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### **Medical Tourism Development, Challenges and Opportunities for Asia**

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#### **Introduction**

Tourism is travel for recreational, leisure or business purposes. The United Nations World Tourism Organization (UNWTO) defines tourists as people who "travel to and stay in places outside their usual environment for more than twenty-four hours and not more than one consecutive year for leisure, business and other purposes not related to the exercise of an activity remunerated from within the place visited". Tourism is vital for many countries, and many island nations, due to the large intake of money for businesses with their goods and services and the opportunity for employment in the service industries associated with tourism. These service industries include transportation services; such as airlines, cruise ships and taxicabs, hospitality services; such as accommodations, including hotels and resorts, and entertainment venues; such as amusement parks, casinos, shopping malls, music venues and theatres. The World Tourism Organization forecasts that international tourism will continue growing at an average annual rate of 4 %. Not only as a result of the important economic contribution of the tourism industry, but also as an indicator of the degree of confidence with which global citizens leverage the resources of the globe for the benefit of their local economies. This is why any projections of growth in tourism may serve as an indication of the relative influence that each country will exercise in the future. Traveling abroad for one's health has a long history for the upper social classes who sought spas, mineral baths, innovative therapies, and the fair climate of the Mediterranean as destinations to improve their health. Medical tourism is actually thousands of years old. In ancient Greece, pilgrims and patients came from all over the Mediterranean to the sanctuary of the healing god, Asclepius, at Epidaurus. In Roman

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Britain, patients took the waters at a shrine or bath, a practice that continued for 2,000 years. From as early as the Neolithic period, people have travelled long distances to specific geographic locations across Europe in order to conduct rituals and for other perceived health benefits. Indeed this practice continued in varying forms throughout medieval times, where by the 18th century the upper strata of European classes often travelled across borders in order to bathe in thermal springs for medical purposes (Goodrich, 1993). In the 21st Century, relatively low-cost jet travel has taken the industry beyond the wealthy and desperate. Countries that actively promote medical tourism include Cuba, Costa Rica, Hungary, India, Israel, Jordan, Lithuania, Malaysia, Thailand, Belgium, Poland and Singapore. South Africa specializes in general surgery, rhinoplasty and a chance to see lions and elephants. Although there are distinctly new trends and patterns emerging in contemporary times, international travel for health purposes has had an extensive history.

Goodrich & Goodrich (1987) conducted one of the first academic studies of health tourism, developing an early definition of the term as: ...the attempt on the part of a tourist facility (e.g. hotel) or destination (e.g. Baden, Switzerland) to attract tourists by deliberately promoting its health-care facilities, in addition to its regular tourist amenities (Goodrich & Goodrich, 1987). In subsequent years, the labels health tourism, healthcare tourism and medical tourism have been used broadly and somewhat interchangeably. Several anthropologists who have looked at the area have used the term "medical travel" (Kangas, 2007; Kangas, 2002; Whittaker, 2008). Another label, "medical outsourcing" is also increasingly creeping into the discourses used by economists and the media (Bookman & Bookman, 2007; Kher, 2006; Wachter, 2006), presumably in context of India's Information Technology services boom. The newest trend in the first decade of the twenty-first century has the middle class traveling from developed countries to those with emerging economies to avoid treatment delays, prohibitive costs for life-saving procedures, or simply high costs for elective surgery.

## 1. Literature Review

Laws (1996) defined medical tourism as a travel from home to other destination to improve one's health condition as one type of leisure. This includes getting indigenous and alternative medical services, and any other form of tourism undertaken with the purpose of addressing a health concern. Connell (2006) describes medical tourism as a popular mass culture where people travel to overseas countries to obtain healthcare services and facilities such as medical, dental and surgical care whilst having the opportunity to visit the tourist spots of that country. Carrera and Bridges (2006) defined medical tourism as travel which is systematically planned to maintain one's physical and mental health condition. According to General Agreement on Trade and Services (GATS), medical tourism is the second mode of trade in health services. In this mode, customers (patients) leave their home country to obtain health care services with high quality and affordable prices, Blouin et. al., (2006). Monica (2007) stated that

