

Medical Tourism in India: Progress or Predicament?

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It is estimated that the size of the medical tourism market in the country will be Rs 1,95,000 crore in 2012. Based on a literature review of healthcare business media, policy documents and a few academic papers, this essay looks at the scope for medical tourism in India and situates it within the Asian context. It traces shifts in policy with the growth of a tertiary corporate health sector that is urban-centric, and subject to minimal regulation and monitoring. The State acts primarily as a steward. The essay also examines the implications of medical tourism for general medical care and how such policy shifts distort health systems. This analysis raises questions of accessibility, affordability, and ethics in medical care, and asks if it is sensible to promote medical tourism in a democratic welfare state, with poor public healthcare facilities for the masses.

Technology has made transcontinental medical consultations a reality. Today, outsourcing of activities like laboratory investigations, medical transcriptions, software development, and telemedicine to countries like India, China, Korea, Japan, has become easier with business process outsourcing (BPO). The competition for opportunities is not limited to the local or regional but is a global phenomenon. Globalisation, it is said, lifts nations out of their isolated existence and makes them part of one “knowledge society”. Their medical institutions and companies no more play a limited regional role but become global actors.

Globalisation is also leading to growing disparities between those who can grab these opportunities and those who are left behind in the race. Globalisation and progressive liberalisation of trade in health services in the Association of Southeast Asian Nations (ASEAN) region contributes to widening inequalities in health and healthcare, increasing disparities between urban and rural areas and between rich and poor. The result is polarisation of healthcare provision and health outcomes in relation to social, economic and geographical marginalisation. Studies have also shown the undesirable consequences of rising costs, consumer exploitation (Wynne 2004) and increasing inequity (Koivusalo and Rowson 2000, Dummer and Cook 2008, Purohit 2001, Arunanondchai and Fink 2007).

Under this new dispensation, tourism took on new labels by categorising the tourists – student tourism, religious tourism, rural tourism, medical tourism, health tourism and even monsoon tourism. Medical tourism is often used synonymously with health tourism. One can, however, differentiate health tourism from medical tourism, where health and wellness tourism indicates travel to spa resorts or for traditional and alternative therapies. Medical tourism encompasses primarily and predominantly biomedical procedures, combined with travel and tourism (Whittaker 2008, Connell 2006). The term “medical tourism” (henceforth MT) was coined by travel agencies and the mass media to describe the rapidly growing practice of travelling across international borders to obtain hi-tech medical care. It is based on cheaper air fares, and internet and communication channels in developing countries and cheaper hi-tech super-specialty medical services for people who can afford it – be they foreign or national medical tourists. Using informal channels of communications and contacts, the practice avoids regulatory and legal scrutiny to generate substantial profits to the providers of various services.

This paper examines the emergence of MT as a policy and its expansion in India, exploring its impact on India’s public hospital system. It also touches upon the issues that MT raises in countries from where patients come. It is based on a review of the literature, including published research, web sites, newspapers,

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magazines, and the travel and tourism magazines that carry MT advertisements. This helps provide insight into the strategies being used for promoting MT.

1 Medical Tourism in Asia

To understand the impact of the journey of MT in India, it has to be located in its regional context. Asia has become a prominent destination for global medical tourists. At only 20% of the cost of treatment in the United States (US) and the United Kingdom (UK), it claims to provide “world-class” medical care. Medical expenses in third-world MT centres are one-eighth to one-tenth of those in the west, offering a business opportunity and better value for money.

The number of medical tourists to Asian countries is increasing by about 20% to 30% each year. It is estimated that medical tourism in Asia will be worth \$4 billion by the year 2012 (Confederation of Indian Industries-McKinsey 2002). The four main countries involved in this trade are India, Singapore, Thailand and Malaysia. Most of the medical tourists come from within Asia (Newman 2006). MT can contribute Rs 5,000-10,000 crore additional revenue for up-market tertiary hospitals by 2012 and will account for 3-5% of the total healthcare delivery market, says the Confederation of Indian Industry (CII)-McKinsey study on healthcare (2002: 1-2).

