CHAPTER 4

Would You Like a Safari With Your Lasik Surgery? The Supply of Medical Tourism

In the 1970s, tourists from Europe and Japan traversed long distances to be treated by Tony Agpaoa, a Philippine faith healer. To facilitate the medical transactions, Mr. Agpaoa put his patients up at his own hotel in Baguio City. Patients were saved the trouble of seeking accommodations and while there, were able to partake in Philippine food and culture in an exotic landscape. While the twenty-first century medical tourism offered in LDCs differ in scope, breadth, and technology from what Mr. Agpaoa offered, in their essence the transactions are the same: medical services are being packaged according to their particular setting. Be it the King Hussein Cancer Center in Jordan, or Cira Garcia Clinic in Cuba, or even Mr. Agpaoa's somewhat rustic facilities in the Philippines, medical tourism entails the supply of health services marketed so as to reach the demand source that sustains them. To enhance the medical experience, tie-ins are offered to tourist services. All in all, both Tony Agpaoa and large modern hospitals share commercial opportunities and management challenges of the medical tourism industry.

Supply is the focus of this chapter. While chapter 3 examined *which* services are in demand (such as invasive and diagnostic procedures, lifestyle medicine, luxury, high-tech medical tourism, border services, and traditional medicine, as well as all the hospitality services associated with the travel and tourism industry such as transportation, accommodation, food, and beverage), the focus here is on *how* those services are supplied and promoted. The chapter begins with an analysis of the respective roles of the public and private sectors. The former, heavily involved in economic development as well as health care and tourism, promotes medical tourism

M. Z. Bookman et al., *Medical Tourism in Developing Countries*

through a variety of efforts discussed below. The private sector pursues its profit interests by attracting foreign patients. Neither sector alone can achieve their goals without the participation of the other. This necessary cooperation is analyzed with an eye on the best way to ensure that medical tourism takes off. The private and public sectors in developing countries are then placed into the global context, as they both function within a framework set by international organizations, and they both tap foreign—physical and human—resources that are governed by international laws and regulations. Finally, the nature and rationale of medical tourism's tie-ins to the tourist industry are described.

The Public Sector

The role of the state in medical tourism must be viewed against the broader role of the state in economic development, in health care, and in tourism.

With respect to the former, Meier and Rauch have divided the literature on the role of the public sector in economic development into three categories.[1] The most optimistic view says that the state is a benevolent leader in development, a force that maximizes social welfare. The pessimistic view states that the government is an obstacle to development because it represents the interests of a narrow group and acts against the majority. A third view says that there is a wide possible range of relationships between the state and development, and each case must be assessed as to whether the state can formulate and implement policy without corruption. It is this middle road that many scholars have supported, and in so doing, they have found that there is indeed a role for the state in economic development. This role has waxed and waned over time, being high in the aftermath of World War II (or LDC independence), dropping somewhat in the market oriented 1980s, and rising once again in the twenty-first century. As Peter Calvert noted, the role of the state was under attack during the 1980s and 1990s when the Washington Consensus orthodoxy reigned, according to which the role of the government should be kept to a minimum.[2] Due to frequent market failures, the state is being brought back in.[3]

This re-emergence of government has been highlighted by scholars. Sinclair and Stabler noted that, "in contrast to traditional neoclassical theory, new growth theory provides a possible role for government."[4] Mittelman and Pasha also identified the role of the state, especially with respect to capital accumulation in the less developed countries.[5] Similar views have been voiced outside scholarly circles, from international organizations and policy makers. According to the UNWTO, "It is widely recognized that the market

alone cannot be relied upon to deliver sustainable development."[6] Similarly, Trevor Manuel, South Africa's Minister of Finance, argued that African states need to expand, not to contract, their public sectors.[7] The arguments are in favor of bringing the state back in to the development effort.

In what way can government jump-start the economy and sustain national growth that the private sector cannot do better? It can take legislative measures; it can provide an institutional framework. It can have a commercial and industrial policy, together with fiscal and monetary policy, to ensure sustainable growth. Government can make direct expenditures and investments (especially in strategic sectors or public goods, or when local private capital lacks sufficient strength to sponsor the required investment, and foreign capital has associated problems). Government can encourage the private sector directly, with liberalizing laws and subsidies. It can also encourage it indirectly by investing in infrastructure.

The World Economic Forum's *Global Competitiveness Report* contains indicators of public sector involvement. This report ranks countries with respect to numerous economic indicators that are not found in official statistics, but rather are based on opinion surveys of top business executives across a broad range of industries. The World Economic Forum, in conjunction with Harvard University, recognizes that "there exist intangible factors that cannot be found in official statistics but that may play an important role for a country's competitiveness and hence its long term prospects for economic growth."[8] It is these intangible factors, as described by opinion surveys, that are used throughout this book to supplement official statistics when they are available and substitute for them when they are not. Only 59 countries are included in the survey (the high- and middle-income countries). Table 4.1 contains values from 1 to 7 (where 7 is the highest) for the composition of public spending (in response to the following statement: the composition of public spending provides necessary goods and services that the market does not provide). Given Singapore's highest ranking (5.8) and Zimbabwe's lowest (1.4), it is clear that destination countries under study fare high by global comparisons. Malaysia ranks highest (4.4), together with Thailand (4.1), and with Jordan (4.0), ranks above the United States (3.9).

Role of the State in the Health and Tourism Sectors

It has been argued that the great strides made in public health in China are all due to the role of government in health care. At the time of Mao Tse-tung, it was the authorities that provided basic health care; in the mid-2000s, it is Liberalization that gave rise to increase in private hospitals

Table 4.1 Perceptions of public spending

Country	*Composition of public spending*
Argentina	2.1
Chile	3.7
Costa Rica	2.8
Cuba	n.a.
India	2.8
Jordan	4.0
Malaysia	4.4
South Africa	3.9
Philippines	2.7
Thailand	4.1
USA	3.9
Singapore	5.8
Zimbabwe	1.4

Note: Later reports do not contain this particular data hence were not used.
Source: World Economic Forum, *Global Competitiveness Report 2000* (New York: Oxford University Press, 2000), Tables 3.02 and 3.03.

and thus alleviated the pressure on the public health care.[9] China's experience shows that the state can be involved in health care in different ways, both crucial and both situation-specific.

At the outset, it should be stated that the health sector is fundamentally different from other sectors in the economy. As noted in a U.S. Department of Commerce trade conference document, "The ethical and human welfare dimensions make [the health sector] qualitatively distinct from most other industries and endow it with *a high degree of political sensitivity* [italics mine]."[10] Health is a political issue, and in many countries the right to health care is stipulated in the national laws (no country goes as far as Cuba in that its constitution addressed the subject in greater detail than is common[11]). Political issues translate into economic questions about how much government involvement should there be in the health sector. This topic has been debated for decades. In a Center for Global Development study of LDC health issues, Ruth Levine identified the importance of governments in delivering medical care in poor countries, stating that they are the chief funders of health care.[12] The CII-McKinsey report on the state of health in India noted that government expenditure meets 80 percent of the financing need.[13]

The public share of health expenditure, presented in chapter 1, is reproduced in table 4.2 together with private health expenditure. It is clear that Cuba has the highest public health expenditure as a percent of GDP (6.5),

Table 4.2 Public and private sector health expenditure as a percent of GDP, 2002

	Public health expenditure	*Private health expenditure*
Argentina	4.5	4.4
Chile	2.6	3.2
Costa Rica	6.1	3.2
Cuba	6.5	1.0
India	1.3	4.8
Jordan	4.3	5.0
Malaysia	2.0	1.8
Philippines	1.1	1.8
S. Africa	3.5	5.2
Thailand	3.1	1.3

Source: UNDP, *Human Development Report 2005* (New York: UNDP, 2005), table 6.

although Costa Rica is surprisingly close behind (6.1). Private health expenditure is highest in South Africa and Jordan (5.2, and 5.0, respectively).

