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Medical Tourism

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Abstract

People travel to destinations or cross national borders in order to obtain health care. The practice has given rise to ethical issues revolving around general thematic and implementation areas as discussed below. Major themes include the economic value of medical tourism and the latter's tendency to amplify health-care and economic inequalities. With countries invested in medical tourism and health-care programs in industrialized countries increasingly downsized, there are push and pull factors that result in a net increase of medical tourists in various locales. The larger health-care and economic inequalities could be reproduced (if not worsened) in medical tourism. Not to be ignored are the issues of safety, liability, responsibility, and variability in ethical regulation of activities relating to medical tourism. Differences in economic, medical, and ethical regulations between and among countries are bound to create problems and challenges for medical tourists and for society in general. Salient practice areas in medical tourism include stem cell therapy, organ transplantation, reproductive health, body modification or enhancement, faith healing, and traditional and complementary medicine; each area presents unique ethical challenges that are mapped out and clarified.

Keywords

Transnational medicine; Ethics of medical tourism; Practice areas of medical tourism

Introduction

Medical tourism refers to the travel of individuals across national boundaries for health-care or related services that otherwise would not be available for any of several reasons. Depending on the particular individual's condition or circumstances, the reason may be high cost of treatment or procedure, a long waiting list, limited health-care capacity in the country of origin, cultural compatibility, favorable regulatory structures and governance, or mere convenience. Whereas medical tourism initially may have started when people in developing countries with limited health-care capability had to seek treatment in economically developed countries, it has come to be characterized by increasing travel among people from developed countries to undergo medical treatment in combination with visiting tourist attractions. Hence, adding medical services to common tourism has emerged as a huge component of medical tourism, alongside foreign travel primarily for the purpose of seeking medical treatment, without intending to spend a holiday or avail of tourism services.

General Thematic Areas

Ethical issues arising in connection with practices in medical tourism acquire variable significance in the various contexts in which different procedures are being sought and consumed. For example, medical tourism has come under intense ethical scrutiny when travel is done for the purpose of organ transplantation because it has been marked by numerous cases of organ buying and selling. Reproductive tourism has been racked by controversy because travel for the purpose of reproductive medical goods and services has seen cases when local women have been paid to serve as surrogate mothers. In the case of stem cell tourism, many vulnerable patients have succumbed to offers of untested treatments in a desperate attempt to find remedies for life-threatening conditions. An elaboration of the specific ethical issues arising in connection with these practices is provided below.

There is also a sense in which treatment with a holiday can now be understood differently because of the very broad range of "treatments" that tourists are being offered and are consuming. For example, it is not easy to see the boundary between some forms of body modification and medical treatment. A consumerist approach to the promotion of some forms of body modification could have the effect of blurring the distinction between touristic services and medical treatment.

Economic Value of Medical Tourism and Impact on Health Care

When supported by governments, medical tourism has been promoted usually as part of an economic growth strategy, with initiatives undertaken less by a health department (if at all) than by an agency for trade and industry or economic development. In many cases, it has been set up to create an export niche for developing countries that are able to identify a comparative advantage in a particular area of medical services. From the perspective of highly developed countries, medical tourism has been rationalized as a way of outsourcing health care with escalating waiting lists and costs. Unfortunately, this solution to developed country problems could create difficulties for local populations (destination countries) that have to face critical health issues of their own, with widening social, cultural, and economic inequities. These inequities may relate to health-care quality, cost, and access, as further explained below. The situation could be aggravated by the decreasing public health funding in developing countries that experiment with tourism-related patterns of health-care system commercialization.