medical tourism occurs when international patients travel across boundaries for their healthcare and medical needs. It can be defined as provision of cost effective private medical care in collaboration with the tourism industry for patients needing surgical and other forms of specialized treatment. Bookman & Bookman (2007) defined medical tourism as travel with the aim of improving one's health, and also an economic activity that entails trade in services and represents two sectors: medicine and tourism. Medical tourism according to Dhaene (2009) is looking for available quality combined with cost effective and low price health services while offering a similar level of safety to the patient. Medical tourism has become a US\$60 billion business with an annual growing rate of about 20%, this is expected to pass US\$100 billion by the end of 2012 (Herrick, 2007; Jones & Keith, 2006).

Steady development in technology and the spread of information in the recent years have changed the nature of exchange, and the nature of specialization and communication among countries. Medical tourism is advantaged by the globalization of both health care and tourism, which already constitute major arenas of transnational economic activity (Bookman & Bookman, 2007). A number of factors are increasing the attractiveness of medical tourism with the following six factors: (a) Affordability: Medical tourism provides an opportunity to reduce costs significantly; (b) Large uninsured population: More than 46 million people in the United States do not have any health insurance. Even people with health insurance must pay out of pocket for elective surgery and pre-existing conditions; (c) Alternative-Innovative therapy: Countries like Thailand and India attract medical tourists due to their offerings of Ayurvedic and other alternative treatment methods; (d) Better quality care: Countries like Singapore boast state-of-the-art equipment, the finest surgeons, and a high-standard of medical care comparable with that of most Western countries; (e) Aging population: The aging population of the developed world is a seriously growing burden on the health care infrastructure; and (f) Long waiting time: Most patients in the United Kingdom and Canada lack timely access to elective procedures and hence have a strong willingness to travel to other countries for the purpose of medical treatment (Grail Research, 2009).

Medical tourists can take advantage of having medical surgery or treatment while enjoying a stay in one of the world's popular tourist destinations. Medical check-ups and health screening are preventive medical services that are also considered to all within the scope of medical tourism. Countries around the world are investing to capture an increased share of the global health care spending. Contrary to some perceptions, the services provided reach beyond cosmetic procedures performed at spa-like medical centers and include more complex, longer-term, and costly care. With public perception becoming more positive, insurance companies are starting to embrace the trend (Grail Research, 2009). The number of countries offering state-of-the-art medical facilities and services to foreign tourists is on the increase especially in Asia. This international trade in medical services also has huge economic potential for the global economy (Bookman & Bookman, 2007), and medical tourism is emerging as

a lucrative sector for many developing countries. Ramirez de Arellano (2007) argues that investment in this sector is one of the most effective means of increasing income, improving services, generating foreign exchange earnings, creating a more favorable balance of trade, and boosting tourism. It is not surprising to see that an increasing number of countries have seized the business opportunities that medical tourism offers.

### **1.1 The Asian Medical Tourism Market:**

Medical tourism occurs when there is a significant price difference between countries for a given medical procedure, particularly in Southeast Asia and where there are different regulatory regimes, in relation to particular medical procedures (e.g. dentistry), traveling to take advantage of the price or regulatory differences is often referred to as "medical tourism". Medical tourism refers to "travel with the express purpose of obtaining health services abroad". The practice of medical tourism does not exist without criticism, particularly when involving patients from developed nations going to developing nations for procedures. It is thought to contribute to the commodification of health and health care by allowing those with the financial means to do so to purchase care that may be unavailable to other citizens. It has been suggested that if the medical tourism industry is properly regulated, medical tourism can provide a viable means by which developing countries can gain access to needed revenue and developed countries can lessen 'bottlenecks' in their health systems. Ramirez (2007) suggested that the presence of medical tourism hospitals in developing nations is also thought to lessen the international brain drain of health human resources for health-care by providing surgeons and others with access to advanced, high technology work environments. Services typically sought by travelers include elective procedures as well as complex specialized surgeries such as joint replacement (knee/hip), cardiac surgery, dental surgery, and cosmetic surgeries, see Table 1.

