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GUILLERMO ARIAS/AFP via Getty Images



People crowd the street outside a dental clinic in Los Algodones, Mexico, in 2017. Americans travel to the town, located on the U.S.-Mexican border, in search of cheaper dental care.

Medical Tourism

Will rising health costs trigger a post-coronavirus revival?

By Kerry Dooley Young

THE ISSUES

Howard Staab remains a big fan of medical tourism.

Sixteen years ago, the self-employed carpenter, lacking health insurance, traveled to India to replace a failing heart valve. The cost, about \$6,700—far less than the \$200,000 typically charged at a U.S. hospital.¹

Staab, now 68, is still leading an active life and is restoring a home in Spain. While he had a second valve replacement at a U.S. hospital in 2018—Medicare paid for this operation—Staab says he would not have hesitated to return to India for the procedure. And he recommends that others in need of cardiac care consider treatment at the facility in New Delhi where he had his first valve replacement.

“I had such a great experience in India,” he says.

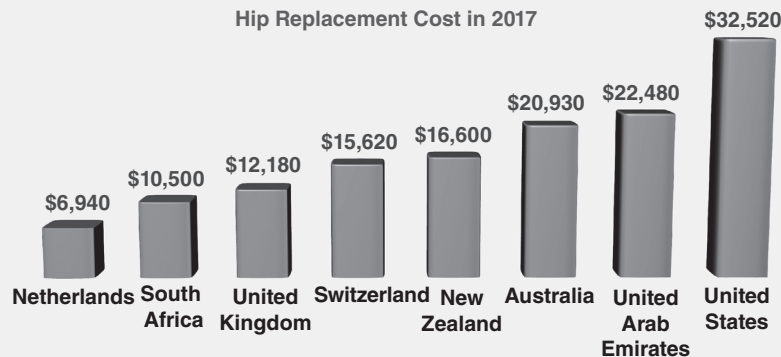
Although the coronavirus outbreak has largely frozen medical tourism because of the international travel restrictions, many experts expect it to resume once the pandemic subsides. And the key driver will continue to be the high cost of medical care at home, says Josef Woodman, CEO of Patients Beyond Borders, a group that advises government agencies and hospitals about medical tourism.

“No one wants to travel for medical care,” says Woodman, who also publishes guides for consumers. “That’s not on the top of the list for a vacation agenda. It’s about saving money.”

From *CQ Researcher*,
April 10, 2020

Hip Replacement Costs in the U.S. Top Other Countries

A hip replacement in the United States cost \$32,520 on average in 2017, more than \$10,000 higher than in the United Arab Emirates and nearly five times higher than in the Netherlands. The procedure also cost less in South Africa, the United Kingdom, Switzerland, New Zealand and Australia.



Source: John Hargraves and Aaron Bloschichak, "International comparisons of health care prices from the 2017 iFHP survey," Health Care Cost Institute, Dec. 17, 2019, <https://tinyurl.com/rz2ceqr>

David Boucher, the chief business transformation officer at Thailand's Bumrungrad International Hospital, is also anticipating a rebound in business. People who were considering traveling abroad for orthopedic procedures before the pandemic hit will still need hip and knee replacements and rotator cuff treatments when coronavirus infections subside, says Boucher, whose hospital is a major hub for medical tourism.

"Once this clears and the airlines open up the flights, they will be back in the air and they will be coming here," he says.

Boucher says he is confident about the future of Bumrungrad, a giant hospital in Bangkok, which cares for more than 1.1 million patients from more than 190 countries each year.² But a shakeout is likely among smaller participants in medical tourism. Some agencies that connect patients with hospitals and clinics abroad probably will close due to the pandemic, said Ian Youngman, an author who specializes in writing about the business of medical tourism.

"The restrictions and virus fears have hit tourism hard, and medical tourism is expected to be hit the hardest," Youngman said.³

Wealthier Americans have long gone abroad in search of treatments unavailable to them at home, including unproven therapies. Staab's journey to India made him perhaps the most famous American medical tourist to seek care abroad due to cost. There was a splash of news coverage and even a 2006 Senate hearing about his Indian heart surgery. But his far-flung experience is far from the norm for the majority of Americans seeking medical care abroad, says Valorie Crooks, a researcher at British Columbia's Simon Fraser University.

"There's an idea of the mythical American patient. It's sort of like a unicorn," Crooks says. "A lot of the coverage tends to exoticize the practice of medical tourism. It suggests that people are traveling all the time from Missouri, for example, to India or that people are crossing into different hemispheres."

Instead, Crooks cites as more typical the dense cluster of dentists in Los Algodones, Mexico, catering to Americans and Canadians. It is a two-and-a-half-hour drive from San Diego and three hours from Phoenix.

I. Glenn Cohen, a professor at Harvard Law School and the author of *Patients with Passports: Medical Tourism, Law, and Ethics*, agrees with Crooks. He says the most common form of medical tourism in recent years has been "driving to our southern border with Mexico."

Familiarity remains the key predictor of where an American might seek care abroad, says Cohen. Immigrants might return to their country of origin for medical care, and their children and even grandchildren may be likely to do so if families have maintained cultural ties, Cohen says. People with connections to Thailand or South Korea, for example, may return to these nations for care, he notes.

While U.S. insurers and employers have not rushed to embrace medical tourism, there have been some

notable pioneers. Privately owned HSM Solutions, a North Carolina manufacturer, for example, has let its employees share in the savings if they get elective procedures in places such as Costa Rica and the Cayman Islands.

It is easy to understand why some Americans look for medical bargains abroad. But these patients may be underestimating the high costs of treating potential complications, says Dr. Usamah Mossallam, medical director for international initiatives at Detroit's Henry Ford Health System.

Patients seen abroad sometimes return home with infections or find their knee and hip replacements must be redone, Mossallam says. These patients then may need to find specialists in the United States.

"It's a whole host of things that are scary to see and deal with. They can't go back to the place" that treated them, Mossallam says. "They don't trust them anymore."

He contrasts this with the experience of overseas patients who travel to America for medical care. The United States is a leader among nations drawing medical tourists, with many wealthy people seeking care at medical centers. Those undergoing a joint replacement at Henry Ford would commit to spending about a month living near the hospital, allowing physicians to monitor their condition, according to Mossallam.

"We feel like we own that person's health. We own that person's process as well as whatever it takes to get them healthy, instead of it being a case of 'send us a large sum of money and we'll do the procedure and then you are on your own,'" Mossallam says.

But Cohen, the Harvard law professor, says Americans can be "very parochial" in their attitudes about the quality of care.

"We assume we have the best health care in the world, but in fact there are many hospitals across the world that do particular things as well as the Mayo Clinic does," he says. "So the average hospital you go to in the United States may actually be worse than the very best hospitals in Thailand or India."

The exact number of Americans traveling abroad for health care is unknown, say Crooks, Cohen and other medical tourism experts. But they agree that certain estimates have been too bullish. A widely cited 2008 report from the Deloitte Center for Health Solutions predicted

that the number of American medical tourists would rise to 16 million by 2017.⁴

That was far above Patients Beyond Borders' estimate—made before the coronavirus outbreak—that about 2.2 million Americans were likely to travel outside the United States for medical care this year.

The group estimated recent spending by medical tourists as averaging \$3,550 per visit. That includes medical-related costs, cross-border and local transport, inpatient stay and outside accommodations.⁵ Costa Rica, India and Thailand are among the most popular destinations.

One reason why the higher projections for U.S. medical tourism failed to materialize may have been the passage in 2010 of the Affordable Care Act (ACA), which dropped the number of Americans lacking health insurance from almost 47 million in 2010 to about 28 million in 2018.⁶

But some consumers still have difficulty finding affordable plans. And the costs imposed by the coronavirus pandemic could produce a spike in the price of medical insurance next year, causing employers and consumers to drop medical coverage, said Covered California, the state health insurance exchange created by the ACA. Covered California's researchers in March predicted health insurance premium increases next year ranging from a low of 4 percent to more than 40 percent.⁷

Cohen says the study of medical tourism relies in part on "anec-data," with the numbers available used to illustrate points promoters of certain procedures and locales want to make. Crooks of Simon Fraser University uses the phrase "triple U's" to describe medical tourism. "It's untracked, untraced and unregulated," she says.

Countries do not collect information about whether citizens have had care abroad. "We do things like ask if somebody has been on a farm because we're concerned about zoonotic disease," Crooks says, referring to maladies spread between animals and humans. "But we don't ask if somebody has accessed care abroad."