There is little data available on the actual number of people travelling to use medical services across south-east Asia. According to the tourism authority of Thailand, 6,00,000 foreigners sought treatment in Thailand and generated 20 billion Thai baht in revenues (\$0.5 billion) in 2004. According to the Singapore Tourism Board overseas visitors surveys, approximately 1,50,000 foreign patients sought healthcare in Singapore in 2000, spending about 345 million Singapore dollars (\$220 million). In Malaysia, the industry was estimated to be worth RM 60 million (\$16 million) with over 1,00,000 medical tourists (Whittaker 2008).¹

Emergence of Medical Tourism in India

The national government’s commitment to providing comprehensive healthcare to the citizens, irrespective of their paying capacity, as part of its welfare policies was given up after 30 years of independence when the Sixth Plan opened up medical care to the voluntary and private sectors. The rapid growth of the private sector over the 1980s, and the emergence of a corporate health sector in the 1990s was a part of conscious policy that chose to promote these segments. This was done through shifting subsidies in terms of cheap land, concessions for equipment and drug import, placing these institutions on government panels and making them a part of government insurance schemes in addition to providing trained personnel and expert physicians through state-supported medical education (Baru 2000).

The Eighth and Ninth Five-Year Plans emphasised primary healthcare for the underprivileged and the importance of involving the private, corporate and voluntary sectors in provisioning of medical care. The Ninth Plan also talked of alternative financing, thereby bringing in the policy of opening up healthcare to private insurance (Government of India 1992, 1997). Thus, the business interests of those other than professional providers of

care found a place in the articulation of the plan as well as health policy (Government of India 2002).

The introduction of user fee in the public sector further undermined the principle of equity. The poor were “targeted for services” in family planning and primary level care (Government of India 1997). The more complicated and expensive technologies were restricted to tertiary level institutions, and thereby became less accessible to the poor and lower middle classes. The national and international pressures for privatisation, however, were too strong to pay attention to these aberrations. The acceptance of the new economic policy and within it, of the health sector reforms by 1992 legitimised cutbacks in public sector investments in health as well as the commodification of health services (Baru and Nundy 2008). These shifts in policy gradually led to India’s acceptance of the economic principle advocated by the Commission of Macroeconomics and Health that investment in health was a route to economic development (World Health Organisation 2001).

The climax was reached when the National Health Policy proclaimed urban medical institutions as service production units at par with production units, and therefore, important sources of foreign exchange earnings (Government of India 2002). Cutbacks in the public sector no doubt lead to its shrinkage and the deterioration of public institutions. This has been used to rationalise the introduction of user fee, public-private partnerships (PPPs) and opening up the public sector to private investment.

Thus, a vision completely contrary to that of the initial five-year plans emerged. (1) A complete separation of services for the poor and those for the better-off and rich was rationalised. While the former got healthcare from peripheral institutions, paramedical worker and village-based volunteers, others had access to hi-tech institutions. (2) The nature of care for the poor itself changed from comprehensive to primary-level care (Qadeer 2002). This liberated public sector tertiary care institutions to make profits through MT and other forms of PPPs and charging for services (Roy 2007). In the process, health services became an instrument for market expansion and financial gains rather than welfare.

MT was a product of this process. The government policy of merging medical expenditure and tourism was announced by Finance Minister Jaswant Singh in his 2003 annual budget speech when he called for “India becoming a global health destination” (p 4). He glamorised the potential of hi-tech, complex technologies that offered relatively cheaper rates and yet earned profits. These could be invested in creating chains of such institutions, and in medi-cities. The malaria, plague and dysentery epidemics of the early 1990s pushed up health sector investments to some extent and the National Rural Health Mission was launched in 2005 to avoid the crisis of confidence and political backlash. But these steps in no way touched the process of instrumentalisation of health for market expansion, business and profit-making. Since then, the disconnect between a “world-class service” sector and a “primary level care” sector has only sharpened. We need to assess the nature of the former to evaluate its implications on the latter.