Tourism does not share the health sector's politically charged premise. No government claims that each citizen has the right to enjoy a beach vacation; no government subsidizes the rental car industry. Nevertheless, the role of the public sector in policy formulation and planning was formalized in 1996 when the Lome IV Convention strongly emphasized the need to formulate policies in the tourism sector rather than letting it develop haphazardly.[14] In the absence of a long-term plan, countries suffer from negative environmental, social, and economic consequences.[15] Thus, tourism is one of the few sectors left in which governments still do extensive planning. They consider limited resources, scarcity, opportunity costs, and perform cost/benefit analyses. They consider the short run and plan for the long run, all the while trying to ensure sustainable long-term growth. They make decisions about the expansion of infrastructure, the reduction of leakages, the maximization of linkages, and the encouragement of pro-poor economic growth. When government is involved in planning the tourism industry, it can identify and monitor tourism activities, as well as measure and evaluate the impact of tourist activity on the infrastructure and resources. It can integrate tourism into regional and national macroeconomic plans and it can consult with the host community if needed. The central government can also better coordinate tourism policies with other government agencies and international agencies.

In addition to planning, the public sector also engages in government expenditure by creating agencies and departments that provide services for visitors, including cultural, recreational, and entry clearance (i.e., visas).

Given scarce resources, government involvement in tourism can result in crowding out of private activity, as discussed in chapter 7. Also because of scarcity, trade-offs must occur within the public sector, as governments must decide which sector to promote. There is much evidence across less and more developed countries of an economic activity replaced by tourism (for example, commercial salt mining at the Wieliczka salt mine in Poland has been phased out to make room for the one million tourists visiting each year).[16]

One way to measure government involvement in tourism is by observing expenditure as a percent of total government spending. Using that measure, the World Travel and Tourism Council found the top spenders in 2004 to be the Cayman Islands (28.9 percent).[17] Destination countries under study have significantly lower expenditures. As evident from table 4.3, only Argentina, India, and the Philippines have values over 4 percent.

Role of the State in Medical Tourism

While there are decades of developing countries' state involvement in health care and, somewhat more recently, in tourism, medical tourism is too new and no comprehensive comparable data are available on its public/private composition. However, on the basis of secondary evidence, it is clear that the variation is huge among destination countries, with Cuba at one end,

Table 4.3 Expenditure on tourism as a percent of total government spending

Country	*Expenditure on Tourism*
Argentina	4.2
Chile	3.7
Costa Rica	3.9
Cuba	1.6
India	4.3
Jordan	3.1
Malaysia	3.2
Philippines	4.6
South Africa	2.3
Thailand	3.1

Source: World Travel and Tourism Council, *Country League Tables 2004* (Madrid: Travel and Tourism Economic Research, 2004), Table 13.

where all medical tourism is in the public sector, and India on the other, where the private sector is spearheading the industry.

How did government involvement in medical tourism come about in developing countries? Until recently, tourism in general was not viewed as a serious industry, not as clearly associated with modernization and growth as a large capital goods factory. Similarly, as long as medical tourism was limited to informal services of traditional healers such as Tony Agpaoa, authorities did not pay attention. All that changed when profits from all types of tourism began to skyrocket. Perceptive governments responded to this unexpected interest in their human, physical, and natural resources by singling out the tourism sector for investment and subsidy. In view of the foreign interest in LDC medical care, governments are doing the same in that sector.

As a result, today every country that can, is marketing its health care for paying foreigners. Marconini notes, "It has become increasingly accepted that national care systems should be regarded as export-oriented industries."[18] Gupta, Goldar, and Mitra remark that the inflow of foreign patients from developing and more developed countries is both possible and desirable, and thus should be pursued aggressively.[19] Such aggressive pursuit is reflected in tourist and health-care policies across the globe. This is true in the more developed countries (witness most recently the strategic plan for recreating the Hawaiian tourist industry by striving to become the wellness center of the Pacific[20]). It is also true in oil-rich Middle Eastern countries (such as the Arab Emirates that have created a trade free zone for Dubai Healthcare City where the authorities promise there will be, "no red tape, hassle-free visas and a streamlined labour process, simplified licensing and applications."[21] In addition, there will be no taxes on sales, income, or capital gains, only corporate tax for financial institutions. There will be no restrictions on capital, no trade barriers or quotas, no need for a local partner, just one-stop-shopping for government services (such as 24-hour visa extensions and other permits).

The public sector promotes medical tourism in all destination countries under study. The Chilean authorities hope to "add surgical operations and cutting edge medical treatments to its traditional exports of copper, wine and salmon."[22] Cuba has a long history of promoting medical tourism and as Benavides notes, "One of the main objectives of the Cuban government has been to convert the country into a world medical power."[23] Indeed, the treatment of foreign patients is the cornerstone of the government's strategy. Across the globe in the Philippines, in 2005, the government announced with great fanfare that the Departments of Tourism and Health are teaming up to provide medical tourism. In India, the national health policy in 2002

specified a role for medical tourism, and a year later, finance minister Jaswant Singh called for India to become a global health destination, marking the beginning of government policy to merge medical expertise and tourism.[24] In Malaysia, the government formed the National Committee for the Promotion of Health Tourism, providing its leadership and indicating its intention to facilitate and encourage the development of the industry.[25] Medical tourism has made it on to the country's five-year plans. A campaign called Amazing Thailand was launched by Thai authorities in the late 1990s, and health care is one of the niches being promoted.[26] As part of the campaign, the government is developing health-care centers in tourist spots outside of Bangkok (such as in Phuket and Chiang Mai).[27]

Once medical tourism makes it onto the government's radar, decisions must be made about how to promote the industry. One dilemma is the question of which subsidies to give, and in what quantities. The Philippine government, for example, showed its support for medical tourism in the 2004 Investment Priorities Plan, which gave investment incentives such as reduced tariffs on importation of hospital equipment.[28] Similarly, Indian authorities have provided benefits such as lower import duties on equipment required for medical tourism. They have also increased the rate of depreciation for life-saving medical equipment.

Governments also give incentives directly to hospitals. Cuban authorities, for example, have granted budgetary allotments as rewards to hospitals that give priority to foreign patients over locals.[29] Malaysia's government has promised their backing and incentives to medical establishments. The Eighth Plan for 2001–05 identified 44 of the country's 224 private hospitals to take part in health tourism, and the Health Ministry then selected 35 to market themselves abroad.[30]

Promoting medical tourism, by necessity, entails the promotion of supporting industries otherwise bottlenecks can easily occur. It is most important to develop infrastructure, including transportation, communication, banking, water and sanitation systems, and electrification. The sectors that produce inputs for the health industry are crucial (including medical equipment, pharmaceuticals, construction of medical facilities and, of course, the education of health professionals). Sometimes authorities also promote secondary products and services that enhance the tourist experience, such as tennis balls and suntan lotion.