The coronavirus pandemic might prompt governments around the world to reconsider their laissez-faire approach to citizens seeking health care abroad, says Heather Wipfli, an associate professor at the University of Southern California's Keck School of Medicine.

Even before the new virus emerged as a major threat, scientific bodies, including the U.S. Centers for Disease

Control and Prevention, raised alarms about the spread of drug-resistant bacteria through medical tourism. With the coronavirus carried into many nations by travelers returning home, governments and scientific leaders are newly reminded just how intertwined nations should be in fighting diseases, says Wipfli, who has published research on international efforts to coordinate health initiatives.

“We might want to have some rules in place to be able to conduct surveillance and monitoring of procedures and patients in order to track whether these kinds of microbes are crossing borders,” she says.

As patients, medical professionals and scientists consider the future of medical tourism, here are some of the issues they are discussing:

Should federal health insurance programs cover medicines and therapies obtained abroad?

A Utah experiment with pharmacy tourism should be copied by federal agencies and programs such as the Department of Veterans Affairs, Medicare and Medicaid, says state Rep. Norm Thurston, a Republican.

Utah’s Public Employees Health Program lets employees share in savings if they travel to pharmacies in Mexico or Canada to purchase certain costly drugs. Utah so far says it has saved about \$225,000 on drugs bought in Mexico by patients who required certain expensive medications, mostly treatments for multiple sclerosis and other autoimmune disorders.⁸

“Why can’t we do this, for example, for the Medicaid program?” says Thurston, who earlier served as Utah’s health reform coordinator. “We could do it safely, and it would save taxpayers a ton of money, both state and federal.”

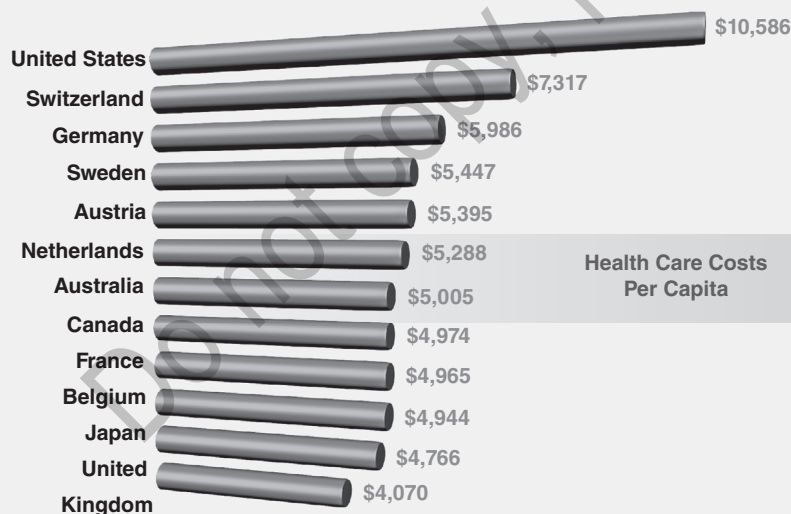
Combined annual spending for Medicaid and Medicare tops \$1 trillion, with more than 100 million covered between the two programs.⁹ Medicare offers health insurance to those age 65 and older, while Medicaid provides coverage for lower-income adults.

Many states already are interested in tapping into Canadian pharmacies for the same medicines sold in the United States. In response, the Trump administration in December released a proposal for creating a safe pathway for certain cross-border sales.¹⁰ This represents a major shift in attitude by the U.S. Food and Drug Administration, which long has said it could not guarantee the safety of these imported medicines.¹¹ The American Medical Association in 2018 endorsed the practice of people buying their medicines in person from licensed Canadian pharmacies.¹²

Why not have Medicare follow a strategy popular with many corporations and seek the aid of offshore partners to lower costs for surgical procedures, asks Dean Baker, senior economist with the Center for Economic and Policy Research, a liberal Washington think tank. Medicare could cover the cost of some elective procedures at foreign hospitals with good track records in these fields, Baker says.

U.S. Health Care Cost Tops Other Developed Nations

The per capita U.S. health care cost in 2018 was \$10,586, far more than for other developed nations. Of 12 countries studied, the United Kingdom had the lowest per capita cost.



Source: “How Does the U.S. Healthcare System Compare to Other Countries?” Peter G. Peterson Foundation, July 22, 2019, <https://tinyurl.com/tmc47sg>

“The savings could be quite large,” he says.

Marc Joffe, a senior policy analyst at the Reason Foundation, a libertarian Los Angeles think tank, also has raised the idea. “Given the very large savings available, it may even be appropriate for Medicare to provide cash incentives to patients choosing medical tourism,” Joffe wrote.¹³ “Further, a medical tourism benefit could be added to Medicaid and to federal employee benefit systems.”

Federal officials could test this approach in a limited way through an experiment involving Medicare Part D pharmacy plans, says Joffe. “That might get traction because there have been a lot of issues with prescription drug costs and people complaining about them,” he says.

In a 2009 op-ed in *The New York Times*, Dr. Arnold Milstein, now a professor of medicine at Stanford University, and Jerome Kassirer, a former editor of *The New England Journal of Medicine*, suggested a path testing whether other countries could offer the same level of care for American senior citizens that U.S. medical providers do.

“Medicare should invite accredited offshore hospitals and their affiliated doctors to participate in all of its comparative performance reporting systems,” they wrote. “Beyond informing Americans contemplating treatment abroad, such comparisons would allow us to learn if our care is the world’s best and to accelerate our improvement efforts if it is not.”¹⁴

To date, no federal agency has taken up that challenge. There are only a few cases where the federal government now pays for medical care delivered abroad.

The Department of Veterans Affairs pays for health services provided for eligible veterans living or traveling abroad through its foreign medical program, accounting for a sliver—about \$59 million—of a \$90 billion annual budget for medical care.¹⁵ Medicare covers foreign health care only in very limited circumstances. These include cases where a foreign hospital is closer to a senior citizen’s home in the United States than the nearest American hospital.¹⁶

U.S. hospitals likely would strongly object to a plan to use federal health care funding to pay for nonemergency surgeries performed abroad even if performance

on surgical quality measures was equivalent to U.S. hospitals, according to Milstein. That would make it difficult for lawmakers to support legislation to test federal payments for medical tourism, he says.

“It would be politically improbable . . . and courageous,” says Milstein, medical director for the Pacific Business Group on Health, which advises large corporations and public agencies.

Even before the coronavirus pandemic hit, insurers who worked with Medicare showed little appetite to test medical tourism, says Matthew Downs, a lawyer based in Washington.

Downs, a former Senate staffer, created a nonprofit organization, the Center for Medicare Portability, in 2011 to gauge interest in extending Medicare coverage for Medicare-eligible Americans living abroad. Downs says he intended to see if the program would cover treatments in Mexico, where a sizable community of U.S. expatriates lives.

Congress often allows Medicare Advantage plans—Medicare coverage delivered through private insurers—more flexibility in testing approaches to health care, such as offering dental plans or hearing aids.¹⁷

But Downs says he dropped his project in 2015 after finding there was little active interest among insurers with Medicare Advantage plans for this kind of expansion.

Mossallam, of the Henry Ford Health System, says he opposes expanding Medicare payment for overseas medical treatments—or even testing the idea.

“That’s actually a scary idea,” Mossallam says. “If we are even suggesting to send people out of this country, what kind of message does that send? It’s saying, ‘We’re the highest quality care, but we’re so expensive we’re going to look at options outside of our own country.’ That’s just insane to me.”

Should developing countries promote medical tourism?

While the coronavirus outbreak has halted the arrival of foreign patients in Thailand for now, the beneficial impact of medical tourism will be felt in Boucher’s Bumrungrad International Hospital, he says. It will have a greater capacity to respond to local people suffering from the infection.



British patient Richard Newman talks with a doctor and nurse following surgery at Yanhee International Hospital in Bangkok to remove fat in 2005. After the 1997 Asian financial crisis, Thai hospitals began promoting their medical care as a less expensive alternative.

This is one example of the benefits of medical tourism for a host nation, Boucher says. “There is no doubt at all,” he says. “It’s a definite asset.”

