such as 'surgery and safari' packages promoted in South Africa and 'sun and surgery' packages offered in Cuba.¹⁸
11. Some medical travellers pursue specialised treatments abroad that are not available or illegal at home, or to which their access is restricted. These

¹⁵ More information on patient mobility trends is available in: Glinos IA, Baeten R, Helble M, and Maarse H (2010) A typology of cross-border patient mobility *Health & Place* **16(6)**: 1145-55.

¹⁶ Johnston R, Crooks VA, and Snyder J (2012) "I didn't even know what I was looking for": a qualitative study of the decision-making processes of Canadian medical tourists *Global Health* **8(1)**: 23.

¹⁷ Based on information from OnlineMedicalTourism (2013) *OnlineMedicalTourism homepage*, available at: <http://www.onlinemedicaltourism.com/>.

¹⁸ Turner L (2010) "Medical tourism" and the global marketplace in health services: US patients, international hospitals, and the search for affordable health care *International Journal of Health Services* **40(3)**: 443-67; Smith K (2012) The problematization of medical tourism: a critique of neoliberalism *Developing World Bioethics* **12(1)**: 1-8.

treatments may be allowed abroad, such as surrogacy, assisted reproductive treatment, abortion, or medically assisted suicide. Unproven treatments represent a high-risk category of medical travel, and include stem cell treatments for a wide variety of conditions and venoplasty for multiple sclerosis (MS). Patients willingly purchase treatments with little or no evidence of safety or efficacy, driven by hopes of improvements beyond what their local doctors have been able to provide. These treatments are usually unregulated or illegal in the destination country and may occur wherever regulation is insufficient to restrict their activity. Treatments that are illegal in both home and destination countries, including organ trafficking,¹⁹ carry additional legal and health risks attributable to operating outside of regulated and monitored medical care.

Risk for patients

12. Medical travellers may encounter a number of physical, emotional and financial risks during and after their care abroad. Travel itself can be risky for sick individuals. Doctors may not be familiar with the patient's full medical history, and records may be difficult to transfer between countries. Cultural and language differences can impair patients' understanding of their care, and patients have limited support from friends and family while abroad. There is also little legal recourse for patients, and patients may be challenged to find quality care if they encounter health complications in low-resource countries. Contact with the clinic or physicians may be difficult afterwards and patients may encounter challenges accessing follow-up care at home, particularly for illegal or unproven treatments. Those attempting to bring a child back from surrogacy or birth abroad may face unique complications, including obtaining parental and citizenship rights.²⁰
13. There are no authoritative numbers on clinical outcomes or recovery rates for medical travellers. The quality of facilities varies enormously, and while complications are a major concern everywhere, they do seem high in medical travellers – a survey found 37 per cent of respondents at the British Association of Plastic, Reconstructive and Aesthetic Surgeons had seen patients with complications from cosmetic surgery abroad,²¹ and Turner identified 26 cases of death following cosmetic and bariatric surgery abroad reported in the news media, over half of which occurred in Mexico and the

¹⁹ Danovitch G, Shapiro M, and Lavee J (2011) The use of executed prisoners as a source of organ transplants in China must stop *American Journal of Transplantation* **11**(3): 426-8.

²⁰ Crozier G, and Martin D (2012) How to address the ethics of reproductive travel to developing countries: a comparison of national self-sufficiency and regulated market approaches *Developing World Bioethics* **12**(1): 45-54.

²¹ Jeevan R, Birch J, and Armstrong A (2011) Travelling abroad for aesthetic surgery: Informing health care practitioners and providers while improving patient safety *Journal of Plastic, Reconstructive & Aesthetic Surgery* **64**(2): 143-7.

Dominican Republic.²² Serious complications and deaths have also been reported for medical tourists of stem cell treatments and organ transplants.²³

Major policy and ethical challenges

14. Medical tourism and cross-border care are not new, but their rapid growth and the diversity of ensuing ethical and policy challenges has made them a topic of immediate importance. As medical travel grows, its impact on both economic and health systems is increasingly felt, yet it remains unclear if the net impact will be positive or negative for either the patients or the societies with which they interact. The ethical and policy issues related to medical tourism at both the individual and systems levels are discussed below. Additional issues related to particular types of medical tourism and challenges to regulation are also presented. Intertwined with these issues are fundamental questions of how to maximise benefits, minimise harm, and create greater distributive justice across inherent inequalities of health and wealth.