Governments must also provide an encouraging environment, one that is conducive to investment, production, and profit maximization. That environment must maximize the potential of the industry with state level reforms that enable medical tourism to develop, including privatization, deregulation, and liberalization of trade. Along with deregulation, regulation

of medical tourism cannot be neglected by authorities. According to Adams and Kinnon, "All considerations point to the need for governments to provide a strong and effective regulatory framework for the private actors involved in trade in health services. But above all, and especially in developing countries, they have to be able to reinforce it."[31]

Taxation is also an integral component of this environment. Authorities must make decisions as to which economic activity associated with medical tourism is to be taxed and how much. As discussed in chapters 5 and 7, tax policy must promote taxes that are low enough not to stifle private activity and high enough to make a significant addition to public revenue. The public sector can further augment its financial capacity with direct payments by foreigners for use of public health facilities.[32] Foreign patients have a small number of beds in public hospitals available to them (and limitless number in private hospitals). By allowing some foreign patients into public hospitals, the authorities earn additional income that will alleviate their pressure on resources (according to a study of the Australian health system, two or three locals can be treated with the income earned from one foreign patient[33]).

Finally, it must be stressed that governments seeking to develop the medical tourism industry must foster cooperation *within* the public sector (as well as with the private sector, as described below). Indeed, the broad nature of medical tourism necessitates the involvement of several public sector bodies including the Ministries of Health, Trade, Tourism, and Transportation. Offices in charge of migration, immigration, and foreign travel must also be involved, as well as the central bank. Communication between the Ministries of Health and Trade is crucial since one may be in favor of regulation while the other may lean towards liberalization. Such cooperation is evident in many developing countries. The Philippine Health Tourism Program relies heavily on the cooperation between the Departments of Tourism, Health, and Energy in order to offer cost-effective medical treatments combined with the best tourist attractions.[34] In India, given its highly decentralized political structure, cooperation between federal and state levels is crucial. Moreover, authorities have started involving the national airline in medical tourism strategies.

However, it is Cuba that has the most extensive cooperation within public sector departments and thus warrants an extended description. According to a WHO study, the success of the Cuban medical tourism model is due to the strategy of coordination and collaboration of the Ministry of Health with other institutions in tourism, commerce, and industry.[35] In order to coordinate, market, and promote international health care, the Cuban government created the state run monopoly SERVIMED whose

functions include coordination with tour operators and the national airline. SERVIMED also developed 42 centers—health resorts linked to surrounding hospitals that provide surgical and rehabilitative treatments.[36] Building business ventures with hotels and building medical resorts and villages that serve as "off-shore medical centers," all required a tremendous amount of cooperation between departments. Such cooperation enabled Cuba to develop a successful export strategy of linking health care with tourism.[37]

The Private Sector

The active involvement of the public sector in medical tourism may give the erroneous impression that governments do not encourage the private sector. With the exception of Cuba, authorities in developing countries have realized that private business tends to be dynamic and adaptable; it tends to respond quickly to technological change and financial incentives, both at the level of transnational corporations, as well as at the level of micro businesses.

The private sector has traditionally been stronger than the public sector in services, so it comes as no surprise that it dominates in the tourism industry. The World Bank takes a strong position on the role of the private sector in tourism, giving it supremacy over the public sector: "While tourism development is predominantly a private sector activity," partnership with governments must be effective to ensure maximum benefit to the local population. Heeding the World Bank position, numerous countries have tourism policies such as the one announced in India in 2001, namely "government-led, *private-sector driven* and community-welfare oriented [italics mine]."[38] The governments of southern African countries (with the exception of Angola) have together formulated a tourism policy in which the role of the private sector is recognized in financing and implementing future developments.[39] In Jordan, the lack of sufficient private sector leadership is viewed as the principal obstacle to the development of the tourist sector.[40]

In part, medical tourism services consist of the health sector that has traditionally been under public control and which, as noted above, is politically highly sensitive. Nevertheless, with the exception of Cuba, economic activity in medical tourism is currently generated by both private and public sectors as all countries under study have parallel private and public health-care systems. These include hospitals, clinics, diagnostic centers, treatment centers, and nursing homes. In Malaysia some 80 percent of health care is provided by the public sector. The private sector is growing rapidly, and offers mostly curative and rehabilitation services. It is financed

on a nonsubsidized fee-for-service basis.[41] With the growing importance of medical tourism, hospital capacity in the late 1990s increased by over 5 percent per year, with private capacity increasing at almost three times the rate of public.[42] Thailand has a larger private sector and a market oriented health-care system that offers its population choice in care,[43] as does Chile's competitive dual system.[44] In both cases, consumer choice is largely based on disposable income: the higher the income, the more private health care will be demanded. With growth and rising incomes, the domestic population demands more private health care. This alleviates the demand on the public sector and increases the competition with foreign patients.

Market Structures in Medical Tourism

At one end of the spectrum, a plastic surgeon in Rio de Janeiro is single-handedly responsible for attracting most foreign patients to Brazil.[45] At the other end, large hospitals predominate (such as Indraprastha Medical Corporation in New Delhi, the third-largest corporate hospital outside the United States in 2005). While both small and large entities exist, it is the large hospitals that have been treating foreigners. By sheer size, hospitals such as Apollo in India and the Bumrungrad in Thailand have become the grandes dames of LDC medical tourism. Their size, measured by the number of employees, sales revenue, and number of unit sales to capital employed, is impressive. They did not start off that way. Initially Apollo's goal was to produce a state-of-the-art hospital for the 250 million or so middle-class Indians who could afford to forgo public hospitals. Then it expanded into medical tourism, attracting foreign patients.[46] Now, major Indian corporations such as Fortis, Max, Tata, Wockhardt, Parimal, and Escorts have made similar investments and are setting up hospitals, and promoting medical tourism.

Medical tourism, especially in the invasive and diagnostic sectors, tends to be dominated by large size firms operating in highly concentrated markets. With the exception of Cuba, where the government has a monopoly on medical tourism, most countries under study have oligopolistic health-care industries in which a small number of producers dominate. Barriers to entry are too high in medical tourism for monopolistic competition to develop. Each producer has some power over price and output, but all are interdependent, and their product depends on those of the others. Firms and industries that are mutually interdependent may begin to function like oligopolies and have reactions to each other's behavior. This is especially true in the cross-fertilization that occurs between corporate medicine for foreigners and the hospitality, air transport, and food/beverage industries.

The large size of medical tourism entities enables economies of scale to occur. In their efforts to maximize profits, corporations set up big hospitals where supply costs per unit of production decline as inputs are increased and output expands. For example, Medicity, on the outskirts of New Delhi, is under construction with economies of scale in mind. It will be a teaching hospital and research institute that will offer medical and nursing degrees while treating Indian and foreign patients in a 1,800-bed facility.[47] Perhaps the most impressive attempt to make use of economies of scale has occurred in the United Arab Emirates. According to its website, the Dubai Healthcare City has invited institutions across the world to partake in this large project—institutions in health-care delivery, education, services, and research and development "to collaborate on the site to take advantage of the synergies brought about by physical proximity, interconnectivity, and professional collaboration."[48] All of these will be organized by clusters—a medical cluster and a wellness cluster. The former will include diagnostics, research, education, clinics, rehabilitation, pharmaceutical businesses, and medical device companies, all in one place.