In 2018, Bumrungrad treated patients from more than 190 countries. In that year, international patients accounted for two-thirds of its revenue, with the nations of Myanmar, Oman and the United Arab Emirates contributing the largest shares of revenue.¹⁸

Bumrungrad’s foray into medical tourism has its roots in the 1997 Asian financial crisis. The private hospital opened in January of that year. By July, demand for care at private hospitals had all but evaporated, Mack Banner, then the hospital’s CEO, said in a 2009 interview. The hospital could have slipped into insolvency—but for a plunge in the Thai currency, the baht, as a result of the financial crisis.¹⁹

Bumrungrad “became half price almost overnight for those paying for their care in U.S. dollars,” Banner said, prompting the hospital to start marketing to patients in nearby countries. “That really began our foray into caring for international patients,” he said.²⁰

Medical tourism need not be viewed as an either-or proposition for developing countries, said David A. Reisman, an economics professor at Nanyang Technological University in Singapore. Investments needed to attract wealthy foreigners may serve local communities as well, he argued.

“Health tourism can deliver the goods. Foreigners get quality care at an acceptable price and without a wait. Professionals are retained who might otherwise have gone abroad,” Reisman said. “The unskilled and the semiskilled obtain jobs and on-the-job training. Economies of scale become possible even if the domestic market lacks critical mass.”²¹

Vijay Govindarajan, a professor at Dartmouth College’s Tuck School of Business, and Ravi Ramamurti, a business professor at Northeastern University, have depicted medical tourism as a potential driver of improved medical care. They cited India’s Narayana Health, a hospital system developed by cardiologist Devi Shetty, as an example of how richer medical tourists may subsidize care of the poor.²²

“The poor increase volume, which improves the quality of outcomes for all, including the rich. It is a perfect matchup: Rich and poor create value for each other, and the hospitals become high-quality, ultra-low-cost players,” Govindarajan and Ramamurti wrote.²³

The Medical Tourism Association, a Florida-based trade group, posts on its website information intended to attract clients interested in drawing patients as medical tourists. The group also hosts conferences and sells other services to aid organizations and countries interested in expanding in this market. The association has a medical tourism calculator, which it describes as “an adaptable tool used by all industry stakeholders to demonstrate the total economic impact of creating a medical travel program.”

“Important factors such as job creation and tax revenues as well as the impact to hospitality and tourism have been less emphasized in medical tourism forecasts,” the association said.²⁴

Some developing nations, particularly in Asia, are vying to attract foreign patients to their hospitals. They see these patients both as sources of revenue and a way to foster improved medical care.

There is a potential for a trickle-down effect on the health systems of poor and developing nations by bringing in medical tourists from wealthier ones, says Swati Gola, a lecturer at the University of Exeter in Britain, who has published research on the ethics of medical tourism.

“I’m not against medical tourism, but what’s important is regulation,” she says.

But often, corruption within national governments can make them ineffective in keeping private medical interests in check, Gola says.

Ronald Labonté, a professor of public health at the University of Ottawa, said nations sometimes subsidize the care of foreigners at the expense of their own citizens. Legal action was required to get Indian hospitals that had given tax breaks for care of the wealthy to deliver on promised care for the poor, according to Labonté.²⁵

In Colombia, hospitals constructed for medical tourists were “tax-free zones” with lower tax rates on commercial activities. In many cases, nations are using medical staff trained at public expense to attract foreign patients.²⁶

“Meanwhile, the money governments spend promoting or subsidizing this economic sector comes with opportunity costs in the areas it doesn’t invest in, like constructing much needed comprehensive primary health facilities,” Labonté said.²⁷

Harvard’s Cohen also questions how well profits from medical tourism have served the poor of the host nations. “Although one cannot reach a conclusive judgment on the subject, there is thus far no good evidence that there have been major trickle-down benefits from medical tourism,” Cohen said.²⁸

Could global standards be established for medical tourism?

Wipfli of the University of Southern California says global regulation of medical tourism is needed. She suggests the Framework Convention on Tobacco Control as a model.

Overseen by the World Health Organization (WHO), the convention came into force in 2005 when more than 160 nations signed on. Public health experts credit this voluntary agreement with helping many nations adopt policies, such as raising taxes and stepping up warnings about the risks of smoking, to curb tobacco use.²⁹

The WHO would have the organizational experience to aid with an effort to create a more unified global approach to monitoring or regulating medical tourism, says Wipfli, the author of the 2015 book *The Global War on Tobacco: Mapping the World’s First Public Health Treaty*.

“If WHO wanted to take the lead again on a treaty on medical tourism, they would have a lot of in-house capacity

that they wouldn’t have had at the beginning of the tobacco treaty,” Wipfli says.

There is a natural ebb and flow to international attitudes toward global agreements, Wipfli says. While there has been a tendency away from such cooperation in recent years, the coronavirus pandemic could lead to renewed interest.

“Coming out of this current outbreak, there might be more heightened desire to formulate more binding rules, given the appreciation at the moment for the interdependence” of nations in health care, Wipfli says.

Y.Y. Brandon Chen, a researcher at the University of Ottawa who teaches health and immigration law, has published work on the profound effects of medical tourism on low- and middle-income countries. In a 2013 paper, he argued for regulating medical tourism.³⁰ People who travel abroad for medical services may be unaware of the toll that medical tourism can take on national health systems, Chen says.

“I don’t think people are thinking about that question, and our argument is that they should when they are making the decision to travel abroad,” Chen says. “Most often they are thinking, ‘I have a medical condition that requires attention and if I cannot get it in my home country, for whatever reason, and there are other options available, I’m going to try them.’”

At a minimum, there should be a shift toward educating people about the risks not only to their own health, but to the impact their visits have on receiving countries, Chen says.

Chen says he does not oppose medical tourism, and having standards could prevent “a free-for-all” developing: “When medical tourism is solely driven by the private sector, which I think to a . . . large extent it is, the for-profit motive comes to the forefront.” In addition, he asks, when allegations of malpractice arise, “which countries’ law do we use . . . and where do we litigate?”

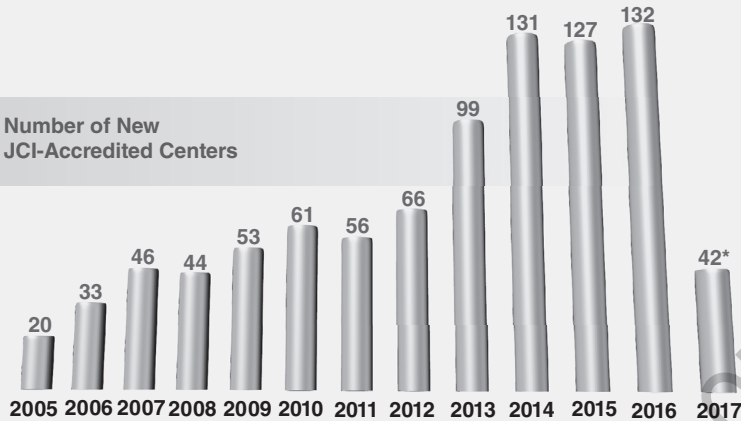
Creating a global standard for medical tourism, however, would be difficult, says Dr. Lloyd I. Sederer, a physician and former chief medical officer for the New York State Office of Mental Health. “There are so many different procedures and so many different countries,” he says. “There’s so much variance.”

Sederer, who also is an adjunct professor at Columbia University’s School of Public Health, was a medical

Global Accreditation of Hospitals and Clinics Rises

The Joint Commission International (JCI) annually accredited more than 100 medical facilities around the world from 2014 to 2016, continuing a decade-long upward trend. The group provides information for traveling patients to find facilities with safe and ethical care abroad. The increasing frequency of accreditations reflects the recent growth of the medical tourism industry.

Number of New JCI-Accredited Centers



* Through June 2017

Source: Amber Mehta, Seth Goldstein and Martin A. Makary, "Global trends in center accreditation by the Joint Commission International growing patient implications for international medical and surgical care," *Journal of Travel Medicine*, Vol. 24, Issue 5, Aug. 21, 2017, <https://tinyurl.com/r9d67p7>

tourist, disclosing in 2012 that he was among the patients—who included basketball star Kobe Bryant and Pope John Paul II—seeking “a novel form of anti-inflammatory arthritis/tendinitis treatment” that then was only available in Germany.³¹

Sederer says he was unaware when he had his overseas treatment of a group called the Joint Commission International (JCI) that performs voluntary assessments of foreign hospitals and clinics. As of March, 1,013 hospitals, clinics and other medical facilities outside the United States held the international group’s accreditation, meaning they had passed the group’s inspections, the JCI says.