People traveling abroad for medical services usually choose the following categories of medical tourism procedures: dental, cosmetic, orthopedic and cardiovascular services. The McKinsey report (2008) states that 40% of medical travelers seek advanced technology, while 32% seek better healthcare, another 15% seek faster medical services while only 9% of travelers seek lower costs as their primary consideration. Southeast Asia and India are the choice destinations for orthopedic and cardiovascular cases due to the high qualities of healthcare infrastructure and several U.S. accredited hospitals and physicians. India provides various healthcare services at 20% of the U.S. cost. In the past several years, the concentration on health care services has increased a lot with different world-class hospitals in Asia. The unrestricted efforts both from the public as well as private sector have placed Asia at the top of the world medical tourism map. Nowadays, a large number of tourists from different parts of the world travel to these Asian countries in search of cost effective medical treatment. It signified that medical tourism in Asia today is a big industrial sector as well as contributing

significantly to the region's growth, see Table 2. It is also considered as the prime source of bringing foreign currency into these countries. A large number of hospitals have entered into agreements with international health insurance companies to compensate the cost of health-care from foreign visitors.

**Table 1. Cost Comparison of Selected Surgeries: (all costs in \$US)**

Procedure	USA	India	Thailand	Singapore	Malaysia	South Korea
Heart Bypass	133,000	7,000	22,000	16,300	12,000	
Heart valve replacement with bypass	140,000	9,500	25,000	22,000	13,400	42,000
Hip Replacement	57,000	7,020	12,700	1,200	7,500	10,600
Face Lift	16,000	4,800	5,000	7,500	6,400	6,600
Lap Gastric Bypass	52,000	9,300	13,000	16,500	12,700	9,300

Source WorldTravel Market, Traveltalk, ,CII, November,2009 (11)

Increasingly, countries have investigated the potential economic benefits and public health costs of medical tourism (Smith et al. 2009). However, there is no systemic collection of data to indicate the global size of this market, and estimations are wide and varied. At the lower end, the number of foreigners seeking medical treatment across an international border was estimated to be 60,000 to 80,000 people per year in 2008 (Ehrbeck et al. 2008). In contrast to this, the Deloitte Centre for Health Solutions estimated 750,000 Americans travelled abroad for medical care in 2007 and predicted that this would increase to 1.6 million by 2012 with a sustainable annual growth rate of 35% (Deloitte 2008; Deloitte 2009).

It would appear that geographical proximity is an important but not a decisive factor in shaping individual decisions to travel to specific destinations for treatment (Exworthy and Peckham, 2006). Whether this is a reflection of the tourism element, meaning that people are travelling with not just medical treatment as the sole reason but also factors related to the wider opportunities for tourism is not clear. Travel distance is likely also related to cost. The demand for services may also be volatile (MacReady, 2007, Gray and Poland, 2008) with travel determined by both wider economic and external factors, as well as shifting consumer preferences and exchange rates. Providers and national governments may seek to challenge existing suppliers, for example Latin American fertility clinics (Smith et al., 2010). A number of governments are also promoting their health facilities and emerging consumer markets are stimulated by brokers, websites and trade-fairs. Exchange-rate fluctuations may also make countries more or less financially attractive, and restrictions on travel and security concerns may prompt consumers to explore alternative markets. Moreover, an unanswered question concerns the status of medical tourism as a luxury good or not. That is, do consumers

spend proportionately more on medical tourism treatments as their incomes rise, how use of services varies with price (price elasticity) and does a worsening of wider economic condition impact deleteriously on the demand for medical tourism. It may even be that a declining economic climate has the reverse effect because reduced public service provisions at home prompts patients to look elsewhere to avoid waiting lists and tighter eligibility criteria.

