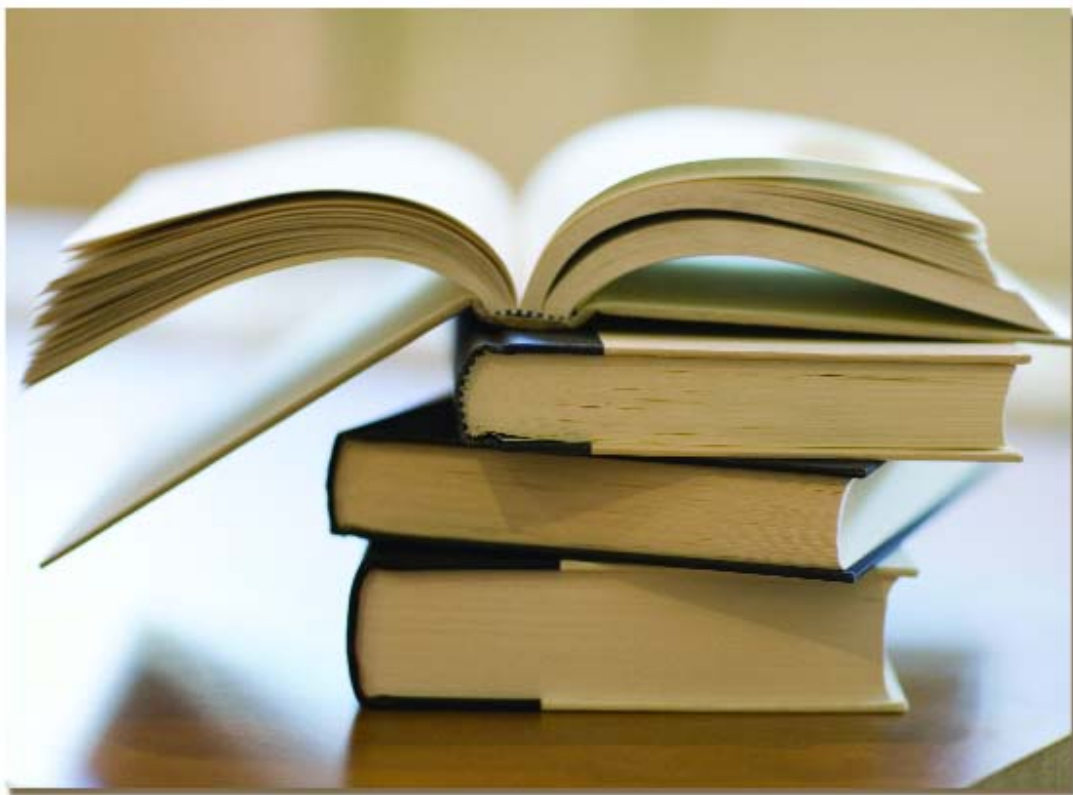


Medical Tourism



Medical Tourism

Contents

EXECUTIVE SUMMARY	4 - 5
INTRODUCTION TO MEDICAL TOURISM	
DEFINITIONS	6 - 8
DRIVERS	9-11
MEDICAL TOURISM INDUSTRY AND ITS MECHANISMS	12
Medical tourists	13
Healthcare providers	13-14
Intermediaries	14-15
Insurance providers	15-16
Internet and website advertising	16-17
Policies and government	17-18
Events	19-20
DISTORTED PICTURE	21
MYTHS AROUND MEDICAL TOURISM	22-23
INCOHERENT DATA AND NUMBERS	24
FACTS, RELIABLE FIGURES?	25-30
LEGISLATION AND ACCREDITATION IN MEDICAL TOURISM – TOWARDS PATIENT SAFETY AND QUALITY OF CARE?	31-33
FOOTNOTES	34-37
REFERENCES	38-40

Executive summary

A growing popularity has recently been gained by medical tourism. There is however no general agreement on a standard definition of this business characterized by speculation-based insight and significant gaps of evidence-based comparable data collection and industry regulation. An inconsistent literature about medical tourism and health tourism adds to the confusion. HOPE has been working for the last two years on trying to get a clearer picture. The report "Medical Tourism" published in September 2015 is the result of this work.

Medical tourism industry faces unreliable data when defining and measuring the market by number of patients. The estimate proposed by McKinsey (2008), 60000 inpatient medical tourists (outpatients like dental tourists excluded), and that by Deloitte Center for Health Solutions (2007), 750000 Americans only travelling abroad for treatment, show an improbable scope from thousands to millions of medical tourists. Medical industry events for stakeholders could be a potential key for industry ranking and knowledge. However, the usefulness of these events is limited by lack of reliable data at the basis of performance appraisal and presentation too.

Drivers originating patients' decision in having medical treatment abroad are not universally classified by scholars or by practitioners. Research is needed on medical travellers' profile and decision-making processes. Various professionals interact with industrial intermediaries that provide either more patient or more provider-oriented packages, often in a dysfunctional referral system. While brokers and agents only contact foreign facilities for treatment lacking medical knowledge, as no regulation exists, medical tourism facilitators follow the entire patients' journey, as they are professionals usually working with internationally accredited health care providers. Furthermore, despite the high risks, medical travel insurance providers showed little interest in offering such insurance since coverage and risk calculation lack standardized data and regulation. Powerful tool for influencing medical travellers' decision, appealing websites and social media do not solve risk-facing problem even when they are very informative ones. The role of States in medical tourism varies. Policy-making, decision-making and even investment-making have been identified to encourage the industry to grow and to promote themselves as medical tourism destinations.

Although this is about health and life, no common regulatory framework, no standard procedure and no transparent practices are in force. Questions are raised about providing locals and tourists an equal or a different treatment and what regulations are needed for cope with entities and physicians who undergo local regulatory framework of the destination country. Desire for more patients' trust, self-regulation and standardization within the industry is bringing international accreditation and certification. However accrediting and certifying bodies do not usually investigate on quality of consequently not comparable or guaranteed medical services and outcomes. Standards vary across accrediting bodies that grant permissive but expensive certificates.

Far from being approached through reliable, comparable and authoritative data, medical tourism relies then heavily on speculation-based information perpetuating references and idea-based reporting as a must in business. Hence medical tourism is not what people think it is. Some myths, i.e. false-to-be statements, are circulating including opinions that medical tourism is a global phenomenon; patients primarily value price; principal medical procedures are performed; the medical tourism market is skyrocketing and new.

To go further HOPE is now working specifically on the European Union experience in medical tourism. European healthcare systems usually provide a universal health insurance but they have different health baskets. There are then a lot of patients that receive medical treatments by travelling within European Union's borders, either in emergency or in elective care. This mobility is facilitated by mechanisms in place, in particular the regulation on the application of social security schemes (1708/71), the Directive on patients' rights in cross-border healthcare (2011/24/EU) but also the cooperation in border regions.

Introduction to medical tourism

Definitions

Though travelling abroad for health benefits is not a recent concept, it has been gaining more momentum and media interest in the last decades. Since the recognition and increased popularity of medical tourism, no unified definition has been universally accepted. This strongly affects the reliability and comparability of data, quality of published research, reports, statistics and articles. There have been however several attempts to define “medical tourism”. We have selected nine of them.

When consumers elect to travel across international borders to receive some form of medical treatment, which may span the full range of medical services (most commonly includes dental care, cosmetic surgery, elective surgery and fertility treatment). Setting the boundary of what is health and counts as medical tourism for the purposes of trade accounts is not straightforward. Within this range of treatment, not all would be included within health trade. Cosmetic surgery for esthetic rather than reconstructive reasons, for example, would be considered outside the health boundary – OECD, 2011¹

When a person, whose primary and explicit purpose in traveling is to obtain medical treatment in foreign country, excluding: emergency tourists, wellness tourists, expatriates seeking care in their country of residence, patients travelling to neighbouring regions to the closest available care – McKinsey, 2008²

Figure 1. Medical travelers



Source: McKinsey Quarterly, *Mapping the market for medical travel*, 2008

Broadly speaking it is the act of travelling to obtain medical care. There are three categories of medical tourism: outbound, inbound, and intrabound (domestic) – Deloitte, 2008³

Term coined by travel agencies and the mass media for the practice of travelling across national borders to obtain health care. It also refers to the practice of healthcare providers travelling internationally to deliver healthcare, which is both pejorative and less common – Segen’s Medical Dictionary, 2012⁴

When people who live in one country travel to another country to receive medical, dental and surgical care while at the same time receiving equal to or greater care than they would have in their own country, and are travelling for medical care because of affordability, better access to care or a higher level of quality of care. “Domestic Medical Tourism” is where people who live in one country travel to another city, region or state to receive medical, dental and surgical care while at the same time receiving equal to or greater care than they would have in their own home city, and are travelling for medical care because of affordability, better access to care or a higher level of quality of care – Medical Tourism Association⁵

When patients intentionally leave their country of residence outside of established cross-border care arrangements in pursuit of non-emergency medical interventions (namely surgeries) abroad that are commonly paid for out-of-pocket – Crooks et al, 2010⁶