The JCI, founded in 1994, is an affiliate of the U.S. Joint Commission, a nonprofit group that has considerable clout over the operations of U.S. hospitals and clinics. About 22,000 U.S. hospitals and other medical clinics and centers have Joint Commission approval.

The federal government accepts the Joint Commission’s accreditation as a qualification for

Medicare and Medicaid payments, the financial lifeblood of many American hospitals. But the work of its international branch may not carry the same clout.

“Losing Joint Commission accreditation is very meaningful in this country. I don’t know about other countries,” Sederer says.

The JCI’s parent organization, the Joint Commission on Accreditation of Healthcare Organizations, is dependent on the fees paid by hospitals and other medical organizations in the United States and abroad for its services. The organization’s 2018 financial statement shows it had \$238.6 million in revenue that year, including \$95.5 million in on-site survey fees and \$85.1 million in annual accreditation subscription fees.³² The clients for these surveys, services and publications are the hospitals that the

Joint Commission and JCI rate. “We pay them, so there is a sort of inherent lack of independence,” Sederer says.

Sederer says the Joint Commission has made improvements over the years in its evaluations of medical care. It now focuses more on the procedures in place than on how well paperwork is done. Still, the group’s work is for the most part no more than a basic benchmark for acceptable quality. “I wouldn’t go to a hospital that isn’t Joint Commission accredited, but beyond that, some are a lot better than others,” Sederer says of his experience with U.S. hospitals.

There has been rapid growth in the number of JCI accreditations, said Marty Makary, a surgeon and the author of the 2012 book, *Unaccountable: What Hospitals Won’t Tell You and How Transparency Can Revolutionize Health Care*. In a 2017 paper in the *Journal of Travel Medicine*, Makary and two colleagues said the annual number of newly JCI-accredited medical centers rose

from one center in 1999 to 132 in 2016. By that year, there were 939 accredited by JCI.³³

These international facilities do not report outcomes to any kind of a central database, making it impossible to compare hospitals in the United States and elsewhere. Makary and his colleagues suggested adding a new accreditation requirement for reporting outcomes, such as the number of infections, lengths of stay and cases where subsequent operations were needed.

But Paula Wilson, the CEO of the JCI, says her organization's mission is not about promoting transnational health care.

"We're neutral when it comes to medical tourism," she says. "We're not against it or for it."

The JCI's growth in accreditation stems in part from doctors from other nations seeking to replicate in their home countries the standards they experienced in the U.S. hospitals where they trained, Wilson says. Nations such as the United Arab Emirates use the program to bolster their domestic health systems, she says.

Neither the U.S. Joint Commission nor its international branch delves into data on how well patients fare in a specific hospital. Instead, they examine how well institutions carry out procedures that are known to improve safety. With global medical officials immersed in the fight against coronavirus in early 2020, Wilson cited as an example preventing the spread of disease among hospital patients and staff. JCI looks at whether organizations employ infection-control officers and what strategies and procedures are in place to prevent the spread of viruses and bacteria.

"We ask, 'Do you have an infection control plan?'" Wilson says. "And is it a good plan? And did you follow it?"

BACKGROUND

Ancient Pilgrims to Jet Set

The impulse to seek medical care in foreign lands dates from the earliest days of recorded human history. Ancient Greeks and Romans traveled in search of better health to temples of the god Aesculapius, whose symbol of a serpent coiled around a staff remains associated with medicine to this day.³⁴

These temples were often built on hills outside towns and near wells that people believed to have healing

powers. They thus attracted many people experiencing ill health and have been compared to modern hospitals.³⁵ By the 16th century, wealthy Europeans traveled to towns such as Bath, England, and St. Moritz, Switzerland, in search of healing waters.³⁶

In the early 20th century, the popularity of psychoanalyst Sigmund Freud and his followers drew many wealthy foreigners to seek mental health care abroad.

"Analysts in Austria and Germany usually spoke several languages," wrote historian Eric Shiraev. "They saw an influx of cash-paying foreign patients, especially from France, Great Britain, and even the United States."³⁷

In 1963, Brazilian plastic surgeon Ivo Pitanguy opened a private clinic. His work and that of the surgeons he trained created a cottage industry for face-lifts and other cosmetic procedures.³⁸ By the 1970s, so many wealthy people and celebrities traveled to South America for such procedures that the phrase "vacation in Brazil" became a synonym for a restorative visit to a plastic surgery clinic.³⁹ In 1980, *The New York Times* profiled Pitanguy in an article titled "Doctor Vanity: The Jet Set's Man in Rio."⁴⁰ Writer Warren Hoge described what happened when foreigners sought Pitanguy's care:

"After arriving in Rio, patients receive a precautionary examination from an internist and pose for the crucial photographs," Hoge wrote. "'Pictures are to a plastic surgeon what X-rays are to a general practitioner,' says a Venezuelan surgeon studying with Pitanguy."



Christopher Pflitz/Getty Images

Brazilian plastic surgeon Ivo Pitanguy reviews a patient's photographs in 2000. After he opened a private clinic in 1963, Brazil became a destination for wealthy foreigners seeking face-lifts and other cosmetic surgeries.

Actor Steve McQueen also drew attention to medical tourism during his battle against an aggressive cancer, mesothelioma. He traveled to Mexico for treatments not approved in the United States that included laetrile, a controversial alternative therapy made from apricot pits. Even though McQueen succumbed to his cancer in 1980, his fight sparked interest in medical tourism.

“In so doing, he put Mexico on the map, popularized unapproved treatments, and touched off a trend toward seeking medical care beyond America’s borders,” wrote authors Kathy Merlock Jackson, Lisa Lyon Payne and Kathy Shepherd Stolley.⁴¹

Ethical Quandaries

Other celebrities have followed McQueen’s path and sought out treatments that are not approved at home.

Reports of sports stars traveling abroad for stem cell treatments have triggered increased public interest. In 2018, actor Mel Gibson told sports commentator Joe Rogan that he thought a course of stem cells had helped rejuvenate his aging father. Rogan’s interview of Gibson and the doctor who administered the treatment in Panama has been watched more than 3 million times on YouTube.⁴²

These kinds of reports frustrated scientists, who saw media accounts overselling the potential of stem cells. These cells can develop into many different cell types, from muscle to brain cells, and thus are seen as having the potential to repair damaged tissues.⁴³ Stem cell transplants have been found to aid in treatment of leukemia. Scientists are studying whether they might have use as well in treating conditions such as Alzheimer’s disease, but the results have been mixed at best.

In 2008, the International Society for Stem Cell Research issued guidelines on the use of these treatments, highlighting in particular the risks for people undergoing care outside of their home countries.

“The marketing of unproven stem cell interventions is especially worrisome in cases where patients with severe diseases or injuries travel across borders to seek treatments purported to be stem cell-based ‘therapies’ or ‘cures’ that fall outside the realm of standard medical practice,” the society said.⁴⁴ In 2016 it issued new guidelines urging scientists and clinicians not to

participate in stem cell treatments that lack clear scientific evidence.⁴⁵

But for-profit stem cell clinics continued to flourish, due to a mix of lack of regulation and patients’ desperate searches for cures. When celebrities undergo and then endorse unproven treatments, they may get better without knowing if there is any connection between their improvement and the procedure, researchers said.⁴⁶

Physicians who sell these treatments have a responsibility to put their theories through rigorous scientific testing, said Dr. George Q. Daley, the dean of Harvard Medical School, who has been a leader in developing the society’s guidelines.⁴⁷ In medicine, physicians seek to show new medicines and treatments work by comparing results of patients given these drugs and procedures against similar patients who do not get them in clinical trials.

“If you apply these criteria, most of the clinics that are involved in stem cell tourism will fall quite short,” Daley said.⁴⁸

In the same vein, transplant surgeons and kidney specialists in 2008 called for an end to abuses seen in trafficking of donated organs and associated medical tourism.

In what came to be known as the Declaration of Istanbul, the group sought to curb abuses in transplant organs, particularly cases where people living in poor nations were coerced into selling their kidneys. It is unclear how many Americans travel abroad to obtain new kidneys, but clearly some do, Harvard’s Cohen says. The federal government has not moved strongly to end or address this practice, he says. Medicare, for example, covers the cost of drugs needed to prevent organ transplant rejection even in cases where a patient had the operation abroad.

“They could disallow them,” Cohen says. “But they don’t ask too many questions about the provenance of organs.”