The cost savings from economies of scale enable suppliers to charge lower prices. While market structure is not solely responsible for comparatively lower consumer prices, they are likely to play some part in the following. In India, the cost of coronary bypass surgery is about 5 percent of what it is in MDCs while the cost of a liver transplant is one-tenth of what it is in the United States.[49] Similarly, Malaysian hospitals are able to offer heart surgery for one-quarter of the price in the West.

Large producers are more likely to squeeze out small suppliers who lack economies of scale, further increasing the concentration of the medical tourism industry. While it might be argued that large corporate hospitals may not be sufficiently flexible to bend to patient demand, the rise in specialized subniches described in chapter 3 points out that this has not happened.

The market for traditional medicine such as acupuncture is fundamentally different as size is hardly an issue. Instead, many small producers offer their services in highly competitive markets with easy entry and exit. To the extent that they are part of a larger structure, it is often the result of their integration with a major hospital or clinic (no different from tie-ins that hospitals have with tourist establishments, as discussed below).

What about the tourist industry that provides the tourism part of international trade in health services? The predominant market structures of the medical tourism and the nonmedical tourism industries are similar insofar as the market is dominated by large providers, be they hospitals or resorts, that reap the highest revenues in the industry. However, they differ in two important ways. In medical tourism, the large-scale providers also see more

patients than the small providers (who are usually providers of traditional medicine or wellness services, such as massages and herbal treatments). This is not the case in nonmedical tourism, where the majority of tourists make use of small-scale providers (such as private home accommodations, small private inns, nonchain restaurants and bars, local guide, and transportation services, etc.). Also, the two differ with respect to the principal source of their investment capital. The hospitals and clinics that provide high-tech, state-of-the-art medicine for foreigners tend to be owned domestically and built with domestic investment resources, as the Chilean and Indian industries attest. By contrast, the nonmedical tourist industry in developing countries has attracted international capital, especially for large hotels and chains. With increased profitability, domestic funding is beginning to pour into tourism.

Components of Private Sector Supply of Medical Tourism

The breadth and depth of private sector involvement in medical tourism is growing by leaps and bounds. The fastest growing components are physical capital, medical technology, and pharmaceuticals.

Physical Capital

The supply of invasive and diagnostic medical services requires the accumulation of physical capital such as hospitals and clinics. All LDCs that promote medical tourism have invested heavily in physical plants and equipment. By sheer number, India surpasses all developing countries. Since 1983, the largest Indian corporations, including Fortis, Max, Tata, Wockhardt, Parimal, and Escorts, have all diversified into medical care, building hospitals and clinics across the country with high-end facilities for international patients (just Apollo Hospitals Enterprise has 37 hospital facilities where 60,000 patients were treated between 2001 and 2004[50]). Similarly, Chile has also built numerous state-of-the-art clinics and hospitals and has not neglected to invest in wellness facilities at its many thermal bath sites (30 are in operation, 100 more are potential sites).[51]

Contents of buildings are also part of physical capital. These include primarily medical equipment (MRIs, CAT scanners, ECG machines, ventilators, mammography equipment, and gamma knife machines), as well as medical software (intellectual output of hospitals, such as research of hospital staff). They also include beds and patient furniture (Apollo Hospitals Enterprise offers private rooms that seem like expensive hotels, while Tata Memorial Hospital in Mumbai has private and deluxe rooms with hospital furnishings no different than in the West).[52]

Medical Technology

The physical capital described above comes alive with the application of medical technology that works with, for example, pacemakers, artificial joints, and silicone breasts. Technology is also embedded in laboratory tests that include biochemistry, hematology, microbiology, serology, histopathology, and transfusion medicine. Diagnostic services including imaging, cardiology, neurology, and pulmonology all rely on state-of-the-art medical technology. Mumbai's Thyrocare, the world's largest thyroid testing laboratory, illustrates how specialized medical technology, in conjunction with air cargo and distribution systems, can yield 200 percent annual growth rates in diagnostic industries.[53]

In addition, the growth of telecommunications and information technology enables diagnosis, treatment, and medical education in what has come to be called telemedicine. Facilities have sprung up in India, the Philippines, Thailand, and Malaysia to enable telemedicine, and in the process, they have expanded the range of services that can be traded in the health sector. These services now include diagnosis and clinical consultations via regular mail or electronic methods, as well as the sending away of laboratory samples for analysis (in Thailand, for example, 17 national telemedicine units are connected to 3 teaching public hospitals, 14 regional hospitals, 7 provincial hospitals, and 20 community hospitals[54]). New words have been introduced to describe this cross between technology and communications: telehealth, telepathology, teleradiology, and telepsychiatry.

Although telemedicine falls under the WTO Mode 1 type of trade, it is nevertheless relevant for medical tourism (Mode 2) for two reasons. First, many hospitals in developing countries simultaneously offer medical services to international patients and are the outsourcing site for Western medical establishments. Indeed, a hospital like Apollo doesn't just see patients. To the contrary, at night its computers do billing and insurance claims for American hospitals and insurance companies. Technicians read and interpret X-rays and CAT scans e-mailed from abroad. Also, these hospitals host clinical trials for Western companies such as Pfizer and Eli Lilly.[55] To further satisfy demand, LDC firms have sprung up to perform medical transcription services for Western health providers. One such company, HealthScribe India, set up in 1994, was originally funded by Indian-American doctors with the aim of providing outsourced medical transcription for American doctors and hospitals.[56] It served as a model for numerous other businesses in the mushrooming telemedicine industry. The concurrent expansion of telemedicine and medical tourism enabled the industries to benefit from spillover effects and reinforce one another.

Second, telemedicine is relevant for medical tourism because it has been used to follow up with foreign patients after they return to their countries. For example, Apollo has set up telemedicine centers for follow-ups with medical tourists where patients go to keep in touch with their physicians. Telemedicine opportunities are expanding daily, and technological change in general is favoring further outsourcing, supporting the saying that "telecommunications has all but eliminated geographical barriers."[57]

Pharmaceuticals

Physical capital and medical technology require pharmaceuticals in order to be useful in medical care. Developing countries consume only 25 percent of the world drug production (and that includes what foreign patients receive).[58] Countries that promote medical tourism must have sufficient drug reserves for their international patients. They must import their supplies or produce them domestically. Moreover, the quality of those drugs must be at least comparable to what patients can receive at home. This is true especially for Western tourists who come to LDCs and expect to receive the most effective drugs in their treatment. In other words, even if developing countries are able to produce generic drugs and use those in the foreign patient treatment, they must meet the stringent criteria of the U.S. Food and Drug Administration. Certainly countries that are part of (or wish to join) the WTO have to abide by international standards for drugs (obstacles associated with pharmaceutical supply are discussed in chapter 6).

Cooperation Between Public and Private Sectors

Sangita Reddy, Executive Director of the Apollo Group in India, said, "It is important for the private sector and the public to work together and try and give more efficient solutions, reach people quicker, extend our reach, and there are many examples of *win-win solutions* when we work together [italics mine]."[59] It is exactly such win-win situations that are being sought out by the promoters of medical tourism. To maximize their number, both private and public sectors are exploring ways of cooperating.