Some destinations have marketed themselves as a healthcare city, or more widely as a Biomedical City. Singapore, for example, from 2001 was promoted as a centre for biomedical and biotechnological activities (Cyranoski, 2001). Despite a number of countries offering relatively low-cost treatments, we currently know very little about many of the key features of medical tourism. Indeed, there are no authoritative data on the number and flow of medical tourists between nations and continents. While there is a general consensus that the medical tourism industry has burgeoned over the past decade and that there is scope for even further expansion, there remains disagreement as to the current size of the industry. Estimates of the numbers of medical tourists generally lie on a continuum between statistics published by the Deloitte management consultancy at one end of the spectrum and a more conservative estimate by McKinsey and Company at the other. Figures that are regularly reproduced in the literature (Whittaker, 2010) draw on data collected and projections made by Deloitte, which put the number of US citizens leaving the country in search of treatment at 750,000 in 2007 (Keckley and Underwood, 2008). This number, Keckley insists, would reach somewhere between 3 and 5 million by 2010 (Keckley and Underwood, 2008, Keckley and Eselius, 2009). Given that US tourists are thought to represent roughly 10% of the global number of medical tourists (Ehrbeck *et al.*, 2008), this would suggest that total worldwide figures would lie somewhere between 30 and 50 million medical tourists travelling for treatment each year. Even where commentators avoid placing a figure on the number of medical tourists, the frequent citation of medical tourism as a \$US60 billion market can be traced back to Deloitte's report (MacReady, 2007, Crone, 2008, Keckley and Underwood, 2008).

**Table 2. Medical Tourists and JCI Accredited Hospitals**

<b>Country: Potential Cost Savings</b>	<b>Number of Medical Tourists (2012)</b>	<b>JCI Accredited Hospitals (2012)</b>
India: 65-90%	850,000	19
Korea: 30-45%	140,000	11
Malaysia: 65-80%	671,727	8
Singapore: 30-45%	850,000	13

Taiwan: 40-55%	90,000	22
Thailand: 50-70%	2,500,000	28

Source: Countries Ministry of Tourism

Drivers of medical tourism include globalization, economic, social, cultural and technological forces. Many domestic health systems are undergoing significant challenges and strain, tightened eligibility criteria, waiting lists, and shifting priorities for health care may all impact on consumer decision making. There is also the emergence of patient choice and forms of consumerism, including within countries that traditionally have had public-funded services. Openness of information and development of diverse providers competing on quality and price now cater for all demands. Glinos et al., (2006) identify five drivers behind the increases in demand for medical services overseas: familiarity, availability, cost, quality and bioethical legislation (international travel for abortion services, fertility treatment, and euthanasia services). It was estimated that approximately 1.6 million Americans travelled to other destinations in 2012, seeking medical services. Transparency Market Research, a leading U.S.-based market research firm, studies the market for medical tourism and states that market is anticipated to grow at a compounded annual growth rate of 17.9% from 2013 to 2019. Witnessing the immense potential for growth in this industry, many countries are now seeking to become major exporters for medical services.

There is an emerging opportunity particularly for Asian and Middle Eastern countries that are catering to the outsourced healthcare requirements of developed countries like the U.S., Canada and some European countries. Owing to the low cost of treatment and presence of high quality healthcare infrastructure, the Asian region has become a major player in the market. Growth in this region is primarily seen due to the presence of well-established medical tourist destinations such as India, Thailand, Singapore, Malaysia and others. The Indian medical tourism market accounted for the largest market share in 2012, owing to influx of large number of patients due to their specialization in cardiac surgeries. However, the Malaysian region is expected to emerge as the fastest growing market in the medical tourism industry in the near future. Growth in this region is primarily seen due to the presence of modern healthcare infrastructure, government support, and geographic proximity to the Indonesian region.

## 2. Medical Tourism Issues and Challenges

Medical tourism can be seen as a solution to health care systems problems of the developed world. The development of the medical tourism industry in lesser developed countries (LDC) carries with it a number of potential benefits that work to address some existing health system problems related to infrastructure development and

retention of health human resources. Foremost amongst these is its purported capacity to spur both local and foreign investment into health care infrastructure ( Connell,2008; Chee,2007; García-Altés, 2005; Connell, 2006).