Challenges for patients and doctors

15. Giving greater freedom to individuals to choose care abroad may increase their access to better options, potentially decreasing inequities between systems. However, a lack of suitable options at home compared to elsewhere may be what drives patients abroad in the first place, and only some will have the means to travel. Individuals of compromised health may go to great lengths to obtain care they feel they need; vulnerable patients are at risk of exploitation from groups selling unrealistic expectations or poor quality treatments. Ensuring patients have good information and access to suitable care is important to ensure patient autonomy, informed consent, and social justice. Little is known, however, about how patients process information and formulate decisions, and what is available in the literature is largely speculative.²⁴

²² Turner L (2012) News media reports of patient deaths following 'medical tourism' for cosmetic surgery and bariatric surgery *Developing World Bioethics* **12(1)**: 21-34.

²³ Dobkin BH, Curt A, and Guest J (2006) Cellular transplants in China: observational study from the largest human experiment in chronic spinal cord injury *Neurorehabilitation and Neural Repair* **20**: 5-13; Gill J, Madhira BR, Gjertson D *et al.* (2008) Transplant tourism in the United States: a single-center experience *Clinical Journal of the American Society of Nephrology* **3(6)**: 1820-8; Thirabanjasak D, Tantiwongse K, and Thorner PS (2010) Angiomyeloproliferative lesions following autologous stem cell therapy *Journal of the American Society of Nephrology* **21(7)**: 1218-22; The Telegraph (8 May 2011) *Europe's largest stem cell clinic shut down after death of baby*, available at: <http://www.telegraph.co.uk/news/worldnews/europe/germany/8500233/Europes-largest-stem-cell-clinic-shut-down-after-death-of-baby.html>.

²⁴ Crooks V, Kingsbury P, Snyder J, and Johnston R (2010) What is known about the patient's experience of medical tourism? A scoping review *BMC Health Services Research* **10(1)**: 266;

16. Patients themselves may have a moral and social responsibility to promote the welfare of communities in which they interact, including where they receive medical care.²⁵ However, evidence suggests medical tourists are largely unaware of how their travel could contribute to local health inequities,²⁶ suggesting there is room to explore the role patients could play in supporting responsible medical tourism practices.
17. Home-country physicians may be consulted by those considering medical care abroad, but may be largely unprepared to advise patients if they have insufficient information on the quality of care provided, or are unfamiliar with the medical procedures being sought. It may be unclear what responsibility or obligations physicians have, both professionally and morally, to advise patients considering options abroad. For example, legal scholars have shown that Canadian physicians may have a professional responsibility and a legal obligation to protect children whose parents intend to take them abroad for risky stem cell treatments.²⁷
18. Continuity of care is a major issue in medicine generally, and a critical issue for medical travel. Physicians may lack adequate information about the care received abroad, and may be hesitant to treat patients who have received treatments they are unfamiliar with or that were obtained unethically. Health professionals are required to provide follow up medical care in emergencies, but it may be unclear how their duties extend beyond this. Medical tourists may request specific drugs, tests, or procedures they believe necessary for their care, but that do not adhere to accepted medical practice at home. Physicians may benefit from policies that clarify these obligations. The UK Department of Health instructed cosmetic surgeons not to undertake elective revisions on foreign-treated patients,²⁸ and some US

Johnston R, Crooks VA, and Snyder J (2012) "I didn't even know what I was looking for": a qualitative study of the decision-making processes of Canadian medical tourists *Global Health* **8(1)**: 23; Lunt NT, Mannion R, and Exworthy M (2013) A framework for exploring the policy implications of UK medical tourism and international patient flows *Social Policy & Administration* **47(1)**: 1-25.

²⁵ Snyder J, Dharamsi S, and Crooks VA (2011) Fly-by medical care: conceptualizing the global and local social responsibilities of medical tourists and physician voluntourists *Globalization and Health* **7**: 6.