Conscious activity, in which a traveler (a medical tourist) aims to receive healthcare services – in his or her own country or abroad to preserve (or acquire) a better health condition, and/or aesthetic appearance of his or her own body, sometimes combined with relaxation, regeneration of physical and mental strength, sightseeing and entertainment – Lubowiecki-Vikuk, 2012⁷

Involves people who travel to a different place to receive treatment for a disease, an ailment, or a condition, or to undergo a cosmetic procedure, and who are seeking lower cost of care, higher quality of care, better access to care or different care than what they could receive at home. Medical tourist generally ill or seeking cosmetic/dental surgical procedures or enhancements – Global Spa Summit Research Report, 2011⁸

A medical tourist is someone who travels outside of his or her own country for surgery or elective treatment of a medical condition. If we apply this narrow definition, we DO NOT include: dental tourists, cosmetic surgery tourists, spa and wellness travellers, “accidental” medical tourists (business travellers and holiday makers who fall ill while abroad and are admitted to hospital), expatriates who access healthcare in a foreign country – K. Pollard, International Medical Tourism Journal, 2011⁹

Two portals for medical tourism (International Medical Travel Journal and Treatment Abroad, both owned by Intuition Communication¹⁰) conduct research and publish reports (e.g. Medical Tourism Climate Survey, Medical Tourism Facts and Figures, The Treatment Abroad Medical Tourism Survey). But they do not provide their definition of medical tourism, unless one purchases their costly reports, in which the methodology is certainly presented.

The terms “medical tourism” and “health tourism” are not synonymous, although they are often confused and used interchangeably. Dr C. Constantinides¹¹ from HealthCare Cybernetics distinguishes both terms and defines “health tourism” as services related to health and involving some travel. As a collective term “health tourism” covers services, which are classified into eight categories: medical tourism, dental tourism, spa tourism, wellness tourism, sports tourism, culinary tourism, accessible tourism, assisted residential tourism¹².

K. Pollard¹³, on the other hand, introduces similar distinction of, what he calls comprehensively, “health and medical travel”. He splits this market into five segments: medical tourism, dental tourism, cosmetic surgery (or esthetic) tourism, spa tourism, wellness tourism¹⁴. It follows that all medical travelers are health travelers, but not all health ones are medical: regarding plastic surgeries, for example the aim is mainly esthetics, not health condition improvement. Hence, health tourism is a broader concept than medical tourism and should not be applied interchangeably. However, this is contradictory to OECD definition presented above. This sample of definitions reveals great incoherence in terminology. The medical tourism market is indeed an industry with significant gaps of evidence-based, transparent knowledge on the topic. So far, it has been working by sharing-knowledge and exchanging-experience basis. It lacks systematic and authoritative data collection concerning health services trade (both on worldwide aggregated and individual’s country level). This however is not possible as long as the sector is not well defined. All in all, this is a relatively recently recognised, unregulated industry with speculation-based insight.

Drivers

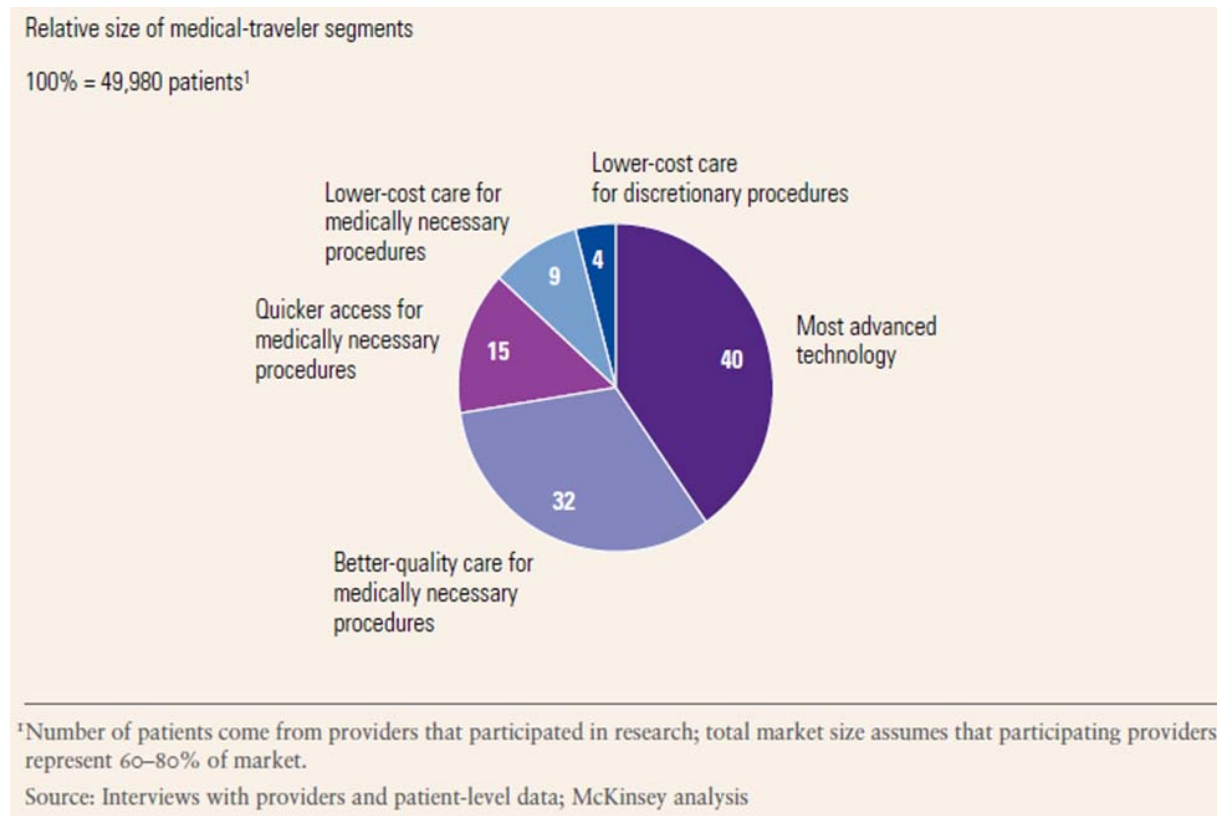
K. Pollard introduced a “model of destination attractiveness”¹⁵. The model covers the complex set of factors that determine patient’s ultimate decision where to pursue treatment abroad. It excludes technology and quality comparisons (as not contributing to being ultimate decision factors) and consists of seven key determinants.

- Geographical proximity, travel time, ease and barriers in reaching the destination. Patients are not willing to take long, indirect flights from/to deserted airports, nor are they willingly going through complicated visa procedures.
- Cultural proximity including language, religion, cuisine, customs and practices. Medical tourism seems to be influenced by familiarity and cultural similarity, for example former colonial connections (India-UK) and diaspora populations (coming back for treatment to a country people emigrated from).
- Destination image, reputation of a country and stereotypes, which are hard or even impossible to reverse. They influence patient’s perception of a particular treatment facility.
- Destination infrastructure on country or treatment facility level.
- Destination environment climate, tourism attractions, facilities compose factors that make the destination more attractive to a patient.
- Risk and reward. Medical tourists need to balance treatment outcomes against potential risks, considering safety, treatment guarantee, track records of particular medical services in destination countries etc.
- Price. Not only the treatment costs count, but also travel, accommodation and insurance expenses.

KMPG, on the other hand, lists geographical proximity and cultural similarities as prime reasons, later lower costs, better technology and wider treatment options, long waiting periods, tourism and vacation as factors that incentivise patients to follow treatment abroad¹⁶.

McKinsey on the contrary, through conducted research, recognises quality drivers as the major ones that influence patient’s decision on destination. They cover in order of importance: advanced technology, better quality, quicker access and at the very end – costs of care¹⁷. The level of importance is presented in Figure 2 (page 10).

Figure 2. Medical tourism drivers



Source: McKinsey Quarterly, *Mapping the market for medical travel*, 2008

Glinos and Baeten¹⁸ assume that patients prefer to be treated “*as close to home as possible in a system they feel familiar with, but under some circumstances they might be willing or even prefer to be treated abroad*”¹⁹. They distinguish five key drivers for patient’s mobility.

- Familiarity/proximity, regarding culture, language, habits, religion, history. Patients feel more comfortable when they feel familiar with the system and are able to speak a mutual language.
- Availability with distinction on the services that are unavailable due to long waiting lists or because they are not all offered in the country of origin.
- Financial costs, the majority of medical tourist pursue treatment that is excluded from the national health care coverage and since patients are forced to pay out-of-pocket, they seek optimal value-for-money services.
- Perceived quality, patients think that foreign healthcare services are of higher quality than in their national systems.
- Bioethical legislation, patients seek treatment that is illegal, hence not provided in their home country.