Reproductive assistance has long been an important niche for medical tourism, due in part to poor insurance coverage for procedures intended to help people conceive and carry children, Cohen says. This field includes in vitro fertilization (IVF), where an egg is combined with sperm outside the body and then implanted in the body. But it also extends to cases of surrogacy where women who live in poor nations carry children for peo-

C H R O N O L O G Y

1960s-1980s *A Brazilian doctor sparks a trend.*

1963 Brazilian plastic surgeon Ivo Pitanguy opens a private clinic, spurring wealthy Americans in the 1970s to travel to South America for cosmetic surgery.

1980 Actor Steve McQueen sparks interest in medical tourism when he travels to a Mexican clinic for controversial treatments to fight cancer. The treatments do not prevent his death from mesothelioma later in the year.

1990s-2000 *Accreditations are instituted for international facilities.*

1990 British medical journal *The Lancet* publishes articles on complications suffered by men who traveled to India for kidney transplants.

1994 The Joint Commission, a well-known accreditor of U.S. hospitals, forms the Joint Commission International (JCI) to evaluate foreign hospitals.

1997 After Thailand's currency collapses, the government hopes to boost revenues by directing tourism officials to market the country as a destination for plastic surgery. Thailand goes on to become a leading medical destination.

1999 Brazil's Einstein Hospital in São Paulo becomes the first health institution outside the United States to be certified by the Joint Commission International.

2002 The JCI awards its first accreditation in Asia, to Thailand's Bumrungrad International Hospital in Bangkok.

2005 CBS's "60 Minutes" airs a profile of Bumrungrad International Hospital.

2006 U.S. Senate Special Committee on Aging holds a hearing on medical tourism, drawing more attention to the practice.

2007 HSM Solutions, a North Carolina manufacturing company, institutes a program to send some employees abroad for medical care, sharing part of the resulting savings with the workers.

2008 An international team of experts creates the Declaration of Istanbul in an effort to combat organ trafficking and curb transplant tourism. . . . The International Society for Stem Cell Research releases guidelines for patients who are seeking stem-cell treatments.

2010-Present *Medical tourism spreads, and controversy grows.*

2010 President Barack Obama signs the Affordable Care Act, which aims to reduce the number of the uninsured and help make medical care more affordable for Americans.

2016 The International Society for Stem Cell Research urges physicians to refrain from giving unproven stem cell treatments.

2017 The U.S. Centers for Disease Control and Prevention (CDC) issues an alert about risks for serious infections seen in people who returned to the United States after having cosmetic surgery in the Dominican Republic.

2018 The state of Utah begins its pharmacy tourism program, paying people to travel abroad to get certain costly medicines.

2019 The CDC issues an alert for travelers about the risk of infection in connection with weight loss surgery in Mexico.

2020 The coronavirus pandemic puts global travel and medical tourism on hold.

ple from wealthier ones. This form of medical tourism raised questions about exploitation of women and the role of medical go-betweens.

India in 2002 legalized commercial surrogacy as part of its broader efforts to boost medical tourism. One Indian

industry group estimated that within a decade the surrogacy industry could generate \$2.3 billion a year. While a surrogate pregnancy in a Western nation could cost more than \$90,000, the cost in India was about a third of that price, with the surrogate receiving about \$6,500 to \$7,500.⁴⁹

Black Market in Organs Persists Despite Anti-Trafficking Efforts

“We should not have foreigners coming here to buy kidneys.”

People considering traveling abroad to black-market clinics for organ transplants should understand the risks involved, including the likelihood that donors have been coerced or exploited, researchers say.

In a paper published in November, five Canadian researchers emphasized the need to boost domestic organ donation rates across nations, while also making the public more aware of how organs can sometimes be obtained unethically.¹

“I wanted to bring this issue back to the forefront,” says one of the authors, Dr. Zaid Hindi, a gastroenterology fellow at Ontario’s London Health Sciences Centre.

In addition, a 2008 study by UCLA researchers suggested that patients may be at higher risk of complications, such as acquiring serious infections, through medical tourism.²

Global efforts to end organ trafficking have curbed, but not ended, this illegal trade. Perhaps as many as 5 to 10 percent of all kidney and liver transplants involve illegally or improperly obtained organs, the United Nations Office on Drugs and Crime said in a 2018 report. Brokers in nations such as India have found ways around medical and legal restrictions, which are intended to allow altruistic donations of organs, but not sales, the report said.³

“A lot of patients would rather purchase a kidney from a stranger than ask a family member,” says Seán Columb, a lecturer at the University of Liverpool’s School of Law and Social Justice, who has interviewed participants in illegal transplants. “They weren’t convinced you could live a healthy life with just one kidney.”

These purchasers of black-market organs intend to spare their relatives and loved ones the risks associated

with donating kidneys, says Columb, who this year will publish a book on these illicit sales. These buyers may even see their purchase as a benefit for the organ donor, with their payments helping to lift people out of poverty, Columb says.

But the donors may not benefit from these sales. Columb last year wrote in *The Guardian* newspaper about an Eritrean immigrant in Egypt who donated a kidney in return for passage to Europe. But the immigrant said he was tricked out of his payment, Columb wrote.⁴

There have been several high-profile prosecutions of organ brokers in the past decade, including a U.S. case. Levy Izhak Rosenbaum, of Brooklyn, N.Y., was sentenced in 2012 to 30 months in prison for brokering illegal kidney transplants.⁵ According to federal prosecutors, Rosenbaum found people in Israel willing to sell their kidneys and then charged New Jersey residents between \$120,000 and \$150,000 for his services. He said the high price was due in part to payments that would be made to people in Israel for their assistance in locating donors.⁶

Rosenbaum admitted to helping kidney donors and recipients fabricate cover stories to fool hospital employees into believing that the transplant in question was the product of a genuine donation, the prosecutors said.⁷

In 2016, arrests of 14 people, including four physicians and a hospital executive, dubbed the “Great Indian Kidney Racket” by local news media, stemmed from the persistence of 23-year-old Sundar Singh Jatav. He was cheated by an organ broker after serving as a donor, Jatav told the *Los Angeles Times*.⁸

Instead of paying Jatav, a broker put him to work as an assistant, Jatav said. That is how Jatav discovered falsified paperwork to show relationships between donors and

Many women saw these payments as opportunities to escape poverty. Ranju Rajubhai told *The Guardian* newspaper that her roughly \$6,225 payment for a surrogate pregnancy would pay for surgery her husband needed for his burns and perhaps contribute toward the

purchase of a house. “One pregnancy won’t be enough, so I am thinking of coming back,” Rajubhai said.⁵⁰

But concerns emerged about the treatment of the Indian women carrying children for foreigners. “His surrogate mother dead, baby boy ‘all right,’”

recipients that did not exist. Jatav, for example, was listed as the sibling of the recipient of his kidney, a woman to whom he is not related.⁹

The transplantation community has made efforts over the years to increase use of living donors, but the demand for kidneys still greatly exceeds the supply. About 95,000 people were on the U.S. waiting list for kidneys as of April.¹⁰ The average U.S. wait time for a kidney from a deceased donor is five years.¹¹

To date, the leading effort to curb black-market kidney sales has come from the transplantation community itself. In 2008, a global group of physicians and researchers created the Declaration of Istanbul, an agreement intended to curb abusive practices in connection with organ donations.¹²

The group's work, carried out through the Declaration of Istanbul Custodian Group, helped pressure surgeons in China to lobby internally to end the use of prisoners as a source for donor organs, says Alexander Capron, former director of ethics for the World Health Organization. The group also has offered advice and encouragement to nations such as Qatar and Israel as they have worked on policies to increase kidney donation rates, says Capron, now a professor at the University of Southern California's Gould School of Law.

The key to the Custodian Group has been its ability to build peer pressure among physicians for more ethical practices, says Capron, who was among the leaders in the creation of the Declaration of Istanbul.

"It provided a clear statement to the transplant community from the transplant community" about what should be considered acceptable, he says of the declaration.

That helped advocates for changes in places such as Pakistan and the Philippines where large commercial organ transplant operations were running, Capron says. These physicians could count on participants in the Custodian Group for advice and support as they lobbied their governments for stronger efforts to prevent black-market sales. The Custodian Group also helped physicians seeking to persuade their fellow transplant specialists to stop participating in organ sales.

"Local champions had the benefit of support and advice as they turned to their colleagues who were on the fence and saying to them, 'You should be on the side of building up our voluntary related programs. We should build up our deceased donation, and we should not have foreigners coming here to buy kidneys,'" Capron says.

—Kerry Dooley Young

¹ Zaid Hindi *et al.*, "Liver Transplant Tourism," Liver Transplantation, Nov. 25, 2019, <https://tinyurl.com/w9ujllq>.