²⁶ Johnston R, Crooks VA, and Snyder J (2012) "I didn't even know what I was looking for": a qualitative study of the decision-making processes of Canadian medical tourists *Global Health* **8(1)**: 23.

²⁷ Zarzeczny A, and Caulfield T (2010) Stem cell tourism and doctors' duties to minors - a view from Canada *The American Journal of Bioethics* **10(5)**: 3-15.

²⁸ Jeevan R, Birch J, and Armstrong A (2011) Travelling abroad for aesthetic surgery: Informing health care practitioners and providers while improving patient safety *Journal of Plastic, Reconstructive & Aesthetic Surgery* **64**: 143-7.

programs have refused follow-up to patients who have gone to China for illegal organ transplants.²⁹

19. Physicians in destination countries are also challenged to act in the best interest of patients. They may not be well positioned to know if patients are fully informed and prepared to make decisions for major procedures such as gender reassignment or assisted suicide, given the brevity of their interaction with the patient.

The economic impact of medical travel

20. Medical tourism and cross-border care present opportunities for unprecedented levels of trade within the medical sector, with significant financial benefits and challenges for the countries involved.³⁰ The revenue generated from medical travellers in destination countries is an important economic incentive for institutions, health systems and governments to pursue these activities. Revenue could stimulate economic development, make medical services more financially viable, and allow infrastructure improvements. Medical travel can create savings for public spending at home, and outsourcing patients through cross-border care arrangements may lead to more efficient use of limited resources, shorter waiting times and greater health care coverage. Countries may develop niche competencies and increase quality of specialised care.³¹
21. However, medical travel is not always less costly for home-countries. Cross-border care in the EU could decrease the ability of national authorities to regulate rates and spending, and could increase overall costs.³² Health complications from medical travel and the introduction of new diseases can compromise care and present additional costs to home systems.³³ It may also be 'unfair' for public health systems to bear the cost of health complications resulting from an individual's choice to pursue options outside of that same system. In Germany, co-payments are required for treatments that result from "non-medically indicated measure

²⁹ Schiano TD, and Rhodes R (2010) Transplant tourism *Current Opinion in Organ Transplantation* **15**: 245-8.

³⁰ Lunt NT, Mannion R, and Exworthy M (2013) A framework for exploring the policy implications of UK medical tourism and international patient flows *Social Policy & Administration* **47(1)**: 1-25.

³¹ Salzer-Muhar U, Pollak A, Aufricht C, Ehrich J, and Lenton S (2012) European challenges: cross-border care for children *Journal of Pediatrics* **161(3)**: 574-6.

³² Suñol R, Garel P, and Jacquerye A (2009) Cross-border care and health care quality improvement in Europe: the MARQuIS research project *Quality and Safety in Health Care* **18 (supplement 1)**: i3-i7.

³³ Kumarasamy KK, Toleman MA, Walsh TR *et al.* (2010) Emergence of a new antibiotic resistance mechanism in India, Pakistan, and the UK: a molecular, biological, and epidemiological study *The Lancet Infectious Diseases* **10(9)**: 597-602; Hall CM, and James M (2011) Medical tourism: emerging biosecurity and nosocomial issues *Tourism Review* **66(1-2)**: 118-26.

such as cosmetic surgery”, shifting responsibility for some costs back to the patient.³⁴

Access and equity challenges

22. There is substantial concern that medical tourism and cross-border care could contribute to health inequities within the involved countries. Health care is recognised internationally as a human right,³⁵ and as a legal and social right in many countries; its suitability as an exportable commodity should be questioned, particularly when local demand remains unmet.
23. Medical travel can be seen as both contributing to and compromising health equity and sustainability of the health systems of patients’ home countries. Cross-border care can create more equitable options for individuals, but the large movement of patients outside of their home system for medical care can also be construed as indicative of a larger-scale failure of domestic systems to address patients’ needs. Medical travel may further undermine equitable access at home by relieving physical and political pressure for systemic improvements.³⁶
24. Some countries may use medical travel directly to create more equitable access for others – such as neighbouring countries providing Zimbabweans with free medical care following the collapse of Zimbabwe’s health system.³⁷ Revenue generated from medical travel could be used by destination countries to subsidise care for the less fortunate as well, particularly in developing countries. Cuba, for example, has used its popular state-owned chain of medical tourism hospitals to generate revenue for public health care.³⁸ However, revenue from medical travel for many organisations could create dependency on foreign income. Furthermore, economic gains remitted to foreign owners or investors will have limited positive externalities domestically.³⁹ It is also hard to ensure positive social impacts from profit-driven health care providers. For example, Apollo

³⁴ Snyder J, Dharamsi S, and Crooks VA (2011) Fly-by medical care: conceptualizing the global and local social responsibilities of medical tourists and physician voluntourists *Globalization and Health* **7**: 6.