Amplification of Health-Care and Economic Inequalities

There has been a discussion by De Arellano and Sengupta (as cited in Hall 2013, p. 16) of "the extent to which medical services should be exported while local populations suffer ill-health and/or poor or no medical services." It has been held by Pettman and Scheper-Huges (as cited in Hall 2013, p. 68) that medical tourism across national boundaries "facilitates and exacerbates

divisions between the developed and developing world, between rich and poor, and between the haves and have-nots" as affluent medical tourists go to poorer countries to seek treatments. The phenomenon has also been described as a "case of those who are significantly better-off poaching the meagre resources of those who are substantially compromised," because the destination country's governments effectively "divert scarce health-care resources to wealthy foreign patients" (Meghani 2011, p. 25). The observation is that medical tourism has the effect of lowering prices of domestic health-care services due to competition. It could then result in injustices arising from longer waiting lines and lower quality health care for affected consumers. Injustices may also result from disadvantaged sectors being crowded out of access to health care and health equity, both in the patient's home and destination countries. Medical tourism also increases the potential for undermining constructive pressure for beneficial health system reforms at home. The reason is that when economic and political elites are able to satisfy their health-care needs abroad, their decreased need for these services may make them less motivated to push for domestic system-level reforms (Snyder et al. 2012).

In the context of consumer-oriented medical tourism, increased commodification and privatization of health care becomes a general ethical concern. Increasing medical tourism tends to make citizens more comfortable with the purchase of health services. Thus, they are more likely to see health care as a commodity, undermining values that constitute the basis for providing public health care as a social good (Snyder et al. 2012). "Private medical tourism operators would be attractive to patients with the greatest ability to travel and pay for services and health needs that are less likely to entail complications and long term health-care burdens" (Snyder et al. 2012, p. 39). Sometimes referred to as "cream skimming," the practice is likely to undermine egalitarian public health goals by giving priority to consumers' capacity to pay.

Medical tourism may also contribute to inequity when it creates new costs that are to be charged to public systems or insurers. For example, complications from treatments received abroad may cancel out benefits that are supposed to be received by domestic patients in terms of reduced waiting times and cost. Emergency complications can be costly, and yet they take precedence over other patients who do not to seek treatment abroad.

In the case of Caribbean countries, medical tourism has been shown to have varying impacts. For example, Cuba appears to have avoided the inequitable effects of resources being diverted from basic services by extending the scope of care provided. In contrast, other Caribbean islands have been seen to suffer without national systems guaranteeing access to care for their own populations. Increased investments in services aimed at attracting medical tourists have tended to distort the local distribution of care, resulting in the lack of basic primary care for a significant portion of their populations (Arellano 2011).

In the context of medical tourists from wealthier, more developed countries going to developing countries, "internal brain drain occurs within nations because physicians prefer practicing in cities rather than rural regions and affluent rather than impoverished areas. . .Highly qualified and skilled doctors and specialists tend to gravitate towards private hospitals to cater to foreign patients, leaving public hospitals short-staffed" (Meghani 2011, p. 26).

Safety, Liability, Responsibility, and Variability in Ethical Regulation

The quality of informed consent in the context of medical tourism may suffer as a result of variability in regulations and degree of implementation. Hence, medical tourists may experience failings in professional or clinical practice that could jeopardize their treatment or their understanding of the procedures they are undergoing, as well as of the significance of those procedures (Hall 2013).

The safeguarding of confidential patient information and IT information across national boundaries by professionals could also be an issue as different national authorities may be guided by different regulations or legislation representing variable ethical and legal standards.

Persons on international travel for medical reasons obviously run the risk of spreading infections that otherwise might have been contained at home. Conversely, travelers may succumb to infectious diseases not usually found at home. Hence, public safety could be jeopardized, especially in relation to infectious agents that have not come to the attention of public health authorities.

Overseas trips for medical reasons take place within a limited time frame. Within that limited time frame, medical tourists have to travel, undergo procedures, and recuperate. The situation could put physicians under too much pressure to perform too many procedures within a tight period to ensure that the medical tourist can complete everything and make it home in time. The rush could expose the patient to unnecessary complications and, in general, affect the quality of postoperative care.

The promotion of medical services online has largely been unregulated. Hence, medical tourists may discover too late that particular promotional materials exaggerate or misrepresent success rates. In addition, medical tourists may not have a good basis when they select destination sites for desired procedures or services.