Current Status of Medical Tourism

Quality care, relatively cheaper services compared to the west, package deals and cheap services from the tourism and hospitality sectors and the options offered by holistic medicine are MT's biggest attractions in India. The price differentials of various procedures for Singapore and India with the west reveal the economic advantage offered to interested patients by Asia (Table 1). This is the most important factor in promoting MT even though along with the best medical treatment, a patient also has a chance to discover India through assured travel facilities for tourism and pilgrimage.

Table 1: Cost Comparison between India, USA, Thailand and Singapore
(Approximate figures in US Dollars)

Procedure	US	India	Thailand	Singapore
Heart bypass	130,000	10,000	11,000	18,500
Heart valve replacement	160,000	9,000	10,000	12,500
Angioplasty	57,000	11,000	13,000	13,000
Hip replacement	43,000	9,000	12,000	12,000
Hysterectomy	20,000	3,000	4,000	6,000
Knee replacement	40,000	8,500	10,000	13,000
Spinal fusion	62,000	5,500	7,000	9,000

Approximate retail costs. US figures based on Healthcare Cost and Utilisation Project data. International figures based on hospital quotes in named countries. Source: Accessed 19 April 2010: <http://www.docstoc.com/docs/12163631/MEDICAL-TOURISM/> p 36.

India's Eleventh Five-Year Plan mentions Breach Candy, Hinduja, Wockhardt hospitals and Apollo NUS Wellness Retreat, Mumbai's Asian Heart Institute along with Hotel Hyatt, J W Marriot, Renaissance and Resort for their excellent and extensive facilities. It also visualises high-end healthcare services through Indian BPO firms like Hinduja TMT, Apollo Heart Street, Comat Technologies, Datamatics and Lapiz that work in the areas of claim adjudication, billing and coding, transcriptions and form processing (Government of India 2008: 275). One-stop centres in key international markets to facilitate patient flow and streamlining immigration for healthcare are envisaged. The CIU, along with Indian Health Care Federation (IHCF), wants to establish an Indian healthcare brand synonymous with "safety trust and excellence".² Thus it is clear that the opportunities and challenges for growth in the health sector are seen primarily within the private/corporate sector, not in the public sector!

Institutions Practising Medical Tourism

India's comparatively better tertiary healthcare services draw clients from neighbouring countries like Bangladesh, Nepal, Pakistan and Sri Lanka that lack such facilities. Earlier too, patients from these neighbouring countries were coming to tertiary teaching hospitals like the All India Institute of Medical Sciences (AIIMS) and were treated according to their economic status. Patients from Pakistan, especially children with heart afflictions, have been regularly coming to Hyderabad and Bangalore corporate hospitals. Today, even government's teaching hospitals are being encouraged to promote MT by strengthening their private facilities. Given the extremely low levels of public investment, this could only be at the cost of facilities for the poor – local or regional. Private hospitals are advertising their services on the web and the Ministry of Tourism has put up its own list of mostly private and one or two public hospitals as destinations for

medical tourists in the major cities of India. These hospitals are destination for patients from neighbouring countries as well as from the Gulf countries, and a few non-resident Indians (NRIs) from the US (Dogra 2003).

These hi-tech hospitals attract patients from the middle-east as well as the west by offering them "First World Quality at Third World Rates".³ Patient flow from neighbouring and south-east Asian countries has increased nearly 12% at hospitals in Chennai, Mumbai, Hyderabad and New Delhi.⁴ Apollo has been a forerunner in health tourism for patients from south-east Asia, Africa, and the middle-east. It has set up a chain of hospitals in Delhi and Ahmedabad with the intention of attracting NRIs from the world over. A combination spa and hospital in Goa, with a focus on non-elective surgeries, has boosted the medical tourism in that state.⁵

In the wake of this newfound potential for MT, most of the private tertiary hospitals are investing heavily to give a facelift to their facilities, to make them visible to not just the local elite but also to overseas clients.