³⁵ According to the WHO Constitution, “the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being...” See: World Health Organization (2013) *Health and human rights*, available at: <http://www.who.int/hhr/en/>.

³⁶ Snyder J, Dharamsi S, and Crooks VA (2011) Fly-by medical care: conceptualizing the global and local social responsibilities of medical tourists and physician voluntourists *Globalization and Health* **7**: 6.

³⁷ Borman E (2004) Health tourism: where health care, ethics, and the state collide *BMJ* **328(7431)**: 60-1; Glinos IA, Baeten R, Helble M, and Maarse H (2010) A typology of cross-border patient mobility *Health & place* **16(6)**: 1145-55.

³⁸ Youngers C, Cameron M, and Mailman T (1997) Health tourism booms in Cuba *NACLA Report on the Americas* **30**: 46-8.

³⁹ Pocock NS, and Phua KH (2011) Medical tourism and policy implications for health systems: a conceptual framework from a comparative study of Thailand, Singapore and Malaysia *Globalization and Health* **7(1)**: 1-12.

Hospitals in India committed hundreds of beds for the free care of India's under-privileged in exchange for Government-subsidised land, but poor oversight has allowed these beds to remain empty.⁴⁰ Medical tourism can shift available resources towards the care of foreigners instead of local patients, increase privatisation, and result in longer waiting times or costlier service for the poor. Medical travel may encourage the development of high-quality medical establishments and help retain medical physicians and specialists from leaving the country – only to then focus on the needs of foreigners.⁴¹ The needs of foreigners may be prioritised over that of locals, shifting resources from preventable public health initiatives towards the development of more expensive clinical interventions that are inappropriate for low-income clients.⁴²

25. The challenges to equitable access to medical care are potentially exacerbated in developing countries, where many are unable to access basic care and essential affordable drugs,⁴³ and where social, economic, and regional geographic inequalities are high.⁴⁴ There is considerable debate within the literature as to the overall benefit or harm to developing countries incurred by medical tourism, but there is little empirical evidence on either side. Developing countries can offer quality care at lower costs, giving them a global advantage to make desperately needed economic gains. However, many find discomfort in medical travel “lauding itself in developing countries as a saviour to foundering local public health systems and a driver for the economic development of their nations”.⁴⁵ The stark reality that medical care has failed to meet the basic needs of its population should call into question the appropriateness of luxury care establishments built to cater to the wealthy, and should question their ability to address growing health inequities in the developing world.

⁴⁰ CBC News (18 June 2004) *Medical tourism: need surgery, will travel*, available at: http://www.cbc.ca/news/background/health_care/medicaltourism2.html; The Times of India (6 July 2011) *Poor mocked as free beds go vacant*, available at: http://articles.timesofindia.indiatimes.com/2011-07-06/delhi/29742742_1_private-hospitals-poor-patients-free-beds.

⁴¹ Pocock NS, and Phua KH (2011) Medical tourism and policy implications for health systems: a conceptual framework from a comparative study of Thailand, Singapore and Malaysia *Globalization and Health* **7(1)**: 1-12.

⁴² De Arellano ABR (2007) Patients without borders: the emergence of medical tourism *International Journal of Health Services* **37(1)**: 193-8; Snyder J, Dharamsi S, and Crooks VA (2011) Fly-by medical care: conceptualizing the global and local social responsibilities of medical tourists and physician voluntourists *Globalization and Health* **7**: 6.

⁴³ United Nations (2012) Millennium Development Goal 8 The Global Partnership for Development: Making Rhetoric a Reality *MDG Gap Task Force Report 2012*, United Nations Publication, New York.