Use of such infrastructure may not be limited to medical tourists, thus benefiting local patients (Arunanondchai & Fink , 2006 ). In fact, most hospitals providing services to international patients are primarily dependent on locals for the bulk of their business (Lautier,2008; Oberholzer-Gee, Khanna & Knoop,2007 ). Investment into more advanced medical services in LDC can also encourage patients who would otherwise travel abroad for care to get care at home, thus keeping capital within the country (Blesch, 2007). Another direct benefit resulting from the new infrastructure necessary for attracting medical tourists is the creation of long-term, highly skilled jobs necessary for a strong tertiary health care system (Whittaker,2008 ). It has also been suggested that the financial (e.g., high salaries) and technical (e.g., high technology work environments) incentives for doctors practicing in medical tourism can slow, or even reverse, the migration of locally trained health human resources abroad (Whittaker,2008; Bajaj, 2007).

Another often cited point is that medical tourism draws hard currency into LDC, particularly from higher income countries (Whittaker, 2008; Lautier,2008; Turner, 2007). Medical tourism is depicted as a potential solution to an array of problems facing health care systems in patients' home countries, which can be most briefly summarized as those of the cost and affordability of care, wait times and access to medical facilities and treatments. The most commonly discussed among these is the issue of unaffordable care. Medical tourism is often presented as providing an option to patients in countries where medical care is prohibitively expensive (York, 2008). An extension of this view is the potential for a vigorous medical tourism industry to drive down domestic costs and encourage price transparency by introducing competition into countries with captive private markets, such as the United States (York, 2008). In countries with publicly financed health care systems, most notably the UK and Canada, medical tourism has been discussed as a solution for reducing long surgical wait lists (Eggertson, 2006). The effects of American Affordable Care Act is still forthcoming.

Medical tourism annual growth potential has regularly been estimated above 25% for LDC such as India, Malaysia and Thailand (Neelakantan, 2003; Ehrbeck et.al. 2008 ). However, estimates of patient and currency inflows and their potential for growth are wildly varied, as definitional issues confound the already difficult attempt to determine the scale of the industry (Ehrbeck et.al. 2008; Hume, 2007). Examples of this include: estimates for the entire global medical tourism industry have been as low as 60,000 patients annually (Ehrbeck et.al. 2008 ), while estimates of the annual American outflow alone have been as varied as 50,000 to 500,000 (York, 2008). Perhaps the best example of speculative reporting has been the widely cited Deloitte report, which estimated an American patient outflow in 2007 at 750,000 and projected its increase to rise to millions by 2012. Regardless of the actual numbers, it is generally agreed that the industry is growing rapidly in many Asian nations, and is poised for significant



growth in countries with the necessary human and technical resources (Whittaker, 2008). India and Thailand's introduction of expedited medical visas is a sign of deep commitment to facilitating trade in medical tourism (Arunanondchai & Fink, 2006). Thailand has gone so far as to try and negotiate the portability of public insurance between countries in the region to enhance the flow of inbound international patients (Wibulpolprasert et al 2004). Medical tourists are particularly valuable because of the money they invest in the local economy when compared with traditional tourists. For example, it has been estimated that medical tourists visiting Asia spend over twice as much as traditional tourists (Jorgensen, 2007).

Accompanying revenue gains in destination countries have been associated revenue losses in medical tourists' home countries. While the scattered estimates of international patient flows calls into question the reliability of estimates that find the United States currently losing billions of dollars annually to medical tourism (Crone, 2008), it is only logical to assume that every patient leaving one health care system for another is taking their capital elsewhere. In response to the travel and care coordination needs of medical tourists, a cottage industry of brokerages has sprung up within patients' home countries. These brokerages coordinate the necessary travel, medical, accommodation and holiday arrangements for medical tourists, in exchange for fees from patients or a commission from the hospitals on a per-referral basis. These brokerages have rapidly expanded to fill a niche and are often based in patients' home countries, thus further spreading the global reach of industry profits. This expansion has been facilitated by the spread of the internet, which has made medical tourism an increasingly accessible option and has helped Canada alone support more than 20 different brokerages (Turner, 2007).