A report commissioned by the Executive Agency for Consumers, Health and Food (CHAFEA) and published in August 2014 shed some light on “Patients’ choice within the context of the Directive 2011/24/EU”²⁰. The study was divided into two phases: Phase I is based on a controlled online experiment and survey undertaken in eight Member States, which investigated the impact of information on respondents’ choice to seek healthcare cross-border in the EU. Phase I also included a survey of payers. In Phase II a shortened version of the Phase I experiment was implemented along with a survey that asked respondents questions about their experience on the National Contact Point websites.

The survey of citizens and doctors, in combination with the behavioural experiment, identified the key drivers of travelling to another Member State for a medical treatment. The most important drivers identified were the following.

- The cost of the treatment in the other Member State relative to the cost of the treatment domestically. Cost is found to be the strongest determinant of deciding to select a cross-border provider of healthcare in our experiment.
- The waiting time of the treatment in the target country relative to the waiting time in the home country is the second most important driver of selecting a cross-border provider of healthcare.
- Trust in the healthcare system in the target country and in particular the difference in trust in the target country healthcare system and the domestic healthcare system is the third most important driver of opting for a cross-border treatment.

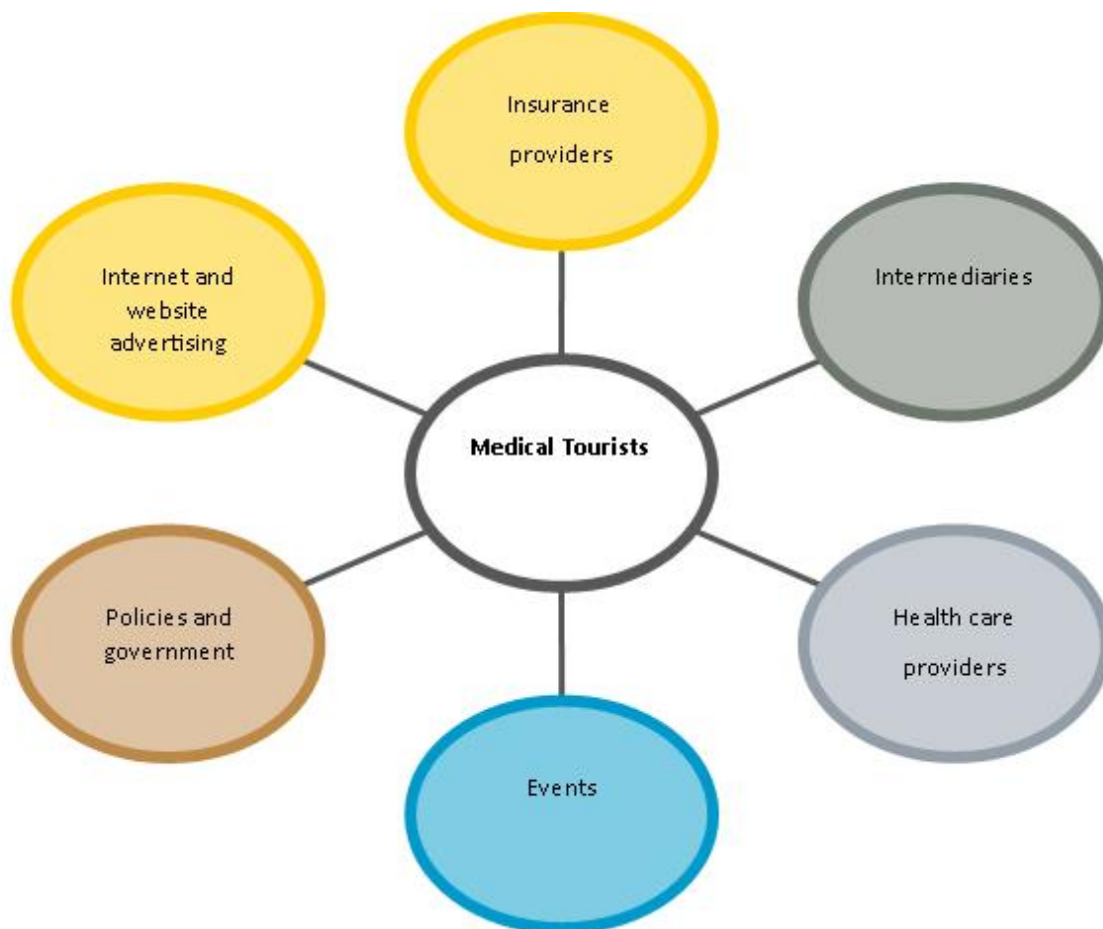
Another set of drivers are categorised into push and pull factors. The former includes high cost of out-of-pocket payment for procedure in home country, lack of insurance or underinsurance, long wait-times. The latter consist of quality of service, care and facilities, mutual language, vacation aspect, political climate, religious aspect²¹.

Medical tourism industry and its mechanisms

The patterns and tendencies in executing medical tourism over recent decades are vague and unidirectional. It might be alternative to regular tourists, which first pick the kind of holiday they want to have, regarding activities, time span, facilities and infrastructure – in short – their preferences. Then, they think of a country and region they can do that in and, at the end, they pick a hotel or resort they want to stay in, trying to utilise their stay and select the most cost-effective option. This could also be the mechanism in medical tourism: patients first decide not on a specific medical facility from the ones all over the world, but, once they recognise their medical needs and other preferences, they choose a country or region and then look for best medical facility within the chosen destination and at that last stage the price might be the differentiator. Therefore, it leaves the price as not-a-first-choice factor²².

The sole use of services is only one part of the medical tourism industry. Other components of this complex mechanism shall not be forgotten or underestimated. As an industry, medical tourism consists of a wide scope of stakeholders, acknowledging mainly commercial, for-profit interests. Beneath are presented major participants of the industry.

Figure 3. The medical tourism industry



Source: partition based on literature review

MEDICAL TOURISTS

Medical tourists are in general patients paying out-of-pocket and pursuing medical services offered in the private sector²³. They are considered to be the manager of their own medical case. The question remains whether medical tourists can manage well, giving the circumstances of asymmetry of information and lack of medical expertise. What needs to be emphasised is that patients carry great responsibility for their health tourism outcomes. Given the lack of international regulation, those responsibilities range from evaluating the credibility of information and rating the facilities before reaching the final decision, through collecting and providing full medical documentation, to minimising risks related to travel and receiving care abroad²⁴. One qualitative research on Canadian medical tourists show that during the decision-making process about treatment abroad a crucial factor is reliable information *“about the reputations of surgeons abroad and hearing testimonials from other patients who had gone to the same facility. Having access to both of these types of information increased participants’ comfort with their attitudes towards having confidence in their decisions”*²⁵. Yet, little is known about the medical traveller’s profile (socio-demographic status, age, gender, health condition etc)²⁶. Also, since it is perceived that *“information frequently used by medical tourists during their decision-making process may be biased and/or lack comprehensive information regarding individual safety and treatment outcomes”*²⁷, research is needed on how the medical tourism information are accessed, processed and assessed²⁸. Further, there are concerns that receiving treatment abroad is driven by commercial and seeking profit priorities, rather than approached purely professionally, which implies manipulating the patient into pursuing unnecessary or multiple treatments²⁹.

“Have to” vs “want to”³⁰

“Have to” and “want to” are two separate mechanisms stimulating medical tourists. The former one refers to medical travellers pursuing treatment abroad as a consequence of national inefficiency of the health care system (long waiting lists, high prices, lack of access or technology, legal constraints). The latter one reflects an elective decision of an individual, who, among competing providers, seeks for world’s most advanced technology and better quality. Such categorisation covers to some extent also the division of factors to pursue medical treatment: the ones that lead patients outside their home country and the ones that attract patients to a foreign country – push and pull factors. Those two sets of factors influence together the decision-making process³¹.

HEALTHCARE PROVIDERS

We observe a great diversity of providers of health services within the medical tourism industry, notably commercial, for-profit entities. Common view is that providers from leading medical destinations are those from developing countries³². However, they are not the only ones. The providers vary from solo practices, through large medical facilities, to groups of hospitals that are a part of corporations. They partner with other industry actors, like travel agents, brokers, insurance companies, as well as other hospitals and universities (often foreign ones with good reputation).

HICs vs LMICs

The earlier mechanism led wealthy patients from developing countries to seek treatment in developed nations, due to health care system inefficiency in country of origin. A current pattern within the medical tourism industry is the reversed flow of patients, recognised now to be from high-income to low- and middle-income countries³³.

Regarding professionals, “internal brain drain” phenomenon is observed in destination countries – medical staff migrates within the country from public sector to private, and from rural areas to cities, seduced by higher salaries and access to advanced technology they are provided with in the medical tourism facilities³⁴. It can be also that professionals receive education and training in developed countries and after that they come back to their home, developing country, to work for private, medical tourism sector³⁵.