Various forms of cooperation between the public and private sectors have been receiving a lot of attention ever since the UN Conference on Environment and Development (also known as the Earth Summit). It was then, in 1992, that transnational corporations and political leaders began saying that everyone concerned with the environment should cooperate and work together, not against each other.[60] Cooperation and dialogue became the key concepts. The former WHO Director-General, Gro Harlem

Brundlandt, said, "Partnership is what is needed in today's world, partnership between government and industry, between producers and consumers, between the present and the future."[61] The term of choice for such cooperation became PPP (public/private partnership). This is defined by Buse and Walt as "A collaborative relationship which transcends national boundaries and brings together at least three parties, among them a corporation (and/or industry association) and an intergovernmental organization, so as to achieve a shared health-creating goal on the basis of a mutually agreed division of labour."[62] Some 80 percent of them are funded through philanthropies.[63] In the 2000s, these public-private partnerships have made it to the top of the UN's list because they enable its agencies to be more effective in their efforts in developing countries. However, while they have been touted as a panacea for health-care problems in LDCs, they have also been very controversial, drawing much criticism.[64]

Thus far, no such formal partnership has been extended to medical tourism. While all parties in destination countries under study agree that mutual ties are important, cooperation is informal and voluntary. This distinction gives rise to large variety in the answers to the following questions: what is the nature of the private/public cooperation, namely, does it entail sharing funds and/or joint decision making; if so, is this cooperation expected to occur always or just sometimes; if sometimes, then under what circumstances? Also, should there be a law that stipulates the nature of the cooperation and, as Judith Richter suggested, should there be regulatory arrangements to implement voluntary (legally nonbinding) codes of conduct?[65] There is not even consensus on the relevance of these questions, let alone their answers. Nonetheless, cooperation between the public and private sectors is crucial for all tourism, and medical tourism in particular, because of the complexity of the industries involved, and the inability of either one to function in the absence of the other. In the absence of cooperation, the two sectors could be working against each other and undermining each other's efforts. Moreover, the public sector alone does not have the resources to satisfy public health demands (with the exception of Cuba that has no private sector), and the private sector alone cannot provide private health care (for foreign or domestic patients) in the absence of institutional and infrastructure support of the government.

Therefore, first and foremost, the public and the private sectors must acknowledge their dependency on each other. Authorities must acknowledge that growth comes from the private sector given its greater investment resources as well as its ability to draw foreign capital. The private sector must lead in identifying and developing opportunities in medical tourism while

staying competitive in the global markets. Governments must welcome private sector growth as it fills public coffers while producing spillover effects that induce indirect linkage benefits. Moreover, given that we are dealing with health matters, the public sector must be careful not to seem too greedy or to be viewed as pursuing profits over public health (as Teh and Chu pointed out, LDC governments want to appear to be politically correct and cannot be seen as willing to forgo the national health service for medical tourism[66]). By allowing the private sector to spearhead the development of medical tourism, the public sector avoids allegations of neglecting public health while still reaping the benefits.

In turn, the private sector must acknowledge the crucial role of government in facilitating entrepreneurial activity. When authorities remove cumbersome regulations, they are aiding businesses by reducing time-consuming, and thus, costly obstacles that discourage private activity. In fact, any form of liberalization policy by the authorities will stimulate private sector activity. (Just how crippling government regulations can be for the private sector is reflected in how long it takes to start a business. According to the World Economic Forum, it takes 2 days to start a business in Australia, 5 in the United States, 81 in Mexico and 105 in Mozambique.[67]) The more liberalized the economy, the greater the public sector's encouragement of private sector needs. Moreover, the private sector must recognize the government's macroeconomic responsibilities and thus must comply with the financial requirements of the center, and pay taxes. The private sector must also operate within the legal framework set by the country's laws and also must abide by regulations set by the center (with specific reference to medical tourism, this might entail cross-subsidizing public health by providing beds at subsidized rates and treating some patients without charge while foreign patients are made to pay). The private sector must recognize the role of the government in facilitating international travel to make medical tourism easier. This entails ensuring embassies and overseas missions are efficient in their paperwork (such as issuing timely visas for visiting patients), and providing convenient passenger transport systems (ministries of aviation have been involved and change of flight plans have been made). Incidentally, because medical tourism has become one of the fastest growing segments in marketing Destination India, the Indian government is introducing a new visa called medical visa. As part of acknowledging each other's roles, the private and public sector must also acknowledge that, although their proximate motivations are different (the former seeks to maximize profits, while the latter seeks to maximize benefits to the largest number of people), they can still find common ground in which progress is Pareto optimal. And so, their cooperation, based on mutual dependency, can

extend into the sharing of facilities, professionals, research, as well as providing complementary treatments.

Chile has been at the forefront in the cooperation between the public and private sectors. Its Santiago Salud is the first public-private health-care network in Latin America, supported by both the Ministry of Health as well as the Governor of Santiago. From the public sector, three hospitals have joined the network, each with a different specialization (Hospital del Trabajador, Hospital Calvo Mackenna, and Hospital del Torax).[68] The public sector is represented by two university hospitals (University of Chile and Catholic University), both complementing each other's specializations. Santiago Salud aims to provide state-of-the-art medical technology with highly skilled personnel and thus place Chile firmly on the medical tourism map. According to the Chilean Minister of Health, Pedro Garcia, Santiago Salud is expected to earn $15 million during the first five years of the program and $35 million within the first decade.[69]

India has also been successful with respect to cooperation. The Ministries of Tourism and Health have pledged to cooperate with each other first, and then together, to seek out the private sector.[70] The CII-McKinsey report suggested that a strong cooperation between the government and the private sector has in fact been achieved, given that the government's first initiative for growth and improvement in the health-care sector was to "spur private investment in healthcare."[71] The Indian authorities are presently seeking to create and formalize public-private partnerships and are exploring the following models: contract out services to the private sector (as is done in parts of India, such as Karnataka), have private management of public facilities (as in South Africa), stimulate private investment to meet public demand (as in the UK), and convert facilities from public to private (as in Sweden) while focusing the public sector on primary care provision in the rural regions (as in Thailand).[72] Any one of these possibilities would give the private sector a foot in the door and a role in something it didn't have before—provision of public health. This cooperation has also necessitated the creation of a go-between between government and private sector.[73] The Confederation of Indian Industries (CII) recognizes that this is huge area of potential for India and is actively working on setting guidelines. It is the coordinating agency between government and hospitals; it has resources to influence policy and its efforts are supported by the government. Another relevant group is the Pacific Bridge Medical, a consulting firm that has assisted companies in the health sector throughout Asia with regulation and business development since 1988.

The International Dimension

Medical tourism is, by definition, an international activity since a national border must be crossed for a transaction to occur. In their efforts to develop the industry, developing countries cooperate with entities in the global economy in a variety of ways that include associations and alliances. However, the most important link to the international economy occurs by way of capital flows. Indeed, direct foreign investment, as well as lending by international institutions, adds dynamism and vibrancy to the industry. International charities and nongovernmental organizations (NGOs) have a small but growing role to play, while advisory and regulatory international agencies set codes of conduct that must be minded. These international aspects of medical tourism are discussed below.