2 Services Offered to Medical Tourists

India is known as the cradle for test tube babies and is popular for surrogacy services (Qadeer and John 2009). Other than these, India offers hi-tech cardiac, paediatric, dental, cosmetic and orthopaedic surgical services as well as traditional healing systems. The medical tourism definitely does not cater to emergency services. The services provided are largely knee joint replacement, hip replacement (mostly orthopaedic), bone marrow transplant, bypass surgery, breast lump removal, haemorrhoidectomy, cataract surgery and cosmetic surgery, etc. Hospitals also advertise for preventive health checkups for family members accompanying the patients in addition to alternate medicine services (Peacock 2009). This is an area that we do not expand upon.

Promotional Strategies

Corporate hospitals in metropolitan and smaller cities like Pune, Goa and Ahmedabad have brought in five-star facilities and hi-tech medicine. Both the state administration and the corporate sector see the benefits of synergy for profits and have hence evolved separate as well as combined promotional strategies.

The state is proposing MT in its own institutions. It invests directly in infrastructure and tourism to push its policy support to the corporate sector in earning foreign exchange by treating MT as a trade. This encourages all the players directly or indirectly involved in MT to invest and expand their businesses – corporate hospitals, the aviation industry, private tour services, travel operators, the hotel and hospitality industries.

We explore these strategies in the section below.

Promotional Strategies of the State

The state has several interests behind its promotional strategies for MT. One is "medical diplomacy" to strengthen international relationships and friendships with neighbouring countries. The little girl Noor Fatima was not the first overseas patient to be treated in India, but the treatment of her cardiac condition was used to improve bilateral relations with Pakistan and for promotion of India's huge potential for MT. The news was all over the media.

Behind this seeming altruism lies the motive of enhancing economic growth, by not only commodifying medical care and supporting the private medical industry but also promoting investments in sectors supportive of MT. These include the Indian Healthcare Federation, private and public insurers, policy institutions, and the industry players mentioned above (CIU-McKinsey 2002).

PPPs with Supportive Sectors: These are being emphasised due to mutual advantages – growing profits for the private sector and less responsibility for the public sector. Tie-ups within the hospitals, hotels and tour operators are being promoted and are on the rise (CIU-McKinsey 2002). Promotion of MT in Goa, Delhi, Mumbai, Chennai is linked to the availability of direct international flights. Cities like Hyderabad, Bangalore have opened international airports and now offer direct flights from abroad to ease travel for patients. Yashoda hospital in Hyderabad has an airport kiosk and is planning a helipad on the terrace to airlift their patients.

As a part of this policy of promoting PPPs, the travel industry and tour operators have also put together packages that include air travel, hotel accommodation, and surgery expenses, claiming savings up to 80% of costs compared to the US. They operate as MT companies to facilitate travel for medical services.⁶ Other than the central government’s list of hospitals for MT on the web, the tourism departments of Maharashtra, Kerala, and Andhra

Pradesh too have created their own web sites to promote state-level MT services.

Medical Visas: A simplified systems of getting medical visas have been developed in order to make travel across borders smoother. Visas can be extended depending on the condition of the patients. India provides a special four-entry medical visa 42A category, designed specifically for this purpose.⁷

Upgrading, Certification and Accreditation: Most corporate hospitals are in the process of upgradation, certification and accreditation. Rating agencies like CRISI and ICRA have graded a few hospitals but certification also needs to come from international agencies like the Joint Commission International (JCI), which applies uniform cosmopolitan standards not only in terms of treatment, but also the infrastructure and facilities provided (Shrivastava 2003b). Apollo Hospitals group is now trying for an accreditation grading from this organisation. All standards cannot be adopted, hence they are also being Indianised (Shrivastava 2003a).