The conditions or procedures that motivate patients or consumers to go for medical travel usually require continuing treatment at home. This gives rise to questions of safety, liability, or responsibility relating to posttreatment care. Once the foreign health-care provider is no longer in a position to provide follow-up procedures, the onus gets transferred to a local professional who may have various reasons for avoiding involvement. A local doctor may not want to deal with something suspected to involve professional negligence, medical malpractice, or some other activities of a criminal nature. For example, it may be prudent to defer to a police investigation in the event of suspected human trafficking, as may arise in organ transplantation. In the first place, the lack of local health expertise may have been the primary reason for medical travel. Hence, appropriate local follow-up care may be difficult to begin with. All of these factors contribute to a scenario where safety easily may be compromised.

Significant ethical issues of resource allocation also need to be addressed especially when there are complications, side effects, or long-term follow-up treatments. In countries like the USA, the UK and Australia, discussions have arisen about costs having to be borne by publicly funded health systems as a result of treatments or procedures undergone abroad without (or even in contravention of) the recommendations of a local health-care professional. These issues have implications for the availability of resources for local population health.

Questions of jurisdiction also arise when legal proceedings are thought necessary to settle disputes. It may not be easy for medical tourists who have returned home to determine who exactly should be held accountable when they have some grounds for dissatisfaction with their care. There may be situations when it may not be easy to determine which country's laws should apply and, if they do apply, whether they can be enforced on the particular persons thought to be responsible. Judgments handed down in overseas jurisdictions are not necessarily enforceable locally, and the implementation of justice may therefore be stymied.

Home countries could already face difficulties in detecting and establishing malfeasance abroad. There are bound to be differences between home and care provider countries not only in terms of legal provisions but also in terms of resources for detecting and prosecuting forbidden practices such as organ sale or contractual surrogacy. In addition, home doctors may discover practices they regard as substandard that may have met provider country standards. In a context where the provision of health care is prized for its commercial value, some health-related standards may actually be sacrificed in favor of commercial gain. Home country physicians may not necessarily be motivated to report substandard practices that they can attribute to intercountry professional differences. Attitudes to reporting and prosecution could vary, and penalties for criminal practices between home and abroad could also differ significantly. Some dubious practices may also be tolerated in the name of intercountry professional courtesy.

Practice Areas

Stem Cell Tourism

Stem cell treatments that are being offered in some countries already present difficulties without being part of medical tourism. Many have not been shown to be safe and effective. Offering such treatments to foreigners exacerbates the difficulties. Variability in medical standards of care and in the evaluation of medically acceptable evidence gives rise to questions of an ethical nature because of the impact on patient safety. Many cheap facilities are made available in countries where oversight may be lax and characterized by a lack of transparency compared to target patients' home countries. The provider countries may also lack the infrastructure for ethics review and rigorous informed consent. This provides the opportunity for practitioners of questionable therapies to peddle their trade among vulnerable patients. The situation could deliberately be allowed to proliferate in some countries that aim to develop the economic potential of the medical services they provide. Such actions by questionable researchers have a "rotten-apple effect" on their own legitimate researchers and scientists in the same country.

As unproven treatments, stem cell procedures need to be subjected to acceptable standards of research so that their safety and efficacy could be established. However, stem cell tourists who obtain treatments are seldom enrolled in organized studies or clinical trials, so records and data are largely unavailable. Moreover, clinics that offer unproven stem cell therapies have been known to take advantage of desperate patients who are left with no other treatment options for their condition. Public education about the benefits and risks of stem cell treatments has been very limited and ineffectual. Moreover, infrastructures for regulatory oversight on stem cell tourism have developed very slowly. Hence, patient safety in stem cell tourism has not been sufficiently addressed.