INTERMEDIARIES

The development of the medical tourism industry created a demand for travel- and care-coordinating institutions, which in turn opened a niche for agencies and brokerages to start up businesses. Intermediaries often offer individually tailored packages, which include arrangement of treatment, recuperation, flight, accommodation, leisure etc. The ones located in country of origin are more patient-oriented, whereas the ones located in country of destination are more provider-oriented³⁶. Since brokers and agents do not hold any responsibility for patient’s well-being and satisfaction, it may be that they do not investigate the competences, qualifications, quality and scope of provided services of the health care facilities they send patients to. Nonetheless, it is obvious that the position of facilitators in medical tourism mechanism is strongly present, since travel arrangements are challenging for patients, as well as for clinics - reaching clients directly in foreign markets is a very costly promotion and marketing approach³⁷. Dr Jagyasi presented, through his research, that the majority of medical tourism professionals find the role of intermediaries significant³⁸. On the other hand, it is underlined that intermediaries should elaborate a kind of edge “to avoid the fate of traditional travel agencies”³⁹.

Additionally, the nature of patient-intermediary-provider relation induces a dysfunction within this triangle and within the referral fee system. In the situation, when the intermediary receives a commission from the provider per referral, it might be the case that the intermediary sends the medical tourist not necessarily to optimal-and-best-for-patient healthcare provider, but more likely to the one that pays the highest commission⁴⁰.

Going randomly through the list of medical tourism agencies, one can notice that some of the agents do not have websites or that the website links lead to nowhere, provide vague or hard to find information about their business and location or do not describe the scope of responsibility they bear as being the intermediary between the patient and healthcare provider. Hence, there seems to be need of regulating medical tourism facilitators, for example by licensing each one of them by the country they function in, therefore it will not allow anyone to be a “medical tourism agent”, as it is the case now⁴¹.

A broad list of medical tourism agencies from all around the world, registered by the International Medical Travel Journal, can be found under:

<http://www.imtj.com/marketplace/medical-tourism-agencies/directory/>

The forum for medical tourism intermediaries is currently more passive than active, managed by International Medical Travel Journal:

<http://www.imtj.com/marketplace/medical-tourism-agencies/forum/?p=1>

An example of certification for medical travel intermediaries offered by the Medical Tourism Association is visible at:

<http://www.medicaltourismassociation.com/en/certified-medical-tourism-specialist.html>

Broker and Agents vs Medical Tourism Facilitators⁴²

There is an alleged difference between the two groups of intermediaries in arranging patient's journey for health: broker and agents; medical tourism facilitators. Generally, anyone is legally allowed to establish a medical tourism brokerage or agency, since neither standards, nor regulations are in force. Agents and brokers may lack necessary medical knowledge and expertise. They normally initialise the contact with the foreign facility for treatment, but do not follow further or provide the patient with other services. They mainly pursue profits by getting fees from patients or per-referral commissions from hospitals. Agents and brokers can disappear from the market as quickly as they appeared on it. A Medical Tourism Facilitator, on the other hand, is usually an organisation run by professionals with technical knowledge and expertise. A team of physicians, surgeons and other medical staff, on the basis of the analysis of medical documentation and consultations, decide which medical facility fits best a patient. Medical Tourism Facilitators have usually agreements with internationally accredited health care providers. They are supposed to conduct an in-depth background check of the facilities they send patients to. Their services include usually all arrangements of patient's journey, including also the independent arbitration between patient and clinic.

INSURANCE PROVIDERS

Insurance is a crucial component in pursuing medical treatment abroad, considering all the risks that can occur during and after treatment. Patients are often unaware and they fail to disclose that the real purpose of travelling is to receive treatment. Failing to reveal such information can invalidate the insurance policy. Traditional travel insurances usually exclude planned medical treatment anyway; they just cover emergency treatment. Hence, the medical traveller frequently ends up being uninsured or with the wrong coverage. Moreover, often the term "medical travel insurance" is confusing and confused by travellers, who think the insurance would cover the post-treatment complications and negligence, but in fact it is only typical travel insurance for (medical) tourists, covering emergency treatment and "lost luggage"⁴³. At the other end, we have international health insurance, which also can be confused with planned overseas treatment, but in fact it just serves to cover expatriates⁴⁴. Generally, insurance is considered for unexpected events. The issue of negligence and malpractice by a hospital is, however, an unexpected turn of events⁴⁵. Medical complication insurance provides cover if the treatment goes wrong. For example, BorderCross Worldwide's medical procedure insurance⁴⁶ offers "*comprehensive medical coverage options to remedy complications incurred from a treatment abroad during the medical tour and when the Medical Tourist returns home*" (for medical complications, trip cancellation/interruption/delay, acute medical treatments, evacuation and repatriation)⁴⁷.

There is a perceived reluctance towards medical-tourism-related insurance on both sides: the patient's and the insurer's. The former is uncertain about the factual coverage of the insurance – if small and smaller print at the end excludes insurer's liability towards covering costs for medical complications. So the demand side is rather cautious about purchasing extra an expensive insurance. The latter finds it hard to calculate risks and underwrite proper policies, since the market of foreign treatment services may not be well described, data unavailable, standardisation and regulations not introduced. Poor quality, nosocomial infections, malpractice and negligence, lawsuits, force majeure – all of it needs to be taken into account when evaluating risks on a global scale. So the best solution for the business of insurance companies is often not to do it, hence there is very few underwriters offering such insurance⁴⁸. As Youngman claims, medical tourism "*will remain a self-pay industry, as insurers are not really interested*"⁴⁹.

There are however some examples of insurance for medical tourists:

<http://www.globalprotectivesolutions.com/>

http://www.compassbenefits.com/medical_tourism_insurance.html

<http://www2.sevencorners.com/medical-tourism-insurance/>

<http://medicaltravelshield.com/maintenance>

<http://sureinsurance.co.uk/our-products>

<http://www.allianz-assistance.co.th/corporate/what-we-do/medical-tourism/>

<https://www.allcleartravel.co.uk>

The International Society of Aesthetic Plastic Surgery (ISAPS)⁵⁰ introduced insurance that registered ISAPS members – cosmetic and plastic surgeons – can offer to their patients. It is only available to approved surgeons and the policy covers corrective and remedial treatment that may follow plastic surgery, including most common conditions that may require revision surgery. Currently over 80 surgeons (2014) worldwide offer such insurance.

Passport2Health⁵¹, first health insurance plan based on medical tourism, launched in 2012 in the UK, is offering patients private diagnosis at home, private treatment overseas in Europe in one of selected network hospitals and follow-up care and rehabilitation back in the UK. The policy was offered to small and medium sized businesses and individuals and in 21 months the insurer sold only 100 policies. Now the insurer does not accept new clients anymore and ceased its activity. The reason behind its failure is perceived in multiple areas. Firstly, it is hard to underwrite such policy that covers treatment abroad - lack of comparable data makes accurate risk estimation hard to achieve. Secondly, the companies and individuals lack knowledge about medical tourism and are not entirely convinced to buy a strange product that offers 30-50% saving on premiums. They do not trust the concept of going abroad for surgery and simply present different preferences – to be treated in the UK, and within the country they seek better policies⁵².

INTERNET AND WEBSITE ADVERTISING

Like many other privately-driven industries, medical tourism industry also needs exposure in form of advertisement. Had not it been for the development of ICT (among other crucial factors), the medical tourism mechanism would not have its today's shape and momentum. Website advertising is now the most common source of information to medical travellers⁵³. Internet allowed that, taking only few minutes, all computer and smart phone owners can shop now for a surgery on the other side of the globe, coming in discounted packages⁵⁴. Probably, only few people would be encouraged to pursue treatment abroad based on letters and correspondence that is taking months.

The website is often the key link and ultimate bargaining chip between the prospective medical tourist and foreign treatment provider⁵⁵. Patients perceive physicians and hospitals as presented on the portals as the conventional doctor-patient relationship is replaced by a virtual one⁵⁶. Based on Internet searches, patients make decisions; hence it is crucial to provide them with appealing websites – without linguistic errors, nice layout and transparent information⁵⁷. Without proper exposure even best clinics cannot succeed, and those that did, and are now destination leaders for medical tourists are probably not the ones with world's best doctors, technology and prices, but with most successful marketing strategies.

Word-of-mouth and sharing experiences in social media are also likely to be powerful marketing tools, since medical tourists are like global "ambassadors" for the destination country⁵⁸. The problem is that what other people publish on the Internet is out of anyone's control over the content and it is likely to stay there

forever, no matter whether it is true or not. It is also advised for the providers to differentiate the marketing strategy throughout specific, niche services and narrowly-targeted groups of potential medical tourists, hence avoiding the strategy of advertising “all possible treatments to patients from all over the world”⁵⁹.

Going through many websites of healthcare providers or medical tourism facilitators, a lot of them give the impression of being fly-by-night and phony companies, with websites full of errors, ranging from linguistic to content-related ones and leaving the website visitor with mistrust and suspicion. That can be discouraging for prospective medical travellers and dangerous to patient’s well-being, if one decides to purchase the services of fake and not professional providers. On the other hand, one has to remember that a decent and “informative” website does not deprive health tourism from treatment-related risks.