Cooperation and Collaboration with the Global Economy

Developing countries seek cooperation and collaboration with the global economy in numerous ways. In order to facilitate medical tourism, they seek to build alliances with insurance companies and develop relationships with tour operators in other countries that can facilitate medical tourism. In order to raise their creditworthiness, hospitals in developing countries forge ties with foreign medical associations and form associations with a famous foreign hospital or medical school. One coveted form such an association can take is that the hospital becomes a branch of a globally recognized hospital (for example, one of the main hospitals in Singapore is a branch of Johns Hopkins University; the Dubai HealthCare City is collaborating with Harvard Medical International as well as the Harvard Medical School). In order to benefit from professional exchange, consultations, and the transmission of technological innovation, hospitals and research institutes in developing countries collaborate in the education sector with foreign countries. Various forms of partnerships develop. Numerous universities in the United States are involved in this way (including the Universities of Scranton and Florida). Germany, one of the leading countries in advanced medical technology, is exploring opening a medical school in Bahrain that could train local physicians and provide postgraduate research opportunities.[74] Jordan, competing to retain its position as the Middle Eastern capital of medical tourism with newcomers such as Bahrain and Dubai, has sought out links to health centers across North America.[75] As a result, its top modernized hospitals all have computerized links to health centers in North America. Apollo in India is in partnerships with hospitals in Kuwait,

Sri Lanka, and Nigeria. Some destination countries also have satellite links to foreign institutions (such as Jordan's King Hussein Medical Center, linked to the Mayo Clinic in the United States for consultations and tele-education).

Dubai Healthcare City undertook the single most ambitious effort at foreign collaboration. Its foreign collaborators include Harvard University (Harvard Medical School Dubai Center Institute for Postgraduate Education and Research), the Mayo Clinic, Harvard Medical International, the Dr. Sulaiman al-Habib Medical Center in Saudi Arabia, Johnson and Johnson, AstraZeneca (this world's fifth largest pharmaceutical firm plans to relocate its Gulf office to Dubai Healthcare City), and Novo Nordisk (also plans to relocate its Gulf office from Denmark to Dubai).

The medical tourism industry also collaborates with private foundations, especially in the West. Cuba is engaged in technology transfer negotiations with private sector in China and India, and as a result of cooperation, its products have been patented in Canada, China, and various European countries. Also, The Bill and Melinda Gates Foundation has been generous in the LDC health-care sector in general, providing grants to local firms to develop, for example, a malaria vaccine.[76] In addition to the private sector, the medical tourism industry collaborates also with governmental organizations in foreign countries. Bharat Biotech in India is collaborating with the Centers for Disease Control in Atlanta and the U.S. National Institutes of Health on development of a roto virus vaccine.[77] The benefits to the United States are great, as production costs are lower in India than in the United States; the benefits to the domestic industry are also great, in the form of employment, technology transfer, income, et cetera.

Private Foreign Investment

In their assessment of medical tourism in India, Gupta, Goldar, and Mitra said that the first priority for growth must be to increase the number of foreign patients coming to India and the second, to increase foreign capital or the foreign presence in India's health sector.[78] Such funding from international sources takes place both, in the private and public sectors, and from the private and public sectors. Private foreign investment comes from the private sector and overwhelmingly takes place in the private sector of developing countries. Bilateral and multilateral international sources transfer money into both public and private sectors in developing countries (the latter is discussed in the next section).

As noted in chapter 2, direct foreign investment has a stimulating role to play in medical tourism (and health and tourism in general). It brings

in foreign exchange and state-of-the-art technology (whether in diagnostic services or airline reservations systems). As a result, it enables the medical tourist industry to take off while at the same time improve both health services and general tourism services. In order to attract foreign investment, developing countries are flexible with respect to the conditions they set on foreign investment. In most cases, they require a joint venture with a domestic firm. Foreigners accept that when investing in health care or tourism, because joint ventures provide local access and connection and knowledge that facilitate production. However, rules and regulations differ between the health sector and tourism.

Medical Tourism

Although all member states of GATS limit foreign presence in the establishment of new hospital facilities, the nature and extent of those limitations differs greatly. In India for example, ever since liberalization of the economy (discussed in chapter 5), there are no caps on direct foreign investment in health services. However, there are prohibitions on foreign nationals providing services for profit (and they must be registered by the Medical/Dental/Nursing Council of India.)[79] In Malaysia, foreign companies have to set up joint ventures with individuals or corporations, and foreign share cannot exceed 30 percent.[80] That percentage is higher in other countries, including Thailand, where foreigners are not allowed to own private hospitals except in joint ventures with Thai partners.[81] In fact, the Ministry of Trade limits foreign participation to 49 percent of total investment. This is not an issue as direct foreign investment in the health sector is tiny—during 1992 to 1998, it was 0.26 percent of total number of shareholders and 0.57 percent of the total value of investment.

What is the evidence of foreign investment in medical tourism? As Richard Smith noted in his study of foreign investment and trade in health services, "Given the rapid development of this area, there are little empirical data."[82] Nevertheless, some secondary information is included below. In India, there is evidence that there is a lot of foreign investment in new hospitals and state-of-the-art equipment by multinationals. These are mostly for the superspecialty corporate hospitals, and most are set up through collaboration with Indian firms. A $40 million cardiac center at Faridabad, the Sir Edward Dunlop Hospital, is set up by a consortium of three sets of companies from Australia, Canada, and India.[83] A German company has been allowed 90 percent equity ownership for setting up a 200-bed facility in New Delhi.[84] In Mumbai, GMBH of Germany has been given permission for setting up an orthopedic clinic with 100 percent ownership.[85] Apollo Hospitals Enterprise received funding from Citigroup, Goldman Sachs Group, Schroders PLC, as

well as investors from the Mumbai Stock Exchange.[86] Jordan has invested extensively in the modernization of public hospitals and medical schools, while at the same time creating incentives for both domestic and foreign private investment in the health sector.[87] As a result, 11 new private hospitals have sprung up, all with state-of-the-art technology. In Thailand, there has been an emergence of joint venture private hospitals formed by local and foreign companies.[88] Even the Cuban state-run monopoly, SERVIMED, has the potential to build more hospitals as joint business ventures with foreign companies or investors.[89] Since Cuba has strength in research, in marketing, and the know-how required to place its products abroad, it has entered into joint ventures with China, India, and Russia (that include setting up vaccine plants based on transfer of Cuban technology).

Direct foreign investment in medical tourism also originates in developing countries. Several private hospitals are spreading out into other countries. India's Rockland Hospital is planning to open a hospital in London where, in addition to regular services, follow-up care would be offered to European patients.[90] Cuba has been involved in other countries' health care for decades.[91] The demand for it is so great in Brazil that Cuba opened a hospital there (funded by Brazilian investors) to treat skin disorders. Also, the Apollo group of hospitals in India is building 15 hospitals in Malaysia, Nepal, and Sri Lanka.[92] In this way, India is competing with Singapore, which had earlier started investing in the health sectors in other countries (The Parkway Group has acquired hospitals in Asia and the UK, and has created joint ventures with partners in Indonesia, Sri Lanka, Malaysia, India, and the UK to produce an international chain of hospitals, Gleneagles International. The Raffles Medical Group has also formed global alliances with health-care organizations in the more developed countries). In Morocco, government bias towards private ownership led to the privatization of publicly owned hotels (so that by 1999, 24 of 37 had been sold[93]). One of the largest hospitals in Thailand, the Bumrungrad, is planning to invest in the Asian Hospital and Medical Center in Manila, thus acquiring 40 percent stake in the hospital. Apollo has linked up with hospitals in Bangladesh, Yemen, Tanzania, and Mauritius. Also, it runs a hospital in Sri Lanka and manages a hospital in Dubai.