⁴⁴ See for example: The World Bank Data :Gini Coefficients, available at: <http://data.worldbank.org/indicator/SI.POV.GINI>

⁴⁵ Smith K (2012) The problematization of medical tourism: a critique of neoliberalism *Developing World Bioethics* **12(1)**: 1-8.

Challenges associated with particular activities

26. Ethical and policy issues will differ between cross-border care and medical tourism, and between the types of medical travel. We briefly highlight a few issues related to particular travel types, recognising these and other forms of medical travel may warrant a more detailed discussion than permitted by the scope of this paper.
27. Medical travel that circumvents domestic regulation could compromise or corrupt domestic values, and could be construed as civil disobedience.⁴⁶ However, it may also act as a 'safety-valve' that allows individual freedom for individual differences without demanding extensive policy change,⁴⁷ if these activities are legal abroad. Activities that are not allowed in either country are more ethically and legally problematic; organ tourism, in particular, has generated international concern. Patients who 'queue-jump' by sourcing organs abroad unjustly deepen organ shortages in the destination country, and the use of financial incentives to 'purchase' organs, often from vulnerable and poor populations, is economically exploitative. In China, new regulations require donor consent for organs and prohibit transplantation to foreigners, but organ trafficking, organ tourism and the harvest of organs from political prisoners are still reported.⁴⁸
28. Coercion and economic exploitation are ethical concerns also associated with reproductive assistance abroad. Surrogates may be subject to fraudulent contracts, lack legal recourse, and may suffer a number of physical and physiological risks, including social-stigmatisation by their communities.⁴⁹ Some commentators believe that these activities are none-the-less justifiable where surrogates benefit economically from their participation, and call for regulation to better protect surrogates and donors.⁵⁰
29. The sale of unproven treatments to desperate patients represents one of the newest ethical and regulatory issues facing medical tourism. Unproven treatments may represent the only option known to vulnerable patients,

⁴⁶ Pennings G, De Wert G, Shenfield F *et al.* (2008) ESHRE task force on ethics and law 15: cross-border reproductive care *Human Reproduction* **23(10)**: 2182-4.

⁴⁷ Pennings G, De Wert G, Shenfield F *et al.* (2008) ESHRE task force on ethics and law 15: cross-border reproductive care *Human Reproduction* **23(10)**: 2182-4.

⁴⁸ Schiano TD, and Rhodes R (2010) Transplant tourism *Current Opinion in Organ Transplantation* **15**: 245-8; Danovitch G, Shapiro M, and Lavee J (2011) The use of executed prisoners as a source of organ transplants in China must stop *American Journal of Transplantation* **11(3)**: 426-8.

⁴⁹ Crozier G, and Martin D (2012) How to address the ethics of reproductive travel to developing countries: a comparison of national self-sufficiency and regulated market approaches *Developing World Bioethics* **12(1)**: 45-54.

⁵⁰ Crozier G, and Martin D (2012) How to address the ethics of reproductive travel to developing countries: a comparison of national self-sufficiency and regulated market approaches *Developing World Bioethics* **12(1)**: 45-54.

many with terminal or degenerative conditions. Groups offering unproven stem cell treatments often use direct to consumer advertising that under-represents risks and claims scientifically unsupported benefits.⁵¹ Prospective patients may trust providers based on misleading information, fraudulent testimonials, or unpublished “data” claiming high recovery rates and patient satisfaction.⁵²

30. Medical tourism for unproven treatments including stem cell and venoplasty for MS increasingly differ from “alternative medicine” in that they are promoted under the guise of medical fact and cutting-edge scientific advances, and presented to patients with unprecedented sophistication. Patients are challenged to both understand and evaluate the information they are given. Physicians and policy makers likewise are challenged to advise patients in a manner that can align their expectations with available evidence, and to devise mechanisms that sort “innovative” treatment from financial exploitation.⁵³ Poor communication between stakeholders may lead society to believe they are being denied life-saving treatment – for example, Canadian MS patients have rallied their Government to provide venoplasty, and feel they have been denied essential follow-up care by physicians, who maintain these treatments are experimental and unethical to administer to patients prior to clinical trials.⁵⁴ While some see value in maintaining ‘hope’ for patients seeking unproven treatment,⁵⁵ others have questioned the ethics of selling patients ‘false hope’ for treatments where there is overwhelming evidence that treatments will fail.⁵⁶

Regulating medical travel

31. There is a clear tension between the goals of economic and health policies within the medical travel sector, and it remains unclear how international and national policies can best balance these interests. Economic growth may be the primary objective of trade policies, whereas the health sector is

⁵¹ Cohen IG (2012) Circumvention tourism *Cornell Law Review* **97**: 1309-557.