Connell (2006) states that "the biggest hurdle that medical tourism has had to face and continues to face, is the challenge of convincing distant potential visitors that medical care in relatively poor countries is comparable to what is available at home in terms of results and safety". Despite this, we can observe that a growing number of patients from developed countries are travelling for medical treatment to regions once characterized as 'third world'

(Herrick, 2007). Medical tourism can be seen as a catalyst for improving the standard of medical care in developing countries. A number of changes to standards of care have accompanied the development of medical tourism in destination countries. Perhaps the most noticeable has been the adoption of international accreditations that are modeled on Western standards (Connell, 2006). The emergence of a global market in health care generated a need for an organization capable of assessing whether hospitals provide an "international" standard of care. Such a body had to have widely recognized standards. Countries such as Thailand and India have national hospital accreditation bodies. However, hospitals wanting to proclaim themselves as "international" medical centers want to be able to claim that they meet "global" standards. An American company filled the gap by offering international accreditation, Joint Commission International (JCI).

The Joint Commission International (JCI) is an offshoot of the primary body responsible for accrediting hospitals in the United States. The development and implementation of JCI has been credited with helping medical tourism to flourish by guaranteeing a standard of care comparable to that found in American hospitals in accredited hospitals (Herrick, 2007). This means of securing the trust of Western patients carries with it the potential for American standards to override local values and approaches to providing health care (Saniotis, 2007; Jenner, 2008). However, the accreditation of an American-style quality of care does not extend to assurances of American-style liability. Most LDC destination countries have limited malpractice laws and insurance requirements, leaving medical tourists with few opportunities for recourse should procedures go awry (Whittaker, 2008, Cortez, 2008). Another concern is the use of Western place aesthetics by medical tourism facilities, a phenomenon that has led to the displacement and homogenization of previously non-Western care spaces (Saniotis, 2007; Connell, 2008). This displacement includes designing hospital lobbies to look like shopping malls and patients' rooms to look like upscale hotels. Medical tourism hospitals are also able to deliver very high nurse-to-patient ratios, higher than those found in wards designated for local patients, due to the low costs of labor in LDC (Cetron & DeMicco, 2006). Medical tourists are also typically given the option of recovering at nearby resorts, offering amenities not replicated in the hospital environments that non-international patients may be required to stay in during recovery (Whittaker, 2008).

Medical tourism healthcare facilities seeking to maintain or improve medical tourists' service quality perceptions within their organizations need to clearly recognize that only by meeting or exceeding medical tourists' service quality expectations can desired outcomes such as satisfaction, loyalty, positive word-of-mouth communication and improved financial performance be achieved (Duffy et al., 2001; Zeithaml et al., 2009). Ensuring high-quality services means attending to expectations used by medical tourists as standards for evaluating foreign healthcare facility service quality (Duffy et al., 2001; Zeithaml et al., 2009). It is, therefore, important to routinely measure medical tourists' expectations as a contributing factor to providing high-quality services. Medical tourism providers should not assume that all medical tourists have the same service quality expectations. In light of the propensity for potential medical tourists to use non-personal information sources (e.g. websites, search engines, advertisements, newspapers, magazines and other publications) to learn about medical tourism and research medical tourism destinations and providers (Medical Tourism Association, 2009; Lunt et al., 2010), overseas hospitals, medical tourism facilitators, governments and national tourism organizations should make sure they do not overstate their service quality (i.e. overpromise) in advertising and other marketing communication to guard against raising customer service quality expectations to unrealistic and difficult to deliver levels. Promises made in advertising and marketing communication need to be controlled and should be consistent with the deliverable service (Zeithaml et al., 2009).