POLICIES AND GOVERNMENT

The role of state involvement in encouraging, developing, structuring and promoting medical tourism in the country of destination varies strongly across nations. Some countries clearly emphasise the promotion of medical tourism industry by undertaking initiatives, which intend to enhance country’s comparative advantages, whereas others just let it be or on the contrary try to stop it. Such policies, to boost the industry growth, include for instance⁶⁰:

- facilitated visa procedures or new medical visa categories;
- tax incentives;
- investment in healthcare infrastructure;
- special organisations solely for boosting the growth of medical tourism industry – either state-funded or private;
- subsidies.

Some countries aim at positioning themselves strongly as medical tourism destination from national level. Governments play active role in promoting medical tourism industry by engaging national ministries of tourism, health, state/regional tourism promotion organisations or by launching studies and research. Some of them even provide dedicated national promotion websites for medical tourism – stamping the industry “state-guaranteed”⁶¹.

Exchange of arguments of the industry professionals, accessible through Internet sources, leave the question of “What should be the role of the state in developing medical tourism?” still open and vaguely answered. Some arguments of Dr Constantinides suggest that: *“one role of the State is that of commercial diplomacy which in the case of health tourism refers to supporting the promotion of businesses and destinations. (...) founding of industry representative bodies must not be State creations and certainly, not State-led. Nevertheless, the private sector should be able to rely on State blessing, endorsement, support and commitment for these initiatives. We should demand that the State be a supporting partner - rather than the leader. And the State should act as the guarantor of consistency and continuity of the stakeholder concerted action initiatives. The State (...) can co-fund initiatives associated with industry shaping and destination enhancement even if this needs to take the form of a Public Private Partnership (PPP). What the State must not do is play the role of entrepreneur. And, in the case of medical tourism, the State must not see medical tourism as a source of revenue for public sector hospitals. (...) The government’s benefit should be in the form of taxes collected from private sector medical tourism activity. Nothing more... Nothing less. (...) But the State is also a decision-making and investment-making stakeholder. (...) We expect the State to: provide legislative and regulatory consistency and certainty; contribute to infrastructure development. (...)*

*In the context of Health Tourism, the primary objective of legislation should be to 'enable' rather than to 'regulate'*⁶². Moreover, the expert claims that introducing incentives and subsidies to medical tourism industry (financed for example from "economic stimulus spending" packages) is an euphemism for dumping⁶³. Such opinions imply somehow restricted and limited role of government and policy-makers in the mechanism of medical tourism. In contrast, other concepts emphasise government structural power, coordination function and mention state-led infrastructure interventions as a state's role in medical tourism development⁶⁴. Further, *"it is possible that increase foreign exchange earnings may be later used for funding the country's own public healthcare system"*⁶⁵.

National policies and legislation can be also disincentivising for investors and health tourism industry development, since counter-productive bureaucracy, ambiguity and preposterous regulations can be imposed⁶⁶.

From another perspective, stormy discussions about the influence of sending/receiving medical tourists on public healthcare provision arose. The issues evolve around the questions like: does the domestic healthcare system benefit or does medical tourism industry "steal" resources from locals in need? How should the government respond to that? What is the properly balanced policy between equitable healthcare entitlement and encouraged medical tourism development⁶⁷? One discussed issue accuses policy-makers of shifting scarce resources and investments from public healthcare sector for domestic patients to private international-bound in a direct way, but also indirectly – by relocating publicly-educated physicians to medical tourism business⁶⁸. It implies that local patients are being excluded from their own healthcare system and that the investments shift from wide-reaching primary care sectors to high-tech specialisations for a limited number of people. Moreover, medical tourist can come back to one's country with medical complications, needing post-operative care which then is funded by the home country.

On the other hand, it is claimed that medical tourism is a solution to health systems defects of destination countries. Firstly, bringing privately-paying medical tourist to the hospital, which brings extra profits, can allow public insurers to underpay for the local insured patients⁶⁹. Secondly, infrastructure investments eventually benefit locals as well, hence medical tourism might create *"long term, high-skilled jobs necessary for a strong tertiary health care system"*⁷⁰. The question of the balance of effects of medical tourism on the country of destination and origin haven't been answered directly and with mutual coherence of researchers. Neither there is a solution to the issue whether the medical tourist should pay for the treatment more than other service recipients⁷¹.

The role of the state should also aim to regulate and introduce transparent standards on patient's safety and malpractice laws in destination countries, along with the regulations on medical tourism facilitators⁷². Political stability may also encourage the development of the sector⁷³. Another contribution of government's initiatives to the industry should be data collecting, reliable data-collecting. Private providers have no interest in delivering to their governments official data on their business regarding medical tourism. These data about businesses functioning on a competitive market are sensitive information, and the business owners are not eager to share and reveal it, if it might put them at a disadvantage.

EVENTS

Major events for major stakeholders in medical tourism industry include conferences, exhibitions, trade shows etc. One can either attend, exhibit or sponsor the events. They are held worldwide and provide key players with a platform to meet and “talk business” – as an integral component in every industry, a mutual admiration society is actively present. Hence, it shall be of no surprise, that the same pattern regards medical tourism industry. But do they eventually deliver awaited results: attracting medical tourists and becoming a recognised country of destination? In general, medical tourists do not attend such gatherings. Mostly competitors do and the rule is: who pays, speaks and shines. What are the expectations of such events? Is it just to chit-chat, exchange experience, anecdotes and speculation-based opinions? Who does really benefit? Here are some rather critical and myth-breaking comments on medical tourism events:

“Just adding another myth: going to global medical tourism conferences brings business. Especially the big ones with 3000 attendees and 200 speakers... where the biggest sponsors and those who pay for big booths get ‘awards’ (...). Obviously, attending big flashy MT conference will not solve the problem, or bring business”⁷⁴

“(...) attend conferences and events, which have little impact on what country consumers decide to go to”⁷⁵

“The industry spends vast sums on conferences and exhibitions, but little on understanding its customer base”⁷⁶

“Attending a medical travel trade show will not generate consumer leads or directly improve the number of medical travelers visiting your destination”⁷⁷

The above citations suggest that medical industry events for stakeholders do not absorb customers directly into the business circulation. Then what is the point of participating in them, actively or passively? Dr Constantinides claims that the key reason behind it (among others), given the situation that the other attendees are in fact competitors, is to establish the “*industry ranking*”⁷⁸. I. Stackpole answers this question with a list of points⁷⁹:

1. to learn best practice from others;
2. to understand more about the sector;
3. to gain insight from others who face similar challenges;
4. to identify market opportunities;
5. to find business partners;
6. to network with the like-minded;
7. to influence the direction of the sector;
8. to meet your competitors... (lots of them);
9. to satisfy governmental or political objectives.

The expert also points out the importance of knowledge transfer and innovation diffusion, networking and befriending business associates. Moreover, he advises stakeholders not to engage in all of the industry-related events, but to pick deliberately and utilise the benefits and opportunities⁸⁰. Hence, in short, medical tourism conferences, exhibitions and trade shows may not be directly about attracting medical travelers and enhancing the popularity of destination countries, but about generating tools and creating the proper aura for business development.

The question to reflect upon remains though: is this component of medical tourism industry the one to be blamed for hyping it? Since no reliable data exists, all the performances and presentations are based on own experiences, ideas and self-praising. And without any evidence-based support they spread around the globe.

Examples of world-wide events regarding medical tourism (recent/upcoming):

<http://www.medicaltourismcongress.com/> (USA)

<http://www.htexpo.com.ua/en> (Ukraine)

<http://www.tourismexpo.ru/spa/en> (Russia)

<http://medicalcitieslse.marcusevans.com> (United Arab Emirates)

<http://www.worldhealthtourismcongress.org/uae/index.html> (United Arab Emirates)

<http://www.medshow.ru/eng/> (Russia)

<http://omanhealthexpo.com/2014/exhibition/> (Oman)

<http://www.kuwaitmedicaltourism.com/> (Kuwait)

<http://www.congresodeturismomedico.com/en/> (Mexico)

<http://www.imtfair.com/> (Turkey)

<http://www.medicaltravelexhibition.com/> (Singapore)

One can notice that Europe is not necessarily the centre of such health tourism-related gatherings.

Distorted picture

“Medical tourism offers travel firms untapped growth”⁸¹ “Medical tourism is a growing trend”⁸², “Why medical tourism is booming?”⁸³ “Today’s hottest global phenomenon in the healthcare sector”⁸⁴.

This is just a small sample of article titles that can be googled in search for “reliable” information and trends in medical tourism. The only thing we can be certain about medical tourism industry is that unbiased, reliable, consistent, comparable and authoritative data are missing. The current available information is speculation-based, not evidence-based. The industry has been re-quoting and re-cycling the accessible information, creating a vicious cycle of references and idea-based reporting, until it became extremely widespread and prevailing within the business. Unfortunately, *“there’s nothing so absurd that if you repeat it often enough, people will believe it”⁸⁵.*

Within the medical tourism industry, empirical research are needed to provide dependable data and information on⁸⁶:

1. number of patients, directions and size of flows;
2. patients’ profile (age, gender, citizenship, socio-economic status, diagnosis and health condition);
3. current market/industry size and its projections;
4. market drivers, patient’s motivations and decision-making process;
5. treatment types;
6. outcomes, success rates of performed procedures, patient’s satisfaction;
7. risks and patient’s comprehension of them;
8. physicians’, intermediaries’ and insurers’ role in assisting patients;
9. tourism aspect.