² Jagbir Gill *et al.*, "Transplant Tourism in the United States: A Single-Center Experience," *Clinical Journal of the American Society of Nephrology*, Nov. 3, 2008, pp. 1820-1828, <https://tinyurl.com/s57bwya>.

³ "Global Report on Trafficking in Persons 2018," United Nations Office on Drugs and Crime, 2018, p. 30, <https://tinyurl.com/yxhmbun>.

⁴ Seán Columb, "Organ trafficking in Egypt: 'They locked me in and took my kidney,'" *The Guardian*, Feb. 9, 2019, <https://tinyurl.com/y4mdwd58>.

⁵ "First Federal Defendant Convicted For Profiting From Illegal Kidney Transplants Sentenced To Prison," press release, Department of Justice, July 11, 2012, <https://tinyurl.com/vckj4nh>.

⁶ *Ibid.*

⁷ *Ibid.*

⁸ Shashank Bengali and Parth M.N., "Duped into selling his kidney, this 23-year-old exposed an illegal organ racket in India," *Los Angeles Times*, Sep. 15, 2016, <https://tinyurl.com/samx53q>; V Narayan & Malathy Iyer, "Kidney racket: Hiranandani CEO, medical director, 3 docs held," *Times of India*, Aug. 10, 2016, <https://tinyurl.com/uc2ygz9>.

⁹ Bengali and Parth, *ibid.*

¹⁰ "Organ Procurement and Transplantation Network: National Data," U.S. Department of Health and Human Services, <https://tinyurl.com/yckqcv2c>.

¹¹ "Transplant Waiting List," American Kidney Fund, <https://tinyurl.com/sz87j2c>.

¹² "The Declaration of Istanbul on Organ Trafficking and Transplant Tourism," *Clinical Journal of the American Society of Nephrology*, pp. 1227-1231, Aug. 13, 2008, <https://tinyurl.com/v58xug4>.

The Indian Express newspaper headlined a story about the 2012 death of Premila Vaghela. The child was born at eight months.⁵¹

"Premila was like many other economically marginalized surrogates, who may suffer or even lose their lives

while carrying a child, and are quickly forgotten," wrote Kishwar Desai, an author who had researched medical tourism for a novel. "The highly secretive and largely unregulated baby factories (many of which are dressed up as legitimate IVF clinics) now mushrooming all over

India are usually only concerned with the end product: the child.”⁵²

India barred surrogacy for foreigners in 2015. Thailand that year also barred foreigners from paying for surrogacy, while Nepal banned it even when unpaid.⁵³ The laws were intended to protect women from exploitation and harm, with operators of clinics

sometimes neglecting postpartum care and failing to explain medical risks to the surrogates. In the wake of these bans, though, the surrogacy business merely shifted to Greece, Laos, Kenya and other nations, according to experts.

Ethical questions also arise when people seek medical procedures that are approved in their home countries,

Medical Tourists Can Bring Home Drug-Resistant Infections

“Even the most obscure pathogens can leap over continents and oceans.”

A 61-year-old man living in the United States bet on beating the long wait for a domestic kidney transplant by buying an organ through a black-market clinic in Pakistan. Instead, he brought home a potentially deadly pathogen, New Delhi metallo-beta-lactamase 1 (NDM-1), which nearly cost him his life, University of Washington researchers reported in a 2019 paper.¹

The man, who was not identified in the paper, lost the new kidney and survived only due to multiple operations and anti-microbial treatments, the researchers wrote.²

Medical travel has fostered the spread of dangerous pathogens such as NDM-1, which is a fragment of DNA that helps many strains of bacteria withstand antibiotics, wrote Sonia Shah, a journalist who has conducted in-depth research on infectious diseases. “Thanks to the power, speed and relative comfort of air travel, even the most obscure pathogens can leap over continents and oceans,” Shah wrote.³

The coronavirus pandemic has served as a reminder of how easily travelers can bring infections back home with them. Coronavirus emerged in Wuhan, China, in late 2019.⁴ By early April, more than 1 million cases had been confirmed globally, with almost all of the world’s nations having reported instances of this infection, known as COVID-19.⁵ In March, the U.S. Centers for Disease Control and Prevention (CDC) warned Americans to avoid international travel due to the pandemic.⁶

The CDC has also in recent years issued warnings specific to medical tourism, made in connection with weight loss and cosmetic procedures. In January 2019, the agency issued a public alert for travelers about the risk of infection in connection with weight loss surgery in Mexico, although it later removed the alert.⁷ Two years earlier, it had issued a similar alert about risks for another infection, nontuberculous mycobacteria, seen in people who returned to the United States after having cosmetic surgery in the Dominican Republic.⁸

In some cases, patients may not volunteer information to their doctors about their medical tourism, complicating efforts to track pathogens acquired abroad, according to Mary E. Wilson, an adjunct professor at Harvard University’s T.H. Chan School of Public Health. At the same time, there has been aggressive promotion of “beach vacations” combined with cheaper elective procedures, such as face-lifts, Wilson says. The high cost of medical care in the United States remains a driving force in medical tourism, and the attendant risk for contracting serious infections, she says.

The high cost “leads people to look for other options and makes them vulnerable to hearing about places where they’re told everything is safe and easy,” Wilson says.

The American Society for Aesthetic Plastic Surgery has sought to gain a better understanding of how often people seek its members’ help to address complications of surgeries done abroad. More than half of its members who participated in a 2018 survey said they had seen two to five

but for which they do not qualify, says Crooks of Simon Fraser University.

People may travel to Mexico for bariatric surgery, for example, if they do not qualify for this weight loss procedure at home, Crooks says. In these procedures, physicians may shrink the size of the stomach, restricting how much people can eat and how many calories their bodies

can absorb.⁵⁴ Some people may want to lose only 20 or 30 pounds and thus not qualify for insurance coverage for bariatric surgery or easily find a surgeon willing to operate on them. In other cases, people may seek more repeat knee replacements than their physicians at home would allow or ask for orthopedic procedures for which they are considered too old or too young, she says.

patients in the previous 12 months with complications from cosmetic tourism.⁹

“Why do patients pursue cosmetic tourism if there are known increased risks?” wrote plastic surgeon Ali A. Qureshi and his co-authors in a paper discussing the survey. “Without question, cost is a key factor, with several studies describing the average cost of a breast augmentation in the United States at \$6,000 vs. \$2,200 in India,” they found.¹⁰

But treating complications can erase the savings. The society’s paper pegged the estimated costs for U.S. management of complications connected to medical tourism at between \$1,001 and \$5,000 for almost one-third of patients, with bills topping \$10,000 in about 15 percent of cases.¹¹

An Arkansas woman, Tamika Capone, told *The Washington Post* she incurred about \$30,000 in follow-up bills due to a rare infection acquired as a medical tourist.

With her weight nearing 300 pounds, Capone wanted to improve her health through bariatric surgery. But her family’s medical insurance would not cover the \$17,500 cost of the procedure, which shrinks the size of the stomach, restricting how much people can eat and how many calories their bodies can absorb. So in 2018 she followed the example of a friend who had it done for about \$4,000 in Tijuana, Mexico.¹²

The Post last year reported that Capone, then 40, acquired a bacteria, *Pseudomonas aeruginosa*, that resists almost all antibiotics. Arkansas health officials told Capone that hers was the first case in which they had seen this organism. News of Capone’s case helped a CDC investigator identify a cluster of these infections seen in people who had weight loss surgery in Tijuana.¹³

“We pounce when we see them [extremely antibiotic-resistant infections] because we know they can smolder and spread,” said Maroya Spalding Walters, an epidemiologist leading the CDC team investigating the outbreak. “And no

one may recognize it until this becomes an out-of-control wildfire.”¹⁴

— Kerry Dooley Young

¹ Jenell Stewart *et al.*, “Transplant tourism complicated by life-threatening New Delhi metallo- β -lactamase-1 infection,” *American Journal of Transplantation*, Oct. 3, 2018, <https://tinyurl.com/vjseqmz>.

² *Ibid.*

³ Sonia Shah, *Pandemic: Tracking Contagions, From Cholera to Ebola and Beyond* (2016), p. 54.

⁴ Derrick Bryson Taylor, “A Timeline of the Coronavirus Pandemic,” *The New York Times*, April 7, 2020, <https://tinyurl.com/wb48cut>.