Just as JCI accreditation is used to market hospitals, academic credentials are used to sell the skills of particular physicians. Degrees, fellowships at elite institutions, and U.S. board certification are all used to promote the professionalism of physicians employed by international hospitals. Websites for hospitals in India and Thailand feature physicians trained in Australia, the United Kingdom, and the United States. The message for customers is that the physicians who will provide their care trained at the best institutions in the world. Hospitals seeking international patients encourage their physicians to obtain U.S. board certification. In the absence of global standards for medical education, U.S. board certification signals an international standard of training. This “international” training and certification of health care providers plays a role in helping medical facilities present an image that they offer “elite-level” medical care. Medical tourists returning to their home countries may bring with them altered conceptions of appropriate standards of care. Exposure to nurse-to-patient ratios that far exceed norms in most systems, hotel-like care spaces and the ability to choose one’s physician from a website may result in patients demanding similar ‘consumer as king’ treatment at home (Whittaker,2008). Expectations such as these are tied to the treatment of health care as a commodity, and may be especially deleterious for overburdened publicly-funded health care systems. More specifically, patients returning from abroad may wish to see elements of their privately-funded care instituted within their home systems. Medical tourism can also create a sense of limitless options for potential patients. If they find themselves unhappy with local options, the seemingly boundless variety of willing facilities and professionals available internationally holds with it the promise for effective treatment somewhere. This can encourage patients to treat medical tourism as a viable solution to medical problems, even if their prognosis is beyond treatment (Kangas, 2007).

## **Conclusion**

The sources reviewed indicate that medical tourism has, and will continue to have significant affects on the health care systems of both departure and destination countries. Despite the growing significance of medical tourism in the international arena, it has been a distinctly under-studied area in academia. To date, normative claims of neoliberal economic development have directed the majority of discourses on the subject. These discourses have not allowed space for the investigation of the potential social effects it may have, particularly on equity for the more vulnerable groups within destination countries. Many issues have not been considered and a number of assumptions remain unquestioned, such as: will market mechanisms actually intrinsically ensure that the growth of medical tourism will assist the wider health systems in poorer countries? Who are the main groups and actors to actually benefit from the policies and new institutions created for the promotion of medical tourism? Further research is required to ascertain the social risks created through the

growth of medical tourism and the groups which are most likely going to be subjected to them.

World-class treatment & highly advanced healthcare infrastructure is the main reason for concentrating on promotion of this kind of tourism in Asia. A scoping review has identified five themes that effectively synthesize what is known about the effects of medical tourism in destination and departure countries. First, medical tourism can be understood as a user of public resources. This includes consuming public health care resources in destination countries through redirecting them to the private sector, and in departure countries through the provision of follow-up care for medical tourists. Second, the practice of medical tourism can be seen as offering solutions to problems. It has the potential to aid in the development of health care infrastructure in destination countries while reducing wait times and costs for care for residents of departure countries. Third, medical tourism is also a revenue generating industry. This industry can generate revenues for destination countries as a form of health services trade. Conversely, it can result in a net loss of capital to departure countries. Fourth, medical tourism can be seen as setting a standard of care. By seeking accreditation, destination countries may develop a Western-oriented standard of care, including in facility aesthetics. Due to low labor costs in destination countries, medical tourists may develop expectations of standards of health human resource provision that are unaffordable, and therefore unattainable, in high-income departure countries. The process of medical tourism can also contribute to the co-modification of health care and a perception of the patient as consumer. Finally, the cumulative effects of medical tourism position it as a source of inequity. Within destination countries, it can contribute to an internal brain drain of trained medical workers from rural to urban areas and from the public to the private sector. Medical tourists can face a significant drain on their own financial resources and, by engaging in travel abroad for medical services, they may contribute to a loss of impetus for reform of their home health care systems.

Medical tourism is likely to remain an increasingly visible and practiced global phenomenon, subject to much conjecture but little regulation or understanding. Medical tourism is becoming a new and emerging international business that is gradually increasing in importance. In capitalizing on the tourism infrastructure that supports this industry, nations do not need to invest much more in supporting medical tourism. As an international business, this is not too different from the subcontracting or the off-shoring of services. With higher costs and expertise, in the future, medical tourism is likely to be the new global trend for providing medical services. The rapid developments in medical tourism demands have left the policing and legislation behind. It would be imperative for this legislation to catch up in order to protect the vulnerable that are unable to make well informed research-based decisions. It remains to be seen in the future which countries will adopt the proactive stance to strategically avoid future problems to maintain and protect their country's reputation in this

important and growing area of healthcare. The travel and tourism demand is expected to reach US\$ 266.1 billion by 2019 (Deloitte, 2009).

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