That cannot be achieved without firstly introducing common and homogeneous terminology on a global scale. Until then, the pumped up speculation and anecdotal bubble will dominate and be considered “the truth”.

On the other hand, as one of the comments to an IMTJ article states, *“we should focus on quality, innovation, best practice and transparency – who needs general market numbers? Neither investors nor medical tourist can take out a message from a global turn over”⁸⁷* That is though for those industry-involved to consider.

Myths around medical tourism

A handful of statements circles within the medical tourism industry. Some of them are claimed to be myths. These false-to-be statements include opinions that medical tourism is a global phenomenon; patients value mostly price; essential medical procedures are pursued; the medical tourism market is a skyrocketing and new phenomenon. However, one should keep in mind that the arguments pointing out and debunking these myths are of the same source – of ideas, thoughts, observations and speculations.

GLOBAL VS REGIONAL⁸⁸

Under a reasonable assumption, made both by Glinos and Pollard, that patients prefer to be treated in a familiar and like-home environment, rather than travelling long-distance outside their comfort-zone for best price to a country they are unfamiliar with, medical tourism might be more regional than global. Youngman from IMTJ claims that medical tourism is a local and regional phenomenon with medical travelers preferring to go firstly within their own country or nearby and then, when they cannot get treated close to home, they pursue far-distance medical tourism. It is also associated with increasing travel costs and time and security hassles. Additionally, he debunks the logic that a patient chooses globally and seeks through thousands of hospitals worldwide to find the lowest price and go there. Youngman also points out tendencies in directions of flows of patients: North Americans go to Mexico or Latin America, Asians stay in Asia, Europeans in Europe. Pollard suggests medical tourism develops more within regions, across borders, with travelers preferring in general short-term journeys to circling the globe in search for treatment in extremely unfamiliar countries.

PRICE VS QUALITY⁸⁹

A major driver of the market is claimed to be towards pursuing best quality and best technology rather than best price. Although patients continue price shopping, they seek for cost-effective offers, not the cheapest – patients simply “*want more value for the price they are willing to pay*”⁹⁰. Offering “the cheapest” implies low quality and can bring out questions: Why is it so cheap? What’s wrong with it? It is claimed that patient is more eager to pick a package of “*reasonable price, guarantee of aftercare and high quality*” rather than “low price, high risk” one. Considering the product is often health, it seems commonsense. Come to think of it - how long would such business of low price and low quality services survive on the medical market, and especially within medical tourism industry, where people can simply choose a better option if they travel anyway?

As far as prices can be compared easily, the problem with comparing quality is that, first of all, it is subjective; second of all, it is the perception of quality patients get after self-evaluating the information they gathered, not the quality itself. Price is considered to be a differentiator during the decision-making process, not a main driver in the process.

ESSENTIAL VS NON-ESSENTIAL PROCEDURES⁹¹

Are people going abroad to treat cancer or to fix nose and get a brand new smile? Are they pursuing essential or non-essential/elective procedures? Does it depend on whether they are wealthy and they “want to” or poor and they “have to”? Which combination of drivers, pull or push factors, determine people to follow either essential or non-essential procedures? First of all, essential treatment is often covered by national health funds, even though there are long waiting lists, patients tend to complain, but may tend to stick to that too. Secondly, non-essential procedures, like cosmetic surgery or dental treatment, are more likely to be paid for out-of-pocket, hence generating the incentives to discover most cost-effective and value for money options. The industry does not provide entirely clear answer to these issues.

SKYROCKETING VS GROWING MARKET⁹²

Medical tourism market is hyped to be skyrocketing by mass media and self-appointed experts. Those opinions are, however, speculative and anecdotal in nature. The industry is likely to be growing, however, it is probably far from reaching the moon. Some even report the market to be stagnating or declining.

NEW VS OLD MARKET⁹³

Medical tourism is not a new phenomenon, but has recently been gaining attention and is currently more frequently discussed. Although medical tourism itself is not a new trend, the flow of medical tourists reversed through the time it exists, to people from high-income countries seeking treatment in less developed nations.

Incoherent data and numbers

McKinsey (2008) started the bidding war of the number of medical tourists with an offer as low as 60000 inpatient medical travelers per annum (leaving outpatients outside of the calculation, which means excluding dental tourists as well)⁹⁴. Deloitte Center for Health Solutions, on the other hand, quoted as much as 750000 Americans only traveling abroad for medical treatment in 2007, suggesting this number to increase to 6 million in 2010⁹⁵. So we see the estimate of number of patients varying between thousands and millions, which consequently makes such data useless. Deloitte also estimated the industry to be worth \$60 billion in 2008⁹⁶. Is it too much, too little? Is it in nominal or real values? Where does this data come from? Only insiders may know, or not.

Contrasting this amount, of whichever value it is, whenever it is true or not, against gross world product of around \$70000 billion (purchasing power parity) in 2008⁹⁷, the medical tourism industry accounts for only 0.09% of global output, which is a drop in the sea. CNN, by contrast, quotes World Travel&Tourism Council that this fraction amounted to 9% of global GDP in 2011⁹⁸. Common sense dictates that it is slightly too much. So we cannot count on McKinsey, Deloitte or CNN, so who can we trust? Valid point made by Youngman presents the absurdity within the industry, which is trying to define and measure the market simply by the number of patients. He points out that other industries put more emphasis on income, profits and losses, analysing which customers are most profitable, not just the number of them⁹⁹.

What is relevant regarding prices comparisons – it would appear to be easily doable and reliable, given the fact that we often can check prices of medical services via provider's websites. However, publication-producers and media often manipulate and use price comparisons between developing country of destination and a high-income one by presenting the highest available price of the latter and the lowest of the former, or whichever way they need to. Not to mention that prices vary within a country as well, so which one to quote might be a confusing dilemma.

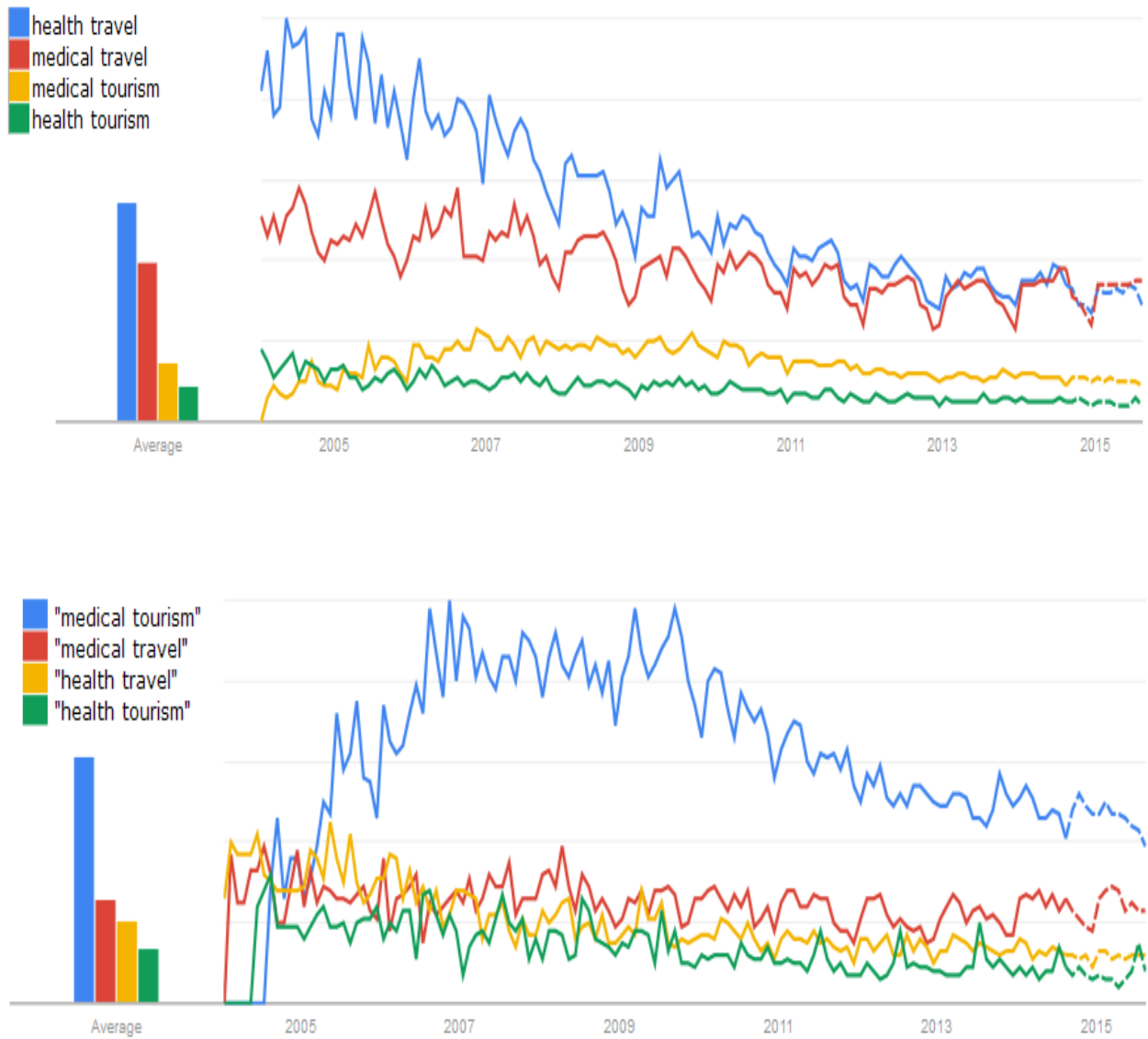
Facts and reliable figures?

