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MEDICAL TOURISM DRIVING THE GROWTH OF THE INDIAN HEALTH CARE SYSTEM

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ABSTRACT

India has an additional requirement of 0.8 million doctors and 1.7 million nurses, apart from facing a significant shortage of paramedics. 45% of the population travels more than 100 Kms to access tertiary level of medical care. Poor accessibility, accountability, affordability, and availability of healthcare services are key constraints that make the idea of 'Health for all' a seemingly impossible accomplishment. Besides, the sector is largely dominated by unorganized private players, mostly comprising of clinics and nursing homes. These facilities offer limited range of services and operate with minimal standards of quality. Moreover, the public sector focus is mainly on primary care with a program based approach. Other issues restricting growth of the sector are of high capital expenditure, high dependence on imported medical equipments, long gestation period for the business to turn profitable, archaic norms for medical education, and absence of any central governing authority for paramedical education.

INTRODUCTION

The proper growth of Indian Medical Health Care System and related issues call for an integrated effort and investment across the entire value-chain of healthcare spectrum. Three broad components of this spectrum are healthcare delivery, pharmaceuticals, and medical equipments. Healthcare delivery comprising of primary, secondary and tertiary care facilities, constitutes a major chunk i.e. 77% of the total market. Pharma and medical equipment segments constitute 14% and 5% of the total market, respectively. While sustained expansion of healthcare delivery facilities like neighborhood clinics, day-care surgery centers, single and multi-specialty hospitals etc. is expected, it is also vital that support sectors and sub-sectors like pharma retail, wellness, medical technology, medical tourism, medical education and health insurance grow alongside and with equal vigor. Though, the role of private sector is going to get extremely crucial, government's contribution towards achievement of above mentioned expected growth in the healthcare sector cannot be undermined. The government's focus on healthcare has seen a positive upswing in the last few years and this momentum is likely to sustain in the coming decade with the implementation of a slew of measures proposed by the government.

Work is already underway in the setting-up of six world-class institutes of medical education, training and healthcare delivery along the lines of All India Institute of Medical Sciences (AIIMS), Delhi. Also, a total of nine under-graduate and post-graduate medical colleges and hospitals are being established by the Employee State Insurance Corporation (ESIC) not only in metros, but many tier-2 and 3 towns of the country. These two measures will greatly improve accessibility and affordability of healthcare services in non-metro cities, apart from providing quality medical education to many doctors and paramedical professionals.

The Research Methodology includes following steps:

DATA COLLECTION

Primary data give original information for specific purposes. It may be collected through survey.

Secondary data consist of information that already exists. The sources of secondary information are news papers, journals, books, magazines and medical Journals. These will be used to get a basic understanding of medical tourism in order to frame relevant questions. The data will be analyzed using correlation analysis.

Step 2: Sampling Techniques and Instruments

For sampling, the deliberate and stratified techniques shall be used.

Questionnaire, Personal Structured Interview, Telephonic Interviews, Internet Feedback will be used as instruments to collects information.

ORIGIN OF MTI

The revolution in the Indian tertiary (specialized) health care sector took place about 10-15 years ago. Medical tourism originated in India mostly for local expatriates and referred patients. 80% of the interviewees reported that the majority of the medical tourists belong to the catchment areas of India, namely Middle Eastern countries, SAARC nations (Afghanistan, Nepal, and Sri Lanka), CIS countries and Africa (Nigeria, Congo, Uganda, Tanzania and Namibia). The medical tourists vary from neonates‘to 14 years in the paediatric age group to 90 years for adults. They seek treatment for procedures such as joint replacement (knee), cosmetic reconstructions, dental procedures, cardiology, oncology, gender reassignment, neurology, minimal access bariatric surgery and alternative therapies such as yoga and Ayurveda. India is a preferred medical tourism destination amongst the patients due to the comparatively low cost of treatment; highly skilled medical and paramedical staff trained in the UK and the USA; and superior medical technology. The host hospitals with national and international accreditation promote medical tourism by means of country-specific marketing strategies, seminars, websites, educating the patients about their positive clinical outcomes, medical tourism facilitators and word of mouth recommendation.

The availability of economic and efficient human resources in India, political stability and accreditation of the multi-specialty hospitals (JCI and NABH) are some of the other growth drivers. India, at present, has 200 hospitals offering specialized tertiary care as against 15-20 in Singapore. Fortis Hospital (500 beds) and the recent Medanta Medicity (2000 beds) near the Delhi airport belt offers huge source of foreign exchange earnings from medical tourists.

Effect of globalization on healthcare policies and revenue with regard to Medical Tourism Industry in India

The globalization of healthcare services after signing of the GATS agreement (Mode 2 with cross-border flow of patients) led to the opening up of the Indian economy to the inflow of superior medical equipment, implants, and pharmaceuticals from overseas and improvement in quality standards with the establishment of the competitive benchmarking system and clinical governance.