⁵ “Coronavirus COVID-19 Global Cases by the Center for Systems Science and Engineering at Johns Hopkins University,” Johns Hopkins University Medicine, accessed April 3, 2020, <https://tinyurl.com/rnjqnh>.

⁶ “Global COVID-19 Pandemic Notice,” Centers for Disease Control and Prevention, March 27, 2020, <https://tinyurl.com/szky2vs>.

⁷ “Drug-Resistant Infections in Patients Who Had Weight-Loss Surgery in Mexico,” Centers for Disease Control and Prevention, last reviewed May 3, 2019, <https://tinyurl.com/weyf24q>.

⁸ Joanna Gaines *et al.*, “Notes from the Field: Nontuberculous Mycobacteria Infections in U.S. Medical Tourists Associated with Plastic Surgery—Dominican Republic, 2017,” Centers for Disease Control and Prevention, March 30, 2018, <https://tinyurl.com/stw578h>.

⁹ Ali A. Qureshi *et al.*, “Report on Current Experience of ASAPS Membership and Management of Cosmetic Tourism Complications,” *Aesthetic Surgery Journal Open Forum*, April 9, 2019, <https://tinyurl.com/r552ns4>.

¹⁰ *Ibid.*

¹¹ *Ibid.*

¹² Lena H. Sun, “They went to Mexico for surgery. They came back with a deadly superbug,” *The Washington Post*, Jan. 23, 2019, <https://tinyurl.com/lyd6eve2h>.

¹³ *Ibid.*

¹⁴ *Ibid.*



A surrogate mother gets her blood pressure checked at a clinic in New Delhi in 2013. Two years later, India banned surrogacy for foreigners, amid concerns about the treatment of Indian women carrying children for foreigners.

“They are looking for a place where they can circumvent the guidelines, where their money can pay for access to something they would not be a candidate for,” Crooks says. “This practice creates a lot of ethical concerns for physicians.”

Thailand Emerges

The Thai government in 2003 began a campaign to promote the country as the “medical hub of Asia.”⁵⁵ The previous year, the JCI awarded its first accreditation in Asia to Bumrungrad International Hospital.

The image of medical tourism was boosted with the airing in 2005 of a segment on *CBS* “60 Minutes” about Bumrungrad. The hospital received more than 3,000 emails from prospective patients within days of the show.

“Former naysayers, including many in the American medical community, could no longer dismiss international medical tourism in general nor Bumrungrad in particular,” wrote Jackson, Payne and Stolley.⁵⁶

In 2006, the Senate Special Committee on Aging held a hearing featuring Staab’s decision to have heart surgery in India.⁵⁷ Among the witnesses was Rajesh Rao, chief executive and co-founder of North Carolina-based IndusHealth, a firm that coordinates medical care abroad as a benefit employers can offer their workers. Rao described medical tourism as an option that could help curb rising U.S. health care costs, even if most Americans never would leave home for medical treatments.

“I don’t believe we will ever run into a situation where everyone just chooses to go,” Rao said. “It will be a healthy form of competition that gets introduced into the system and not one that basically goes out of control.”⁵⁸

IndusHealth has worked with the American firm perhaps best known for its participation in medical tourism, HSM Solutions of Hickory, N.C. HSM makes a variety of products, including components for bedding and seats for school buses. Since 2007, it has offered its workers the option to share in the savings and receive cash payments if they travel abroad for elective surgeries.

HSM shares 20 percent of the savings up to \$10,000, says Tim Isenhower, director of benefits for HSM Solutions.

“We did that to get people interested in the program,” Isenhower says. “They are taking time away from home, they have to hire babysitters and things such as that.”

HSM’s program has been the subject of several news stories over the years, including one in *Kiplinger’s Personal Finance* and an *ABC News* broadcast.⁵⁹ In February, a Denver television station broadcast a story about HSM employee Tony Martin traveling to Costa Rica’s CIMA Hospital for a knee replacement. The average cost of a total knee replacement is almost \$50,000 in the United States. The same procedure might cost just over \$20,000 in Costa Rica.⁶⁰

Isenhower says he gets calls from other companies about medical tourism. Fellow adopters include Ashley Furniture of Arcadia, Wis. Kaiser Health News last year reported on an Ashley Furniture employee’s trip to Cancún, Mexico, for knee surgery. *The New York Times* ran the article with the headline, “A Mexican Hospital, an American Surgeon, and a \$5,000 Check (Yes, a Check).”⁶¹

Still, to date, employers have not embraced this approach as quickly as Isenhower had expected.

“It’s been slow. A lot of people aren’t grasping it like I thought they would, but I am not concerned about selling it,” Isenhower says. “It works for us.”

CURRENT SITUATION

‘Sticker Shock’

Changes in U.S. health insurance likely will keep Americans shopping abroad for elective procedures, once

they are able to travel again, says Woodman, of Patients Beyond Borders.

The spotty coverage of health insurance plans is leaving many Americans directly responsible for more of their health costs. Some 28 percent of workers who get insurance from their employer face deductibles of at least \$2,000. One in eight—13 percent—have deductibles topping \$3,000.⁶²

There is also the prospect of so-called surprise billing, the unexpected and sometimes devastatingly high cost for the services of physicians who are not part of patients' insurance networks. In the past two years, about one in five insured adults had an unexpected medical bill, according to the Kaiser Family Foundation. And two-thirds of adults are worried about facing these kinds of high costs for themselves and their family, Kaiser found.⁶³

Woodman said about 80 million people are now underinsured due in part to inadvertent changes in health coverage resulting from the Affordable Care Act. Employers and insurance companies have looked to shift more medical costs onto consumers through increased premiums, higher co-pays and policies that exempt the insurers from paying for care.

"An acquaintance of mine with a decent enough health plan was surprised to hear that a single hip replacement was going to set her back \$12,000," Woodman said. "In brief, the false sense of security offered by employer 'skinny' plans often result in extreme sticker shock—and patients shopping cross-border for care."⁶⁴

Woodman wrote that \$6,000 was the dividing line for whether traveling abroad was worth it. A procedure costing less than that amount in the United States was best performed domestically; for those costing more than this amount, patients would probably save money going abroad, he wrote.⁶⁵

Woodman also cautioned against promotions that emphasize the fun activities people could potentially combine with medical travel, such as beach time and shopping sprees. He said people instead should think of medical travel more as a business trip than a leisure junket.

"Websites and health travel brochures peppered with zealous recreational promotion tend to ignore the realities of health travel," Woodman said. "Long flights, post-treatment recovery, and just plain being alone in a

faraway place can be overwhelming, even for the most optimistic health traveler."⁶⁶

HSM's Experience

Isenhower of HSM says his company started its medical tourism arrangement with an Indian hospital, but has shifted over the years to use centers closer to home, including facilities in Cancún and Costa Rica.

The trips to India proved to be too taxing, he says, describing calls from workers who awoke after 20-plus-hours of travel yearning for familiar sights like a Taco Bell. HSM employees in need of orthopedic care in Costa Rica stay at resorts, which are more suited to their needs, he says.

"We're manufacturing people. A lot of these people have never been out of the state of North Carolina, much less flying to India," Isenhower says. "I've not had anybody call homesick from" Costa Rica, he adds.

With pharmacy tourism, lawmakers are eyeing ways to get savings from certain state workers making only short trips from home.

Washington state Sen. Karen Keiser, a Democrat, this year introduced a pharmacy tourism bill based on the Utah model. It seeks to create a pharmacy tourism program that would let people covered by Washington's Public Employees' Benefits Board and the School Employees' Benefits Board use a pharmacy in nearby Canada to buy certain costly drugs, as well as insulin.⁶⁷

Cost is not the only factor driving Americans to consider health care abroad. People who have had treatments in other nations cite a straightforward approach to billing and the friendly attitude of medical professionals as an advantage over domestic care. In a posting for the *Medium* website titled "Oh My God, You're Going To MEXICO For Medical Care?" journalist Shelly Fagan gave a glowing review to both the cost of her care and the approach of her dentist and his staff.⁶⁸

Fagan said she decided to look across the border after her dentist retired and she struggled to find a replacement. One dental office said she would need to start her treatment there with a \$150 consultation fee.

That "experience aptly demonstrates one of the more subtle issues I have with American health care," Fagan wrote. "They treat you like you are a problem—not a customer—and taking your money is doing you some sort of favor."

Can people be treated as safely abroad as at home?