⁵² Based on the author’s research, including site visits and interviews at clinics, hospitals research centers and therapy providers in China, November 2011. For an example of scientifically unsubstantiated recovery rates claimed for traditionally “untreatable” diseases, see: www.sinostemcells.com. See also: Patra SW, and Sleeboom-Faulkner M (2010) Bionetworking: between guidelines and practice in stem cell therapy enterprise in India *SCRIPTed* **7**: 295-310.

⁵³ Lindvall O, and Hyun I (2009) Medical innovation versus stem cell tourism *Science* **324(5935)**: 1664-5; Johnston R, Crooks VA, and Snyder J (2012) “I didn’t even know what I was looking for”: a qualitative study of the decision-making processes of Canadian medical tourists *Global Health* **8(1)**: 23.

⁵⁴ CTV News (5 May 2010) *MS patients rally to demand CCSVI treatment*, available at: <http://www.ctvnews.ca/ms-patients-rally-to-demand-ccsvi-treatment-1.509355>.

⁵⁵ Murdoch CE, and Scott CT (2010) Stem cell tourism and the power of hope *The American Journal of Bioethics* **10(5)**: 16-23.

⁵⁶ Guest J, and Anderson K (2010) Hopes and illusions *The American Journal of Bioethics* **10(5)**: 47-8.

more likely to recognise equality and health access objectives.⁵⁷ How far governments wish to liberalise the international trade of medical services deserves urgent attention, as policies currently under development may be difficult to reverse once finalised.⁵⁸ Part of the challenge remains that much of medical tourism is informal and poorly documented, making informed policy decisions difficult.⁵⁹

32. A number of policy options could shape medical travel. Governments could criminalise medical tourism by their citizens even while abroad, such as is done for genital cutting in the UK, sexual acts with minors in the United States, and fertility tourism in Turkey.⁶⁰ However, detection may be difficult and penalties too harsh for many forms of medical travel, and this approach may further drive activities underground. Governments could also prohibit insurance companies from covering medical travel, and could refuse citizenship to children of foreign surrogates.⁶¹ Formalised cross-border care agreements between countries or institutions may increase quality of care and cost savings by 'channelling' medical travellers towards institutions or procedures with favourable clinical outcomes at low comparative costs.⁶² Professional societies can also help set professional ethics standards in both destination and in patients' home countries. For example, several physician societies in Canada have clarified that physicians must provide emergency care but are not required to follow treatment plans of foreign doctors,⁶³ and the Chinese Diabetes Society issued a statement against the use of stem cells to treat diabetes.⁶⁴

⁵⁷ Pocock NS, and Phua KH (2011) Medical tourism and policy implications for health systems: a conceptual framework from a comparative study of Thailand, Singapore and Malaysia *Globalization and Health* **7(1)**: 1-12.

⁵⁸ Timmermans K (2003) Developing countries and trade in health services: which way is forward? *International Journal of Health Services* **34(3)**: 453-66.

⁵⁹ Timmermans K (2003) Developing countries and trade in health services: which way is forward? *International Journal of Health Services* **34(3)**: 453-66; OECD (2009) *Written statement to Ministers' round table: medical tourism and global health congress*, available at: www.oecd.org/dataoecd/33/47/43952547.pdf, pp1-3.

⁶⁰ Cohen IG (2012) How to regulate medical tourism (and why it matters for bioethics) *Developing World Bioethics* **12(1)**: 9-20.

⁶¹ Cohen IG (2012) How to regulate medical tourism (and why it matters for bioethics) *Developing World Bioethics* **12(1)**: 9-20.