A superficial overview of more „numerical“ accessible studies on medical tourism exposes at sight their subjective nature, lack of randomisation and representativeness of analysed samples. For instance, worth 420€ a copy Treatment Abroad Medical Tourism 2012 Survey, conducted on behalf of Intuition Communication, presents strong sampling bias with majority of surveyed patients coming from the UK (total sample of over 1000 patients). Hence, the results of the study cannot be generalised to the global population, neither European. Another example of study conducted by Intuition Communication – Medical Tourism Climate Survey 2013 surveyed over 400 participants, representing organisations from 77 countries. The USA, the UK and Turkey provided most respondents, which again indicate the presence of a sampling bias. The Survey listed top six medical tourism destination countries in terms of patient numbers in the following order: India, Thailand, the USA, Germany, Turkey and the UK. The list of leading destination countries by patient numbers from the Survey lacks credibility, since the surveyed participants are not a representative sample and are probably likely to vote for countries they come from – the majority of respondents share the same country as three of the top six destinations. Intuition Communication Ltd as an owner of two largely present medical tourism portals (International Medical Travel Journal and Treatment Abroad) delivers “statistically incorrect” research, which do not allow to make any generalisations and assumptions about the medical tourism industry as a whole. Absence of reliable information and statistically significant research results, even despite the abundance of publications found on the Internet, leaves the industry un-described. If no reliable data in absolute values can be found, is there any source that can bring us some understanding at least about the trends in medical tourism industry? What about Google Trends?

Google Trends¹⁰⁰ shows popularity of a particular term over time. The horizontal axis of the graph represents time (starting from 2004), and the numbers on a vertical one reflect how many searches have been done for a particular term, relative to the total number of searches done on Google over time, globally (or regionally when we include regional search). The numbers don't represent absolute search volume numbers, because the data is normalised and presented on a scale from 0-100. If they weren't normalised, regions with the most search volume would always be ranked highest. Numbers represent search interest relative to the highest point on the chart – each point on the graph is divided by the highest point and multiplied by 100, which doesn't convey absolute search volume. When comparing more than one term, bars, which appear next to the chart, represent the average of all points on the graph for that search term. When the search term consists of more than one word, results can include searches containing all words in any order. Other related terms may be included in results. No misspellings, spelling variations, synonyms, plural or singular versions of searched terms are included. When one puts the searched terms in quotes, results only include the exact search terms included inside of the quotation marks¹⁰¹.

The graphs presented in Figure 4 show somewhat downward trend in Google search of medical tourism related terms (health tourism and travel are also included, since definitions might be confused by medical tourists), which, interpreted with great caution, can reflect loss of relative interest of Internet surfers in medical tourism industry. On the other hand, it can be that potential medical tourist type in the Google browser more specific terms, perhaps immediately related to destination country or specific procedure, not to the concept as a whole. Interesting is also the fact, that putting the terms in quotations (difference between the first and the second graph) changes the order of general popularity of terms and the their trends notably.

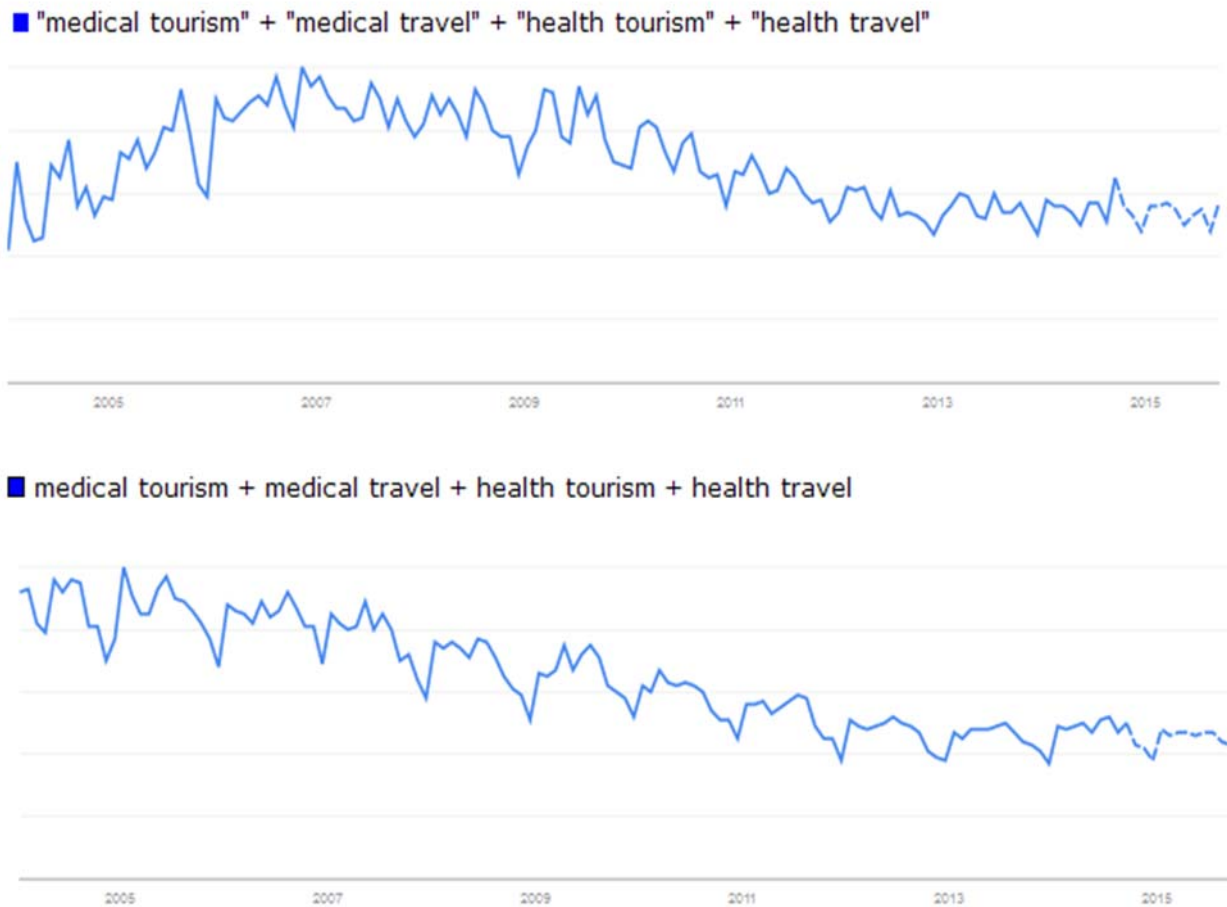
Figure 4. Medical tourism related terms searched in Google Trends, with and without quotation marks, with projections, 2004-2015



Source: Google Trends (<http://www.google.com/trends/>)

Combining the above search terms into one generates graphs presented in Figure 5. Whether quoted or left without quotation marks, there is a noticeable downward tendency in relative popularity of those terms among other searched terms in Google. The second graph in Figure 5 exposes clear annual seasonality – each year in December the relative interest in medical tourism decreased, indicating that a plastic surgery or dental treatment is still not a prevailing gift that can be found under the Christmas tree.

Figure 5. Combined medical tourism related search terms in Google Trends, with and without quotation marks, with projections, 2004-2015



Source: Google Trends (<http://www.google.com/trends/>)

Figure 6. Regional interest of medical tourism related terms in Google Trends in 2014

Search term: "medical tourism" + "medical travel" + "health travel" + "health tourism"



Search term: medical tourism + medical travel + health travel + health tourism



Source: Google Trends (<http://www.google.com/trends/>)

Figure 6 shows regional interest in search terms typed in Google. In the case of medical tourism it might reflect the interest in medical tourism from the position of a country of origin. The countries, in which the industry related terms gained most relative interest, for the terms in quotations, were mainly Asian ones: India, Singapore, Philippines, Malaysia and then Canada, Australia, the UAE. For combined terms without quotation marks the popularity was the biggest in: Canada, the UK, Australia, Ireland, New Zealand, Singapore and South Africa. The language (English-speaking) barrier is certainly strongly influential in the case of regional interest results.