Part of the reason why patient safety is being compromised is the conflict between the economic objectives and the medical objectives of medical tourism. "Different ministries within the same government may have conflicting activities and aims (e.g., Thailand's Medical Council trying to curb unregulated practices while the Board of Investment is encouraging the development of medical businesses)" (Einsiedel and Adamson 2012, p. 43). At the same time, there is another kind of conflict that persists between stem cell clinics with questionable therapies and those that have engaged in sound and legitimate research in the area of regenerative medicine. The latter claim that their legitimate research efforts have suffered because of public perception relating to stem cell treatments of a dubious nature. The situation results in a kind of double jeopardy as patients are exposed to safety risks in the case of dubious treatments and deprived of the possible benefits arising from sound and legitimate research.

Transplant Tourism

Transplant tourism has given rise to ethical issues relating to standards of care for organ donors and recipients as well as to informed consent from donors. In addition, it has also been held that the globalized procurement of organs can undermine success of deceased organ donation programs, the pursuit of national or regional self-sufficiency in transplantation, as well as the performance of physicians' "obligations to promote public health, justice, beneficence, and non-maleficence" (Martin 2010, p. 19). In some countries, organs are procured from executed prisoners. The practice has given rise to concerns that the opportunities thus created present unscrupulous sectors an opportunity to encourage the imposition of capital punishment or manipulate the timing of executions in order to accommodate potential demand for organs.

Experience with transplant tourism has shown that its commercial aspects have bred corruption and coercion. The view has been held that corruption takes place when the sale of organs is allowed to continue, thus denigrating "views of how goods (organs, personhood) are properly valued, in that it may 'dehumanize society by viewing human beings and their parts as mere commodities'" (Cohen 2013, p. 273). As for coercion, it has been held to take place when the poor are enticed to sell their organs without being given reasonable

economic alternatives. Legitimate organ donation is said to be crowded out when commercial transplant tourism takes place because the latter could have the effect of reducing the procurement of organs overall by motivating individuals to sell when they otherwise would have donated or causing individuals to refuse to donate at all because they fail to see a legitimate place for organ selling.

Reproductive Tourism

Reproductive tourism was first given the name "procreative tourism" to refer to the practice of citizens exercising the freedom to reproduce by going to states with lesser regulation. It refers to travel to obtain the kind of medically assisted reproduction desired. "The main causes of reproductive tourism can be summarised as follows: a type of treatment is forbidden by law for moral reasons; a treatment is not available because of lack of expertise or equipment (like pre-implantation genetic diagnosis (PGD)); a treatment is not available because it is not considered safe enough (for the moment); certain categories of patients are not eligible for assisted reproduction; the waiting lists are too long in the home country; and the costs to be paid by the patients are too high in their home country" (Pennings 2002, p. 338). The pertinent ethical issues somehow match the consumers' motivations as outlined above, and perhaps the most striking thing about the listing is that it includes the incompatibility of some services sought with ethical values prevailing in the home country.

Medical tourism for surrogacy arrangements has given rise to numerous controversies of an ethical nature. To begin with, the practice is premised on contractual obligations that are not legally recognized in various jurisdictions. The lack of a legal framework means that children born under such arrangements are rendered vulnerable under many possible circumstances. For example, contracting parents have rejected some children after prenatal or neonatal discoveries of undesired medical conditions.

The providers of eggs for assisted reproduction very often are recruited on the basis of traits deemed desirable by consumers. Choices are often made on the basis of misleading or inconclusive evidence. In the case of ova donation, a large consumer base in Europe creates a high demand for ova with "European" characteristics, such as light skin and hair coloring. "While a large market in gestational surrogacy has emerged in India, the market in ova provisioning has grown in Eastern European countries, such as the Czech Republic" (Crozier and Martin 2012). These practices are open to the charge of "corruption" as described in the section above pertaining to transplant tourism. Reproductive tourism faces the issue of "conflicting or inconsistent legislation and practice" in high-income regions "from which reproductive travellers originate, as well as deficient or absent legislation in lower income destination countries that contribute to the challenges of regulating this practice" (Crozier and Martin 2012, p. 46).