Non-Medical Tourism

Typically, Western tourists travel to LDC resorts on Western airlines and stay in Western brand name hotels. They rent cars bearing Western names such as Hertz or Avis, and book land packages through Western companies such as American Express or Thomas Cook. All this implies that the foreign component of LDC tourism is huge. In fact, it is much larger than the

combined public and private domestic shares. The largest form of foreign participation is through direct foreign investment, which takes place in two ways, as in medical tourism. A foreign company may purchase or build a tourist facility from scratch, or it may lend investment capital to a domestic tourism enterprise. Such joint ventures are common. As mentioned in chapter 2, LDC governments welcome foreign investment because it satisfies the high capital requirements of the initial investment in infrastructure and facilitates, it transfers some of the risks to foreign firms, it facilitates the transfer of technology and managerial know how, it is a reliable source of tax revenue, and it stimulates development in other parts of the economy through backward linkages. Governments often adopt policies that encourage the inflow of venture capital to construct resorts and hotels that are then favored with a variety of tax incentives.

In addition, foreign involvement in the LDC tourist industry occurs through the intermediary sector including tour operators and travel agents. There are many such operators and the market is highly competitive.

Both with respect to medical tourism and nonmedical tourism, there are problems in foreign ownership and control that have led to various forms of regulation. As discussed in chapter 2, high leakages may occur as a result of the repatriation of profits and incomes. Also, foreign business activities may drive out domestic competition and suppress local entrepreneurship.

International Lending Institutions

Since public-private cooperation and collaboration in health have become common, international lending institutions such as the World Bank and the International Monetary Fund (IMF) do not limit themselves to funding public projects in developing countries, but rather have expanded to include private companies. Nevertheless, their primary health related objective is to fund public health projects. Such projects usually focus on policy and institutional reforms aimed to improve service delivery.[94] They also support the development of health financing policy and aim to increase the efficiency of public expenditures. These institutions explore a pro-poor focus to increase the availability of health care to more people. Also, sometimes the projects promote outsourcing in order to achieve efficiency gains. Indeed, the countries under study have received money from the international community for this purpose.

International lending occurs for public health programs, not for private medical care for profit. Nevertheless, it is relevant for a study of medical tourism insofar as international lending is used to build infrastructure that is crucial for the industry's development. Developing local infrastructure, as

well as health and education services, improves the overall investment environment for tourism and thus attracts investors. It provides those inputs that private tour operators as well as hospitals offering medical services require (such as roads, bridges, and airports) but won't invest in themselves. The World Bank has considerable experience in infrastructure investment, including hospitals, roads, water and sewage systems, communications, and transport systems. Indeed, most of their loans to LDCs have been major infrastructure development projects.[95]

When LDCs lack resources for the development of tourist facilities, they turn to international lending institutions. These include multilateral banks such as the World Bank and the Inter-American Development Bank. Also, UN agencies such as UNDP and the Global Environment Facility are involved in tourism projects, although not in a lending capacity. The UNWTO, an association of 138 government tourism boards with some 350 affiliate members, coordinates with multilateral and bilateral aid agencies and development banks in the provision of tourist related projects. However, it is the World Bank that potentially has the largest role in tourism development as its projects are based on the linkages between tourism and sustainable development in the economic, environmental, and social areas.[96]

International multilateral institutions provide LDCs assistance in formulating tourism policies and integrating tourism into broader policy frameworks. They help out with feasibility studies and risk assessments. They might even train local and central governments to build capacity and manage growth in that sector. Among multilateral institutions, it is the UNWTO that is most heavily involved in counseling countries on how to attract foreign investment. It also provides technical assistance to destination LDCs.

Charities and NGOs

There are numerous civil society and professionals groups working to improve health in developing countries. They include, among others, Health Action International, the Global Fund, Interactive Health Network, Healthlink Worldwide, Medact, Médecins Sans Frontières, NGO Forum for Health, Physicians for Social Responsibility, and the People's Health Movement. Charitable foundations have sprung up (the biggest and most ambitious is the Bill and Melinda Gates Foundation). With respect to tourism, some NGOs have also recently emerged, calling attention to the negative aspects of tourist development and making an effort to include local populations in tourism decisions. At this point, NGOs have not paid any

attention to medical tourism, although if it continues developing on its current growth trajectory, it is likely that pro-poor redistributive efforts will emerge.

Advisory and Regulatory International Agencies

International organizations coordinate public and private sectors in developing countries, and formulate a behavioral framework within which developing countries' governments can operate.[97] Given the novelty of medical tourism, rules have yet to be set in that area, so only the health and tourism industries are discussed. Legal considerations specific to the development of the medical tourism industry are addressed in chapter 6.

Health

In 1978, 134 countries and 67 UN bodies and NGOs got together in Alma Ata (Kazakhstan) for the International Conference on Primary Health Care and agreed on the principle of health as a human right. They adopted the Alma Ata Declaration that laid out the steps by which Health For All would be achieved by 2000. As a result, health is being discussed at the World Economic Forum and Group of Seven Summits, and commitments are increasingly being made. Although international organizations have put health issues on center stage (even if it is SARS and avian flu that receive much of the attention), health still has to compete aggressively for scarce resources with other ends in order to, in Lee's words, "grab a bigger share of the peace dividend."[98]

With respect to advocacy, international efforts aim at ensuring health care for the most underprivileged: the rural poor, mothers, infants, and mentally ill individuals. They urge governments to address the health care of all people. When the WHO makes the case for a particular program or target population, it disseminates information, develops new programs, and sets norms and standards (such as the Framework Convention on Tobacco Control, the Code of Marketing of Breast-Milk Substitutes, and International Health Regulations). The WHO also mobilizes funds and goodwill and organizes major eradication programs (such as Roll Back Malaria and the Tobacco Free Initiative). UNICEF is also involved in health initiatives, such as the Child Immunization Program among others.

To the extent that international organizations have addressed medical tourism, it has been in the following ways. First, it has been recognized that there is need to document this growing sector and in order to do so, there is a need to establish a comprehensive and systematic database on global transactions in the health sector.[99]

Second, one of the more notorious forms of medical tourism is what has come to be called transplant tourism, namely organ and tissue transplantations.[100] This occurs when patients travel to countries where they can purchase organs and thus bypass the queue in their home countries. Transplant tourism did not come to the attention of world organizations until reports from China, India, and South Africa surfaced about the sale of organs, especially among the most vulnerable, the poor and uneducated, who were most willing to sell their organs. The WHO recommendations are designed to harmonize global practices so as to control the practice.