Figure 7. Related searches of medical tourism related terms in Google Trends in 2014

Search term: "medical tourism" + "medical travel" + "health travel" + "health tourism"



Search term: medical tourism + medical travel + health travel + health tourism

Source: Google Trends (<http://www.google.com/trends/>)

Related searches are popular search terms that are similar to the initially typed term in Google. In the case of a combined term (with and without quotation marks) “medical tourism + medical travel + health travel + health tourism”, people mainly searched for insurances, clinics, associations and medical tourism in India and Thailand. Searching for treatment in India and Thailand can suggest that India and Thailand are destinations people are most interested in.

As a tool, Google Trends has also its significant limitations. The first one is that trends data is not available for all regions yet. Second limitation is that it does not display the relative results of searches in different languages for the same term, so the bias regarding inclusion of results only in English is present. Both limitations deform the perceived reality of the medical tourism industry, considering in particular the fact that the claimed trend in the industry is that people from high-income countries travel to less developed-nations (effected in particular by both: the language bias and lack of data collection). One also needs to remember that Google Trends doesn't generate absolute volumes, but just the popularity of a term over time and location.

More information on Google Trends and methodology:

<https://support.google.com/trends/?hl=en#>

Legislation and accreditation in medical tourism – towards patient safety and quality of care?

Even though the final products of medical tourism often include health and life, the industry is usually running under no common regulatory framework, no standard procedures, and no transparent practices. International and comparable data on quality, safety, hospital acquired infection rates, adverse events, readmission, morbidity and mortality following treatment abroad in overseas facilities is lacking. Medical tourism, as a part of health sector, is also burdened with the risk of nosocomial infection, infection-related deaths, etc.¹⁰² Some claim that healthcare regulations should be applied equally to locals and tourist and treating a local should be of no difference than treating a foreigner, therefore there is no need for medical tourism regulation¹⁰³. Yet on the other hand, there is a medical traveller, coming from far away to a foreign country to an environment of great asymmetry of information.

In order to enhance patient's trust some providers pursue international accreditation or certification. Such pursuit indicates a desire for self-regulation and standardisation within the medical tourism industry¹⁰⁴. Eventually though, such stamp of approval/credibility provides no factual protection to the patient (they are rarely provided with post-operative care¹⁰⁵) and when post-treatment complications arise upon return home, patient's well-being is often in the hands of national health care provider in the country of origin¹⁰⁶. What is more, physicians in home country are not eager to treat medical tourists, who experienced some malpractice and negligence, fearing they might be sued for complications stemming from treatment received abroad¹⁰⁷. Moreover, patients seek treatment abroad for procedures that are unproven, experimental or illegal in their home country (e.g. stem cell therapy), which poses a threat to their lives¹⁰⁸. Internet and social media are abundant in examples of botched-up surgeries and post-operative complications, as well as dissatisfied patient's reports. One exemplary idea, presented by Pollard, is to introduce complications insurance compulsory for all patients pursuing cosmetic surgery (which could also be implemented in other medical procedures)¹⁰⁹. All in all, quality, safety and satisfaction are undoubtedly important issues in medical tourism industry, and yet they have not been introduced officially and directly to the mechanism.

The standards applied by different accrediting bodies vary, depending on the local environment. Hence, in order to standardise standards and criteria International Society for Quality in Health Care¹¹⁰ (ISQua), through its International Accreditation Programme, accredits the accreditors¹¹¹. ISQua accreditation was granted to 26 accrediting bodies so far, only 5 of which are of European origin¹¹².

Joint Commission International¹¹³ (JCI) is an US private nonprofit organisation, which accredited almost 700 organisations (2014) from around the globe. *"JCI identifies, measures, and shares best practices in quality and patient safety with the world. We provide leadership and innovative solutions to help health care organisations across all settings improve performance and outcomes. Our expert team works with hospitals and other health care organisations, health systems, government ministries, public health agencies, academic institutions, and businesses to achieve peak performance in patient care"*¹¹⁴.

Accreditation Canada International¹¹⁵ (ACI) is analogous accrediting body to JCI. The scheme has approved almost 80 organisations so far (data from September 2014), with the majority of accredited institutions coming from Brasil (25) and the runner-up being Slovenia - 15 organisations (16 total) were accredited in the year 2014. Apart from accreditation ACI also offers advisory and education services.

Temos¹¹⁶, founded in Germany, is another example of an accrediting body. So far they have developed 5 certification programs. The mission of the certifying body is *“founded on the improvement and optimisation of the quality of medical and non-clinical services for international patients in medical facilities worldwide through a unique and voluntary certification system (...) The aim of all Temos certification programs is to validate and optimise the facility’s medical, nursing, diagnostic and non-clinical services for international patients and medical tourists including the complete patient care cycle before travelling abroad, within the hospital or clinic and for the post-treatment and post-discharge procedures including the follow-up”*.¹¹⁷ Medical Travel Quality Alliance¹¹⁸ (MTQUA) certifies non-medical services to international patients and medical tourists. Through certification a network of providers of different medical tourism services is created. The certification is only a form of commitment, with no legal obligation and liability towards services-purchasing medical travelers. MTQUA also offers Medical Travel Patient Registry¹¹⁹, within which a patient gets 24/7 assistance, treatment monitoring, communication with family. Upon request it offers reviews of hospitals, doctors, bills, treatment plans and care management plans.

“Code of Practice for Medical Tourism”¹²⁰ is an initiative of Treatment Abroad portal. The primary aims of the code are to: *“encourage the development of best practices amongst medical tourism agencies and healthcare providers; drive quality in the medical tourism sector; provide reassurance to patients about the services promoted on the Treatment Abroad site”*. It is facultative and imposes no liability on facilities that accepted it¹²¹. So far it has been accepted by only eight facilities, with the majority coming from Europe¹²².

A literature review suggests that international accreditation and certification entails mirror goals to the ones that result from national accreditation and certification, but on wider – global, not domestic – level. Dr Constantinides claims that no special accreditation or certification is needed, since foreign patients should receive the same quality and standard of care as local ones - *“Consequently, no special legislation should apply to facilities and providers treating health consumers from abroad. Any certification or accreditation – in addition to the mandatory license – should be purely optional”*¹²³. Other arguments question patient’s perception of accreditation’s relevance. It might be that *“patients (...) have little knowledge or sensitivity toward accreditation”*¹²⁴ and that *“the average, general public would not know or understand the significance of accreditation and what it means. (...) However, I would suggest that individuals who would be travelling to undergo medical procedures are slightly different to the general public and are more likely to have researched the quality of the product and services they will be using. (...) these people would probably have developed knowledge of accreditation and be using it as one means to gauge the likely safety and quality of both the practitioners and facilities they will be accessing”*.

In contrast, within the same article, strong support towards accreditation’s relevance for patients is presented by B. Fateha: *“We should never underestimate the level of knowledge of patients! With the availability of internet, patients do understand the meaning of accreditation, and they value accredited facilities due to the expected healthcare quality and overall efficiency. If a medical tourist is given a choice of attending an accredited hospital versus a non-accredited hospital, the choice would be clear: to go to an accredited one where the hospital services have been surveyed and thus the patient is assured of hospital’s compliance with the required international standards”*¹²⁵. Accreditation and certification is not an ultimate determinant of patient’s decision and even *“some of excellent hospitals refuse to be accredited. But accreditation is a good start”*¹²⁶.

It has been yet not well examined whether patients understand accreditation and certification concept and whether it eventually impacts their decision regarding picking the facility (neither the mechanism whether patients choose a particular doctor or facility first). Regarding patient's satisfaction with care – one German study ("Is there an association between hospital accreditation and patient satisfaction with hospital care?"; 36,777 surveyed patients from 73 German hospitals in 2007) showed no significant association between accreditation status of the hospital and patient satisfaction¹²⁷.

Accreditation and certification schemes receive very strong criticism from other actors of the medical tourism industry. The usefulness and credibility of such document is questioned, since the accreditors and certifiers are accused of offering easy to get, but expensive certification procedures and trainings, with the promise of business and quick inflow of medical patients. It is claimed that it is not about raising standards, enhancing quality and introducing transparency, but about new opportunity to make money out of poor believers – the providers and, indirectly, medical tourists¹²⁸. The stamp of approval given by more and more accrediting and certifying nonprofit organisations to more and more providers diminishes its value to be from "about the quality" to "about the quantity". At the end, it is the business of accrediting and certifying bodies to grant and re-grant the certificates, not to investigate and seek for proofs on poor quality that a facility offers.

Quality of medical services provided from abroad is not comparable between the countries of destination and cannot be guaranteed. Medical tourist it destined to make a misinformed choice. Firstly, it is hard to compare every medical facility or doctor, even for specialised procedure. Secondly, unified indicators for such comparisons of quality and safety are not implemented¹²⁹. One proposition to introduce quality comparability within the medical tourism industry is to implement worldwide OECD Health Care Quality Indicators¹³⁰.

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