The National Accreditation Board for Hospitals and Healthcare Providers (NABH) has been set up under the national accreditation structure to establish and operate an accreditation programme for healthcare organisations (Anon 2009). Out of 30 applicant hospitals, two have already been granted accreditation and rest are undergoing different stages of evaluation. There are

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over 15,000 hospitals in the country but only 550 hospitals have the potential to become part of the Indian accredited healthcare hub. It is assumed that these will motivate other hospitals to follow suit and become showcases for MT (Gyani 2008). However, to get accreditation, hospitals incur huge initial and recurrent costs, which are not affordable for mid-range hospitals and out of the question for public hospitals, given the financial crunch. It is not surprising then that the NABH has been used primarily by private corporate hospitals. Data on improvement has yet to come into public domain for scrutiny. While these hospitals compete for the accreditation tag, the secondary and most of the tertiary public sector hospitals stay out of this net as they are in any case crowded with the less privileged!

Medical Tourism Council: The Maharashtra government in collaboration with the Federation of Indian Chambers of Commerce and Industry (FICCI) – Western Region Council has launched the Medical Tourism Council of Maharashtra (MTCM) (De Souza 2007). This council will operate as a nodal agency responsible for smooth operations of the MT sector and for attracting medical tourists, besides promoting Maharashtra's affordable cost-effective treatment and healthcare facilities. It is yet to be seen how far the affordable cost-effective treatment and healthcare facilities improve, without raising the cost of treatment.

Introducing New Legislation: Curiously, the now circulating National Health Bill (Government of India 2009) replaces the *provisioning* obligations of the state, which were clearly stated in the National Health Policy of 2002 (Government of India 2002), by *free access* to healthcare “by any healthcare service providers, public or private” (Government of India 2009: 13). It thus not only legalises both PPP and MT but also promises massive additional state subsidies to the latter through third-party payments. The requirements of a public health system are not defined and the difference in costs between the public and private sector, the importance of long-term monetary efficiency and the principle of strengthening primary healthcare are not highlighted. A system that could not regulate the private sector in over 60 years is now to, “adopt and implement national strategies and plans of action” to fulfil its obligations within a year of the passage of this bill (Government of India 2009: 15)!

Corporate Strategies for MT Promotion

The MT packages of the major corporate sector hospitals are advertised through the internet, private web sites and media channels. Official web sites of central and state tourism departments advertise MT under the “Incredible India” slogan. Many individuals have opened portals on the web about MT services and packages. The monthly magazine *Express Healthcare Management* promotes MT and some of the travel and tourism magazines too cover stories on it. These blatantly commercial advertisements use slogans such as “Bright sun, blue sea, cosmetic surgery” (Mydans 2002) or “where the cost saved on one MRI could pay for a return ticket, medical tourism is bound to boom”.⁸

MT is also being promoted through popular magazines, tourist guides, business magazines and journals on tourism. Textual and

video testimonies of cured foreign patients and administrators describing the excellence of the treatment, the low cost, the professional approach, the technical expertise, the dirt-cheap medicines, the affectionate and caring doctors and staff, and the cutting edge technology are all displayed on hospital web sites as evidence of efficiency.

Concierge Service: Various concierge services to facilitate the patients' convenience are also offered at some places. For example, hospitals may have kiosks at airports, offer airport pickups, bank transactions, or tie-ups with airlines for tickets and may help facilitate medical visas by the government. With more Arab patients coming in, some hospitals have hired Arabic interpreters, stocked up on prayer rugs and opened up a kitchen serving religiously acceptable meat preparations in corporate hospitals in Chennai and Hyderabad (McKennis 1999).

Holistic Centres within the Corporate Hospitals: Most of the big tertiary hospitals are opening up holistic centres within the premises, with yoga and meditation programmes along with naturopathy, herbal medicine, acupuncture and homeopathy departments. The claim is that these enhance treatment. However, these services are charged for and add to additional revenues. The hospitals have small spaces for the relatives to pray in, thereby wedding science with religion and traditional with modern medical practices.

These MT centres make efforts not to look or smell like hospitals. Hence, the decor is softened and the air is filtered. Gigantic, carpeted lobbies with deep sofas, potted trees and blonde-wood reception desks with the look of expensive hotels are popular. A homely and comfortable feeling to the patients and their accompanying kin is ensured. The reception lobbies in the corporate hospitals are adorned with huge paintings, sculptures, marbled floor and designer lights. There are bookshops, flower shops and cafés selling low calorie cakes and pastries, all to add to the attraction and profits!