⁶² Cohen IG (2012) How to regulate medical tourism (and why it matters for bioethics) *Developing World Bioethics* **12(1)**: 9-20.

⁶³ Collège des médecins du Québec (2011) *Management of multiple sclerosis patients returning to Quebec after venoplasty treatment for chronic cerebrospinal venous insufficiency (CCSVI)*, available at:

<http://www.cmq.org/en/MedecinsMembres/Profil/Commun/AProposOrdre/Publications/DocumentsReference.aspx>; College of Physicians and Surgeons of Alberta (2011) *Managing patients with multiple sclerosis after out-of-country endovascular treatment for 'CCSVI'*, available at: http://www.cpsa.ab.ca/Libraries/Res/Managing_patients_with_MS_after_out-of-country_endovascular_treatment_for_CCSVI.pdf.

⁶⁴ Zhu D, Chen L, and Hong T (2012) Position statement of the Chinese Diabetes Society regarding stem cell therapy for diabetes *Journal of Diabetes* **4(1)**: 18-21.

33. Regulation may be easiest from within destination countries, which may have interest in deterring particular activities.⁶⁵ For example, Hong Kong has banned Chinese women in late stages of pregnancy from entering in order to curb a lucrative birthing business. Some expecting mothers prefer to give birth in Hong Kong to avoid China's one child policy and to gain their child access to Hong Kong's health care and education benefits, but the extent of these activities were preventing local women from accessing care, prompting Government intervention.⁶⁶ Regulators may also decide to tolerate circumvention of domestic regulation - for example while illegal, no UK resident has been charged for accompanying a person abroad for assisted suicide.⁶⁷ Allowing circumvention as a policy approach, however, may unfairly burden patients. Addressing the regulatory, quality and infrastructural insufficiencies within domestic health systems that motivate medical tourists to seek care abroad may be essential to medical travel management. For example, Portuguese women stopped going abroad for abortion following the legalisation and inclusion of abortion under national health coverage.⁶⁸

Questions to consider

34. The rapid growth, extent and diversity of medical travel activities as well as the ongoing negotiation of cross-border care and trade agreements lend urgency to the complex ethical and policy issues associated with these activities. Broad potential avenues for further inquiry include:
- How can better empirical data be generated to improve insight into medical travel activities (including patient numbers and mobility, tracking of clinical outcomes, and identification of best practices)?
 - Which forms of medical travel should be encouraged and under what conditions?
 - How can patients be best protected and informed about their health care options?
 - What are the obligations, responsibilities and best practices for home-country physicians to patients before and after care abroad?
 - How can vulnerable individuals and populations in destination countries be protected against unethical forms of medical tourism and exploitation?
 - How do the needs, rights and interests of individuals balance against those of society with respect to medical travel?

⁶⁵ McMahon D, and Thorsteinsdóttir H (2010) Regulations are needed for stem cell tourism: insights from China *The American Journal of Bioethics* **10(5)**: 34-6.

⁶⁶ CBC News (2 April 2013) *Baby delivery business boom fading in Hong Kong*, available at: <http://www.cbc.ca/news/world/story/2013/03/28/fitzpatrick-hong-kong-mainland-births.html>.

⁶⁷ The Independent (21 September 2009) *Swiss turn against 'suicide tourism' as UK law softens*, available at: <http://www.independent.co.uk/news/world/europe/swiss-turn-against-suicide-tourism-as-uk-law-softens-1790713.html>.

⁶⁸ Glinos IA, Baeten R, Helble M, and Maarse H (2010) A typology of cross-border patient mobility *Health & place* **16(6)**: 1145-55.

- What are the distributive impacts of medical travel across society in home and destination countries, particularly with respect to socioeconomic impacts on equitable health care and access?
- Will the premature global marketing of scientifically-based unproven treatments influence medical governance, practice and advancement?
- How can innovative treatment, compassionate care and exploitation be differentiated with respect to unproven treatments?
- To what extent is the liberalisation of medical trade desirable and what are the ethical implications of greater health care commoditisation for society? Is trade of medical services an 'exceptional' industry warranting special oversight?
- How can health authorities and regulators best influence, shape or control medical tourism practices?