Third, there are regulations pertaining to trade in health services that also have a bearing on medical tourism. The 1994 General Agreement on Tariffs and Trade (GATT) stipulated five multilateral trade agreements that have implications for trade in health matters.[101] First, countries may ban the import of products in order to protect public health. In addition, countries adhere to the following:

1. TRIPS (Trade Related Aspects of Intellectual Property Rights) that sets standards for the protection of intellectual property (and has ramifications for the importation of drugs);
2. SPS (Sanitary and Phytosanitary Measures) that affects national policy for food safety;
3. TBT (Agreement on Technical Barriers to Trade) that deals with the production, labeling, packaging, and quality standards of pharmaceuticals, biological agents, and other consumer products; and
4. GATS (General Agreement on Trade in Services) that deals with movements of consumers across international borders in order to get or give health care, the movement of capital across boundaries in the form of direct foreign investment, as well as the newer areas of e-commerce and telehealth.

Tourism

International agencies promote public sector coordination with the private sector in LDCs. The UNWTO offers its support by fostering a business friendly environment that gives private investors the possibility for commercially viable tourism projects and public/private partnerships. The IMF, as part of its structural adjustment programs in LDCs, supports the creation of a liberal environment for the tourist industry (one that includes privatization and foreign investment).[102]

International institutions also set behavioral norms for the industry. They seek to protect migrant workers and implement employment regulations. They also promote broad social inclusion in tourism projects. In this way,

UNWTO's Global Code of Ethics for Tourism has been exemplary: according to its Article 5, local populations must share in the economic benefits they generate, and Article 9 stipulates the rights of self-employed workers.[103] Also, the World Bank has partnered with indigenous people in LDC tourist destinations to launch an initiative supporting culturally appropriate development projects.[104] International institutions also provide a legal framework for the development of tourism (such as the GATS, as well as the inclusion of LDC tourism in, for example, the Uruguay Round).

Tie-Ins: Would You Like a Wilderness Safari With Your Lasik Surgery?

Imagine flying into an airport in order to have a medical procedure and flying out the same day, perhaps after a guided tour of the city. There is no need for imagination as this is a reality in Germany. The Munich airport has become a center for medical tourism with a clinic that has two surgery rooms, a MRI, and 13 beds. Patients are picked up from their arriving aircraft and taken through immigration. After diagnosis and/or treatment, patients either check into an adjacent hotel, go sightseeing, or fly back home.[105]

LDC medical establishments that cater to medical tourists offer significantly more in the way of tourism than a mere tour of downtown. Such tie-ins include, at the minimum, simple services such as helping out with foreign exchange, arranging interpreter services, and ensuring that proper dietary requirements are met. They might entail a few moments of personal exchange with a local in charge. At the other end of the spectrum, tie-ins are of much longer duration. The longest carries permanent benefits, such as European citizenship if a child is born in Ireland while visiting. In between the momentary and the permanent lie many different options. Some clinics assign to each patient a personal assistant for the duration of the post hospital recovery. Others include a recovery vacation. The package of services offered to international patients by Chile's Santiago Salud involves cooperation with travel agencies that make tourism arrangements, if the patients choose to engage in tourism along with their medical treatment.[106] The tie-ins to medical care at Bumrungrad Hospital in Thailand at a minimum include round-trip airport transfer, 24 hours/day assistance, and a Bangkok orientation tour. Patients can schedule excursions, trips to beaches, shopping sprees, and visits to ancient sites. All of these are scheduled around medical appointments. Wilderness safaris and game park excursions are the most frequent tie-ins offered by South African hospitals. Cuban hospitals offer seaside packages, bicycling tours, and Havana-by-night excursions. The huge

La Pradera complex outside Havana merges a hospital and resort facilities on a single site, enabling ambulatory patients an easy hour at the beach.[107]

Tie-ins extend to airlines. Many Asian airlines offer frequent flyer miles to help patients return for follow-up visits.[108] The Bumrungrad is exploring ways of offering frequent flyer miles for their medical services. Its CEO says that they are trying to figure out how to calculate miles: "If you have a cholecystectomy, how many miles do you get?"[109]

The tie-in options available to international patients are broad and suited for all tastes. If international patients choose not to stay in the crowded and congested capital city of Bangkok, the resorts on the coast sell beach holidays together with cosmetic surgery. Tourists can fly directly to Phuket and check in to the Phuket International Hospital that advertises "bright sun, blue sea, cosmetic surgery."[110] Another Phuket hospital, the Bangkok-Phuket, established a company in 2003 called Phuket Health and Travel Company in order to promote its medical tourism with the emphasis on the tourism.[111] In Malaysia, hotels provide package visits that include medical checkups and referrals to hospitals.[112] One hotel even has its own clinic (Palace of the Golden Horses near Kuala Lumpur). The Sunway Medical Centre is associated with the Sunway Lagoon Resort Hotel and promotes medical holidays. Tour operators arrange trips to popular resorts such as Malacca and Penang after cosmetic surgery. For those who are not inclined to taste exotic foods, hospitals such as the Bumrungrad have made it possible to order room service from familiar establishments such as Starbucks, McDonald's, and Au Bon Pain. India and Thailand both offer packages for getting a filling, extraction, or root canal with a vacation.

Why would the tourist want a tie-in? While it is not the reason people travel to one medical center over another, the tourist seeks out this exotic experience as a positive externality associated with the medical procedure. Patients are targeted by promotions that inform them of the beautiful experiences they can have at little cost—in other words, maximize the experience while minimizing the cost. The Bumrungrad Hospital website suggests that the money one saves on root canal work will more than pay for a luxury vacation. Even the Iranian Health Minister, Masoud Pezeshkian, suggested the price differential between medical procedures in Iran and the UK could be applied towards tourism.[113]

While tourists view tie-ins as important components of their medical travel, suppliers of medical tourism view them as an important component of their marketing. Tagging a vacation on to a medical service is viewed as a form of competition and hospitals are offering not only competitive prices for medical services, but also service usually associated with five-star luxury hotels. They view tie-ins as a form of product differentiation, so the range

of tourist experiences is improving and expanding. Suppliers of nonmedical tourism, such as hotels, are also attracted to the opportunities of tie-ins (according to Johanson, those resorts that allocate their resources to focus on health and wellness will dominate the resort market[114]). Governments have also jumped on the bandwagon. For example, Chinese authorities have recognized that foreigners who have come to China specifically for health-care services often travel within China afterwards.[115] In Iran, the Health Ministry is expanding ties with the Cultural Heritage and Tourism Organization in order to promote linkages between health and tourism.[116]

Some suppliers have deemed holiday tie-ins to medical procedures to be almost irrelevant since medical tourism tends to be associated with pain and suffering, and those who do it are not likely to care about vacations. Henderson said that medical tourism arises "from pain and suffering and carries intimations of human mortality, which are discordant with the hedonism of mainstream tourism."[117] She goes on to say that the priorities of such tourists deviate from the typical leisure tourists. Henderson's argument is certainly valid for major illnesses as some invasive procedures, especially those that carry large risks, are unlikely to leave the patient seeking a sun tan. However, medical tourism in the twenty-first century entails more elective invasive procedures than not. Furthermore, most diagnostic procedures and all lifestyle medical tourism are likely to utilize the tourism component. The lower the severity of the medical condition requiring travel, the greater the influence of the tourism component is likely to be. If more people in the future travel abroad for more and varying medical reasons because of cost or other issues, then they will likely be partaking in serious procedures, and then, the tourism component of medical tourism is likely to fall. Tourist planners will have to continuously come up with more interesting and relevant tie-ins if they want to forestall the evolution of the practice into simply medical travel.