Medical Exhibition and Conferences: India's leading medical exhibition and conference, HOSPImedica India 2003, was organised by FICCI in Hyderabad during 14-16 February (EHM News Bureau 2003). The conference involved top-level decision-makers from the medical industry and hospitals in India, well as group participation by hospital managers from countries like Germany, Austria and China to promote “high-end healthcare services”. Leading players in the latest products and technologies – Siemens, Larsen and Turbo Medical, BD India, Philip Medical Systems, and BOC India – from India reserved their space at the exhibitions.

Chairpersons of hospitals and senior doctors along with Hospital Federation of India (HFI) and the CII go to UK, Dubai, China and other countries to attend fairs and display the packages offered by their hospitals (Sama 2004). Besides popularising MT, these corporate organisations also promote the organisation of medical conferences. Behind the curtain of science, promotional efforts become an integral part of these conferences, as was the case with quinacrine (Rao 2004).

Setting Up National Level Bodies: To market India's specialised healthcare potential globally and address the various issues confronting the corporate healthcare sector, leading private hospitals across the country are planning to set up a national-level body on the lines of National Association of Software and Service Companies (NASSCOM), the apex body of software companies in the country. Talks are on between the Association of Hospitals of Eastern India (AHEI), Association of Hospitals (AOH) and other hospital associations in Pune, Delhi and other cities to form this body and give a boost to healthcare. The body would address issues related to infrastructure, health insurance, the role played by third-party administrators (TPAs), biomedical waste management, investments by foreign investors, tax benefits and promote India as destination for medical tourism. It is felt that not only the private hospitals but the country too stands to benefit from this by earning foreign currency (Roy Choudhury and Dutta 2004).

International Linkages: Corporate hospitals in developed countries have links with Indian corporate hospitals and do help in referring cases when their own queues are very long (Kang 2003). Major hospitals are forming partnerships and international linkages with other countries. Mohali's Fortis Hospital has entered into a mutual referral arrangement with the Partners Healthcare System, which has hospitals like Brigham Women's Hospital and Massachusetts Hospital in Boston under its umbrella, to bring patients from the US (Kohli 2002). Apollo and Rockland are in talks with National Health Services (NHS) of the UK to bring their patients for treatment at cheaper rates in India (Shrivastava 2003b). The Apollo group has tied up with hospitals in Mauritius, Tanzania, Bangladesh and Yemen. In addition, it runs a hospital in Sri Lanka, and manages a hospital in Dubai (Dogra 2003). As a packaged initiative, Rockland is soon going to start a Rockland hospital in London. This will also act as a follow-up care centre for patients from Europe (Dogra 2004).

3 Implications of Medical Tourism

Asia has become a prominent destination for global medical tourists. Within it, India has a relative advantage, as is evident from the institutions involved and the services offered as well as the low cost of treatment (Table 1). Its so-called "win-win situation" however, is based on the assumption that services for the haves and have-nots are totally independent of each other and the disconnect is rational. It is this very assumption that is flawed. In its effort to fill its coffers through MT, the government has underplayed the obvious contradiction between a vast uncared – for majority and an unethical focus on profits through MT. It has ignored many of the underlying negative implications of MT such as shift of subsidies to the private sector and extremely low inputs in public sector healthcare (Roy Choudhury and Dutta 2004).

India has 16% of the world's population, 18% of the world's mortality and 20% of the world's morbidity and our public expenditure on health is still 1% of gross domestic product (GDP). Budget 2010 is no different from the previous years (Bali 2010). Added to this is the incoming evidence of inequity and rising costs of medical care. The huge gap permitted between the

salary scales of public and private professionals has encouraged the movement of personnel from the former to the latter. This is particularly true of the shortage of nurses in the public sector, who are leaving for private and overseas jobs (Shaffi et al 2007).