Body Modification Tourism

Body modification tourism belongs to the class of practices that involve elective procedures. Being elective, it also tilts more heavily to the touristic rather than medical end of the medical tourism spectrum. "'Electiveness' conveys choice, lending itself to arguments that focus on the 'consumerisation' of health practices, even contesting the label 'health' as useful for considering elective body transformation at all" (Holliday et al. 2015, p. 299). Because elective procedures may also be excluded from insurance cover, concerns about safety may be exacerbated.

When the practice involves travel to distant locations for cosmetic surgery, there is a "significant financial and psychological pressure to proceed with surgery. The widely accepted principle of informed consent may be superseded by the decision to 'package' and pay for both travel and treatment prior to an initial surgical consultation, with significant financial implications if a patient changes their mind about a particular procedure" (Jeevan and Armstrong 2008, pp. 1423–1424). The need for preoperative counseling becomes significantly more important especially in cases where risks include severe complications or the nature of the procedures give rise to exaggerated expectations of positive outcomes.

In Thailand, gender reassignment surgery (GRS) is gaining popularity, partly because of the country's perceived lack of regulatory infrastructure for assessing candidates under the World Professional Association for Transgender Health (WPATH) Standards of Care, which is required across Europe, North America, Australia, and New Zealand. In the latter countries, psychiatric approval is often required before transgender persons can have access to hormone treatment or surgery. Because gender variance is not generally regarded as a mental disorder in Thai culture, psychiatric evaluation for GRS is regarded by most Thai medical experts as unnecessary (Aizura 2010).

Tourism for Faith Healing

Medical tourism applies also to faith-based interventions. One of the oldest reasons for people to visit distant lands is for them to seek treatment with the help of sacred sources or religious rituals. Pilgrimages from ancient times to the present are partly health-seeking behaviors. Such "spiritual encounters" could include private healing ceremonies with a shaman in Peru, Sufi meditation sessions in India, sessions with a Balinese traditional healer, or Christian pilgrimages to Fátima and Lourdes. Often, the motivation involves the possibility of physical healing.

"Faith healing" seeks to treat illness through religious beliefs and spiritual interventions rather than through modern biomedical practice foregoing the latter in favor of health by faith may be interpreted as a sign of desperation (especially in cases of people without access to treatment). But faith healing cannot be summarily dismissed without having to consider its significance to people practicing it and finding ways to extend at least the understanding of the illness. While believers infected with HIV, for instance, may replace treatments with visits to healers, health-care workers need to understand that, to begin with, some 80 % of people in low-income countries rely on non-allopathic medicine for their primary health-care needs. Health programs that simply ignore faith healing may prove to be irrelevant in the minds of the sick and show disrespect for them.

Complicating the issue is the ambiguous nature of "faith healing" itself. While it can refer to the faith of those seeking healing, it can also be about the faith of certain religious practitioners that attract people seeking health. Most of all, "healing" is not always about addressing physical or allopathic issues. It can also be emotional or spiritual. Motivations for faith healing may also include seeking personal and spiritual relations, the development of personal self-awareness that includes contact with sacred nature, gods, or spirits. Faith healing in host countries may even involve the use of plants or products (like ayahuasca) whose legitimacy or legality may be questionable in tourists' home countries.

At the core, religious rituals in tourism set a time structure that differentiates "sacred time" from the normal and profane – the very idea of tourism as a modern phenomenon. Touristic faith healing, therefore, is a "sacred journey" taken by people with or without formal religious affiliations in such journey; an assessment of risks and benefits cannot readily be undertaken. "Intangibles" like personal self-awareness may be pitted against probable harms associated with travel to distant lands in general and possible drug (like ayahuasca) use in particular. Not to be underestimated are the possible legal and moral liabilities and responsibilities of tour operators who arrange spiritual encounters. Spiritual healers, who may not necessarily be used to "productizing" the healing experience they provide, may stand to lose in otherwise nonmaterialistic transactions.