It has led to a transformation of medicine from a country-specific domain to a multinational delivery of healthcare with multiple private hospitals emerging on the global stage such as Medanta Medicity, Fortis, Apollo and Max Healthcare. Globalization has also enabled the expansion of hospital networks overseas, such as Apollo Hospitals in Yemen, Fiji, Mauritius and

Middle Eastern countries. It has also led to the sharing of best clinical practices.

The MDA policy bolsters the wellness sector and incentivizes the hospitals participating in medical tourism as reported by 40% of the interviewees. The Indian National Health Policy of 2002 for promoting medical tourism is better suited for primary and secondary healthcare than tertiary. The foreign exchange earned is invested in medical research and in offering subsidized treatment to the underprivileged.

OPPORTUNITIES OF MTI

With increasing patient awareness and marketing strategies, the trend has reversed from a patient accustomed to being treated by an Indian doctor in his own country to the consumer (medical tourist) following the provider to India. MTI has established niche markets' with different countries specializing in certain procedures such as orthopedic and cardiology procedures in India (Macready 2007).

In succinct, as reported by **100% of the interviewees**, MTI offers affordable, qualitative, diverse medical care by skilled personnel; an increase in foreign exchange and revenue for host country; mushrooming job opportunities for hospitals, tourism industry and insurance companies; augments the global standing of the developing country; encourages greater investment in the health care infrastructure of the host country and simultaneously promotes a reverse _brain drain' (migration from developed to developing countries) of medical staff. (Appadurai, 1990; Weisbrot *et al*., 2000; Cornia, 2001; Dollar *et al.*, 2002; Sharpley, 2003; Fried and Harris, 2007; Horowitz, 2007; Turner, 2007)**.**

It ameliorates the state of overburdened health systems of industrialized nations like USA with 46.6 million people uninsured and helps to combat the long waiting lists for surgeries for UK patients (Starr Sered and Fernandopulle, 2005; Aston, 2006; Milstein and Smith, 2006a; Horowitz, 2007). Simultaneously, it provides opportunities for: cosmetic surgeries; procurement of rare drugs and procedures restricted in developed nations; privacy for patients undergoing fertility treatment; and drug rehabilitation along with an added excursion to the host destination (Batson and Oster, 2007; Breen 2007).

The medical tourism sector has been comparatively recession-free in India (60% of respondents). Additionally, with President Obama's healthcare reform in USA, India offers ample opportunities in the medical tourism sector as it offers cheaper treatment. The corporate offices (such as Blue Ridge Paper Products Inc, USA) are also offering packages with India as a medical tourism destination to its employees to cut costs. Additionally, with the increasing geriatric (elderly) in USA and UK there is a greater demand for health care services than can be delivered.

The Indian hospitals such as Apollo, Max, Fortis and Medanta have made agreements with insurance sector (TPAs) to cover post-operative complications for medical tourists such as BUPA, Aetna, Kaiser, Blue Cross and Blue Shield. There is an observed shift in economics from a zone of un-affordability to a zone of affordability of healthcare services such as medical tourists from Nigeria. Another factor is the indirect effect of hosting the Commonwealth Games in Delhi, 2010 where there has been an improvement in the infrastructure of the multi-specialty hospitals with an increase in bed numbers to accommodate the potential rise in foreign patients (medical tourists). McKinsey, US management consultancy, forecasts that Indian MTI will grow to $2 billion per annum by 2012.

CHALLENGES OF MTI

The major challenges of globalization of healthcare services with regard to MTI have been in the

area of public sector health inequity due to the private hospitals catering to medical tourists causing a "brain drain" from public to private hospitals. On one hand, some authors such as Bookman (2007) believe that it leads to greater access and quality of healthcare services. On the other hand, **40% of the interviewees** and few researchers argue that it leads to unequal work-force distribution (Lipson, 2001; Gawanade, 2003; Sengupta and Nundy, 2005; Wibulpolprasert *et al*. 2004; Herrick, 2007; Kapur, 2007).

Secondly, there is concern over ethical issues associated with procedures like organ transplantation and reproductive tourism for medical tourists. **60% of the interview respondents** either refuse to comment on these parameters, deny any such claim or give inconclusive answers. In addition, due to multiple hospitals offering facilities for medical tourists, there is greater competition amongst them both within them both within India and with countries such as Singapore and Thailand. The quality of care offered under such circumstances is questionable (**40% of the interviewees**).

Next, the medical tourists are also wary of fraudulent medical tourism facilitators and the occurrence of post-operative complications after departure from India. Hospitals reported difficulty in attracting medical tourists from publicly run healthcare systems such as in USA, UK and Canada due to: the logistics of long distance travel; negative image of India with regard to hygiene and security; four hour travel limit imposed by the UK government for its citizens; opening up of the European Union for UK patients and high customer service expectation as reported by Mudur (2004b), Macready (2007) and **60% of the interviewees**. Besides, there are security implications for the treatment of patients from Pakistan. Though the cost of treatment offered for medical tourists in India is reasonable, the hospitals contend that there is a gradual surge in the cost of treatment due to rising import costs of medical equipments and implants being imported. But, the payment potential of the medical tourists (Nigeria) is not increasing at the same rate.

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