Attracted by the higher scales and an open system of consultancy, experienced specialists too are moving away from public sector. While experienced doctors in the public sector are allowed to work in private institutions that benefit from their experience and fame, the government has no innovative policy to retain competent professionals or to regulate salaries and employment conditions across sectors.

Marginalising the concept of comprehensive primary healthcare by limiting primary-level care to at best First Referral Units (FRUS) and district hospitals denies tertiary care to the less-privileged unless they are ready to sell off their assets. This is reflected in the burden of debt due to illness treatment, which has increased to 40% of the total debt as per the 52nd round National Sample Survey (2000).

MT caters to the diseases of the rich. Hence the services these institutions promote are not necessarily in accord with the epidemiological priorities in the country. Only the upper crust gains through this skewed priority in service structure. As a result, MT may not have any significant impact on the pattern or the prevalence of major diseases in the country, where under-nutrition, communicable disease and high maternal and infant mortality still prevail. Unregulated privatisation and MT in fact create distortions and have negative implications for health, as in the case of Assisted Reproductive Technologies (ART) services that use underprivileged women for surrogacy and uninformed young women for harvesting of ova (Qadeer 2009; Gupta 2006) or the case of comprehensive primary healthcare now truncated by fragmentation (Qadeer 2002).

Another critical dimension of this growing industry is the probable impact it has on the countries it serves. Already there are concerns expressed in the US. Asian MT is seen differently by different stakeholders. The insurance companies and medical organisations see its "outsourcing potential" for lowering their own costs and enhancing profits. The uninsured and those who cannot afford their own private services see it as an opportunity. The state sees it as a mechanism for savings and as a price control mechanism in its medical market.

However, there are those who point out that in the long run, Asian MT is going to take away hi-tech procedures and leave American hospitals with unused capacity. Since most MT tourists are elderly patients going for non-emergency procedures, they also argue in favour of implementation of the Employee Retirement Income Security Act of 1974 that makes old-age healthcare secure and possible within the US (Brady 2007). There is a move to restrict use of insurance for MT purposes. Others point out that there are already companies floating to enhance MT to India. For the US government, outflow of clients in the medical market is an outcome of the healthcare and pharmaceutical malpractices, problems with the insurance systems and the high executive compensations that the Health Maintenance Organisations (HMOs) charge. It sees Indian MT as a loss for high-profit procedures and a challenge to the healthcare system.

MT then is a gamble for quick money while the market lasts. It fills private pockets but there is no evidence that those are transferred to the larger healthcare systems or shared. The so-called low cost of these services is at the cost of lower-level personnel while others make huge profits (Qureshi 2001).

Can any democratic country, be it developing or developed that has prided itself on its welfare policies, so distort its health

service sector that it begins to completely ignore the needs of two-thirds of its population? Can its brand of "safety, trust and excellence"⁹ for its tertiary level medical care services be restricted to those who access private and corporate sector care alone? In the name of international standards and opening up to the world, India must not lose sense of its specific context, for this in itself can become the nemesis of democracy.

NOTES

- 1 The Malaysian currency is called ringgit, but more commonly designated as RM.
- 2 Accessed on 19/4/2010: http://www.healism.com/blogs/the_stanley_rubenti_medical_tourism_blog/india%E2%80%99s_medical_tourism_growth_and_aspirations/
- 3 Accessed on 19/4/2010: http://www.healism.com/blogs/the_stanley_rubenti_medical_tourism_blog/cheap_healthcare_in_india_first_world_quality_at_third_world_rates/
- 4 "Medicare in India: Land of Healing". Accessed 27 May 2009: <http://www.indovacations.net/english/medicare.htm>
- 5 Accessed on 19 April 2010: http://sociologyindex.com/medical_tourism_in_india.htm
- 6 "Med India: Brilliant Physicians Unbeatable Prices". Accessed 27 November 2009: <http://www.medindia.us/>
- 7 "Medical Visa". Accessed 27 November 2009: <http://www.incredibleindia.org/pdf/medicalvisa.pdf>
- 8 http://www.sociologyindex.com/medical_tourism.htm.
- 9 The same as Note 2.

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