YES

Karen Timmons
CEO,
Global Healthcare Accreditation

Written for *CQ Researcher*, April 2020

Before the coronavirus pandemic, one group estimated that between 21 million and 26 million patients globally crossed borders to receive care, with a market size of between \$74 billion and \$92 billion.

While people have traveled for treatment for thousands of year, most commonly the rich traveling to more-developed countries, medical tourism has undergone fundamental change in recent decades, especially in the last one. Disparate motivations are fueling the growth in medical tourism: more affordability, better and quicker access to care, higher quality, specialty treatments (e.g., clinical trials, robotic surgery) unavailable in their home country and anonymity.

These trends will only grow in a world of increasing costs of care, rising numbers of noninsured or underinsured, growing middle classes in developing countries such as China and India, and long wait times in countries with single-payer systems such as Canada and the United Kingdom. Self-insured U.S. employers have begun to contract with providers overseas in narrow networks for treating employees for specific conditions, using quality and safety metrics that providers must meet. Employers share the savings with employees, providing cash payouts as incentives, with employees exempt from deductibles and travel costs for the patient and a companion.

A key factor in enabling trust and confidence is accreditation. With the introduction of internationally recognized standards of quality and patient safety in 1998, the Joint Commission International facilitated global standardization of hospital care by applying consensus standards based on quality improvements and evidence-based practices. Since then, numerous other international and national accreditation schemes have also applied standards to hospitals and clinics. The Global Healthcare Accreditation (GHA) Program for Medical Travel Services was established in recognition that medical travel encompasses much more complexity along the entire continuum, and has established standards and norms for organizations treating medical travel patients.

It is likely in the next decade that patients, insurers and employers will be the main drivers for more transparency from hospitals, health care organizations and physicians. There is a need for more data on clinical and patient experience outcomes, and to have more comparable information to make sound

NO

Dr. Gregory A. Greco, DO, FACS
Chief, Division of Plastic Surgery,
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Written for *CQ Researcher*, April 2020

The American Society of Plastic Surgeons (ASPS) represents greater than 8,000 board-certified plastic surgeons in the United States. Our society advocates for excellence in plastic surgery training and certification and holds its members to the highest standards.

Cosmetic surgery tourism can seem attractive to U.S. citizens. Cosmetic surgery at a reduced price in a foreign, sometimes exotic country may seem enticing. However, the consumer must ask the ultimate question: "Where am I comfortable having my complications?" Plastic surgery is still surgery and poses inherent risks.

Surgical complications can occur with any surgery. These include blood loss, blood clots (deep vein thrombosis, or DVT) in the legs that can travel to the heart (pulmonary embolism), infections and wound complications. Complications can range from minor to life-threatening and may occur hours to weeks after surgery. Experiencing a complication in a foreign country can potentially jeopardize your life. Often, patients may not allow ample time at their surgical destination for appropriate preoperative assessment and postoperative care.

Patients should consider the following factors when contemplating foreign travel for surgery:

- Is your surgeon qualified? What resources are available to check and verify your surgeon's credentials? Are they certified to perform the intended surgery? In the United States, a physician's credentials can be verified with multiple regulatory agencies.
- Are you having your procedure in a licensed facility? ASPS requires all members to operate in nationally accredited operating rooms. They are held to the highest standards for delivering safe surgical services, focusing on infection control, patient safety and medical emergency preparedness of the facility and the staff.
- Communication barriers: Depending on the destination country, a patient may not be able to effectively communicate with their surgeon and care team. Effective communication is essential for successful outcomes.
- Limited legal recourse: Patients may have signed waivers to file a lawsuit, either with the physician or the medical tourism company. It remains difficult to establish jurisdiction in U.S. courts for foreign defendants.
- Air travel and surgery: Flying and surgery may increase your risk of developing blood clots in the legs, a sometimes fatal complication.
- The hidden costs: The initial reduced fee for surgery may seem enticing; however, if there are complications resulting from your

choices regarding cross-border medical travel: infection rates, complications, mortality and morbidity rates as well as by procedure and cost, much like Trip Advisor does for the hospitality industry. With this information, a patient can receive safe and highly satisfactory care abroad.

procedure, you may be faced with several realities. Extended stays in the destination country, airline reservation change fees, complications back in the United States that are treated by a new physician and possibly your personal health insurance denying any resulting hospitalizations. *Caveat emptor!*

Fagan said some dentists in the United States often will try to upsell patients with dire warnings about the state of their teeth. But in Mexico, there were “no hysterical warnings of imminent structural failure.” She had a filling done for \$45, less than a third of the \$150 cost in the United States.

As more people test cross-border health care, there could be increased medical travel due in part to the greater emphasis on patient satisfaction, Isenhower of HSM says.

He relates his own experience when he ruptured his knee’s posterior cruciate ligament (PCL) while skiing in Colorado. Isenhower says he first sought care from his physician at home in North Carolina, who told Isenhower he likely would need a knee replacement and might not ski again. The doctor ordered an MRI and said he would call Isenhower back. While waiting weeks to hear back from the physician, Isenhower contacted a physician in Costa Rica. The medical staff there often deals with PCL injuries in soccer players. They replaced two tendons, and Isenhower says he was skiing again within about six months.

“It’s just a totally different experience” getting care in Costa Rica, Isenhower says. “If people in the U.S. saw that, they would realize how behind things are in the U.S. The service is not what it should be for the cost we pay.”

Coronavirus Impact

Travel bans and restrictions due to the threat of coronavirus infection have put a quick dent in businesses dependent on medical tourism.

The U.S. State Department in March warned Americans to avoid all international travel due to the global impact of the outbreak.⁶⁹

IndusHealth, which has worked with HSM and Ashley, announced on its website in March that it had temporarily suspended all planned international medical travel.⁷⁰

In the Mexican border town of Juárez, across from El Paso, Texas, the travel ban dried up sales for businesses

that cater to visiting Americans.⁷¹ Lucio Cano, a pharmacist in Juárez, has sold medicines to Americans for 23 years, knowing repeat customers by name.

“Sales are down . . . I estimate by 60 percent,” said the pharmacy owner. “I’ve only seen this happen once before, during the drug violence of 2009-10. Back then, nobody came. Now, business is just as bad.”⁷²

OUTLOOK

Disruption Ahead?

For the next six to 18 months, medical tourism will be at a standstill, says Labonté of the University of Ottawa. Even an easing of travel restrictions might not be enough to immediately revive the industry, he says.

Until the coronavirus outbreak is brought under control, the private hospitals set up for medical tourism would risk censure if they were to resume care of foreign patients.

“Border closures, self-isolation requirements, bed and medical supply shortages, will lead to triaging of remaining health care capacities,” Labonté says.

This will be the case even in the low- and middle-income countries that have promoted medical tourism for economic purposes, he says. Many of these countries will soon face a rise in coronavirus cases. Their public health systems could face substantial consequences if they were to allow foreign patients to occupy hospital beds for elective procedures. And fewer people from rich nations may be willing to go abroad in search of care, due to concerns about emerging infections, Labonté says.

“Given the extent to which tourism of any form is presently in a downwards tailspin, one can only imagine medical tourism to fare even worse,” Labonté says. “Even over the longer term, the fear of novel pathogens like [coronavirus] may particularly impact transborder health care, in both supply and demand.”

The coronavirus presents an unprecedented challenge to medical tourism, but this industry has overcome other

disruptions so far in this century, says Woodman of Patients Beyond Borders. These include terrorist attacks and bombings in India, a 2014 coup in Thailand and the SARS virus outbreak of 2002-03, as well as major disruptions in airline traffic following the 9/11 attacks in the United States and a 2010 volcanic eruption in Iceland.

“It always bounces back, and it’s always for the same reason,” Woodman says.

Once international travel resumes, many people likely will seek abroad the medical treatments they cannot afford at home, he says. Americans likely will shoulder more of their health costs in the years ahead, according to the Centers for Medicare & Medicaid Services (CMS), the federal agency that administers those programs. It said consumers’ out-of-pocket spending on health care likely rose 4.8 percent in 2019. For the 2020-27 period, it predicts an average annual growth rate of 5.0 percent.⁷³

The average annual growth in total U.S. medical spending is projected to be 5.7 percent from 2020 to 2027, CMS said.⁷⁴ The calculations do not factor in a potential increase due to spending this year on the response to the coronavirus.

“To ask if there is a future for medical tourism is to ask if there is going to be a structural change in the U.S. health care system, and I would say probably not,” Woodman says. “Nothing kills medical tourism as long as prices remain as high as they are in the United States.”

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