Tourism for Traditional and Complementary Medicine

Medical tourism also pertains to traditional and complementary medicine. For example, thousands of tourists flock to Korea where there is "cooperation between Western medicine and traditional medicine" (Euronews 2012). Hundreds of plants, minerals, and animal parts belong to a typical dispensary in a "traditional" hospital in Seoul where such herbal medications are expected to help address ailments "objectively diagnosed" by Western medicine (Euronews 2012).

In "traditional" medical facilities, however, adequate or appropriate standards of care are not always known. It will not always be clear what procedures, chemical compounds, or ancillary care patients may be consenting to.

Definitionally, "tradition" is practice and context specific. Expectations of medical care are set in one tradition and addressed in another. For the part that works for both medical tourists and traditional medical providers, a case of "harmony" of traditions can easily be made. But for outcomes that are bad or at least unclear, issues of vulnerability and exploitation, unjustified risks, liability, and responsibility can always be raised.

Conclusion

It is quite clear that many aspects of medical tourism are being driven by market mechanisms. Thus far, developments have not shown that market mechanisms are leading to a growth capable of improving the wider health systems in resource-challenged countries. On the contrary, the growth can undermine the health requirements of developing country populations. More discussion is needed to help resolve the issues arising from the interplay of such factors as the justified need of patients for better access to care in the appropriate geographical context, a concern about the costs to individuals of seeking care at home or abroad, and the public health and health equity implications of individual choices to seek care in local or foreign contexts. There might be a need to better educate potential medical tourists on system-level concerns that might come into conflict with their individual-level concerns. Differences in economic, medical, and ethical regulations between and among countries are bound to create problems and challenges for medical tourists and for society in general.

Cross-References

- ▶ Brain Drain
- ▶ Commercialism and Healthcare
- ▶ Organ Trade
- ▶ Quality of Care

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Medicalization

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Abstract

Medicalization designates a multidimensional social process whereby a growing array of conditions and experiences of human life become defined, understood, and managed through medical and medically related expertise. Over the last 50 years, the multidisciplinary study of medicalization has been distinctly infused with moral concerns gravitating around issues of aspirations, freedom, power, and domination in society. In light of the accumulated scholarship, the medicalization of life and society is considered a development characteristic of modernity and late modernity with ample and disputed implications. Processes of medicalization are seen as constitutive of far-reaching transformations in contemporary societies, including globalization; the emergence of new forms of political and economic power; and the redefinition of social, cultural, and moral practices.

Moral questions surrounding medicalization relate to a wide array of bioethical elaborations on topics like reproductive health, end of life care, genetics, or the conduct of medical research, to take only a few examples. However, bioethical analyses of medicalization qua medicalization, as comprehensive social phenomenon are yet to be fully developed. In this respect, social justice and human rights perspectives may be particularly suited to contribute normative frameworks for the ethical examination of medicalization. Such contributions would enrich the critical debate of moral aspects of medicalization and would further an ethically grounded local and global health governance.

Keywords

Medicalization; Social control; Medical domination; Normalization; Medicalized identities

Introduction

The medicalization of society was studied mainly in the social sciences and increasingly in other disciplines, including bioethics. Scholarly contributions were designated by different terms over time, such as the theory, thesis or critique of medicalization, and, more recently, as medicalization studies. The latter are defined as the "interconnected yet diverse contributions that together give a picture of the process of medicalization, by focusing on the origins, content, conflicts, and consequences of medical definitions and treatments of human problems" (Conrad 2013, p. 200). The study of medicalization encompasses diverse theoretical perspectives and vocabularies and is distinguished by the multiplicity of sites and instances of medicalization being investigated with either narrower or broader lenses. Moreover, the medicalization debate has been traditionally underpinned by a preoccupation with issues of power and domination in society, and the worth and moral implications of medicalization have been a constant concern for scholars.

Reflecting a diverse and thematically complex literature, the purpose of this contribution is twofold: to offer the reader an overview of key propositions advanced in the study of medicalization over the last five decades and to emphasize critical moral and ethical concerns embedded in the problematic of medicalization, such as the creation of medicalized identities as part of new regimes of social control or the depolitization