Chapter – 2

METHODOLOGY & SURVEY OF LITERATURE

The main aim of this chapter is to define objectives of the study, outline methodology for carrying out research study, and to review existing literature on Healthcare Sector. In India the term “Healthcare” is usually associated with hospitals, but comprise of multiple aspects like pharmaceuticals, Hospitals, diagnostic Centres, ancillary centers, Health insurance, Telemedicine Healthcare software, medical tourism and medical equipment India’s Healthcare Sector presents a not-so-healthy paradox as it is supposed to be. A CII-McKinsey study shows that the Indian Healthcare Sector is performing poorly on all the dimensions of coverage, purchasing, delivery and marketing standards. In spite of vast potentiality in terms of recources, expertise, Cost advantage India is missing the trees for the over powering greenery liberalization, privatization and globalization have bought unprecedented and dynamic changes in economic, trade and international scenarios across the world especially in India, which led to growth of service sector. The service sector touches a wide gamut of activities, namely health, IT education, welfare, communications, travel, banking, Insurance and other financial services. According to CII-McKinsey report 2003 and Economic Times Healthcare report India’s Healthcare sector is growing at 13 percent per year over the last decade and contributing 5.2 percent of GDP of India.

World Health Report 2009 and organization of pharmaceutical producers of India (OPPI) 2000 estimated that India has 503900 doctors, 737000 nurses, 162 medical colleges, 143 pharmacy colleges and 350000 chemists. There are around 15,000 plus hospitals accounting for 900000 beds. The private sector accounts 70 percent of primary medical care and 40 percent of all hospitals care India. 80 percent of medical personal are employed in private (Healthcare) sector. Even though per 1000 persons 1.5 beds available in India compared to China and Brazil, the bed ratio is 4.3 beds per 1000 persons, But Indian Healthcare delivery system stand at par with Global standards. Indian doctors have good reputation across the world. If Indian Healthcare industry could gets its performance right, the market size could be as large as Rs. 1500 crores. According to the McKinsey study the medical tourism could
generate annual revenues to the tune of Rs. 10,000 crores by 2012; the reason is quite clear i.e. India’s rich, talented and highly skilled professionals able to offer quality Healthcare at fraction of cost offered at USA & UK. The relevance of marketing strategies to make India globally competitive is need of the hour to enhance standardization, accreditation, reach and integration of all sectors. Indian Healthcare sector has not attempted fully to make it competitive. Many misconceptions of marketing suffer due to acutely malignant form of product orientation. Many Healthcare organizations consider themselves as product driven organization regards the patient as passive recipient of their treatment and affords little scope for a genuine interaction take place between provider and patient. Number of structural reasons makes Indian Healthcare system as poor performer.

Indian health delivery system (Berman and Khan 1993, world bank1999 I ministry of Health and family welfare 1995, Planning commission 1996) studies documented many serious problems with respect to accessibility, efficiency, quality and marketability not only to Indian community but international sectors. At the same time due to advantage of cost, experts and no waiting ques, India is more preferred by many foreigners’ especially very industrialized nations of world. A combination of many factors have lead to recent increase in popularity of Indian Healthcare in areas like medical, dental and surgical care. The ancient systems of medicine Ayurveda, Unani, Yoga caught the attention of people at large all over the world. The medical tourism has become a channel to make Indian Healthcare globally competitive. Medical tourists are generally residents of industrialized nations of the world. The countries they travel are typically the less developed ones with favour able currency exchange ratios. Many travel companies partner with specific hospitals there by arranging at a cheaper price for their patients than are could arrange on their own through the hospital directly. Medical tourism is a rapidly growing industry with countries like Cuba, Costarica, Hungary, India, Israel, Jordan, Lithuania, Malaysia, South Africa, Thailand and the Philippines.

The cost savings are significant for example, if the average surgeon’s fee for eyelid surgery in the US is $ 2500, and in Philippines a qualified surgeon will charge only $ 600 to 1500. And in India it costs $ 400 to $ 1000. India wants more medical
tourism, but it does not have the necessary tools to impress patients looking abroad for their Healthcare solutions. However by earning accreditations, standardizing medical practices and getting government, hospitals and tourism agencies, India can increase its medical tourism industry and enhance Healthcare sector globally competitive.

The **globalisation** of Healthcare takes place through 4 modes according to GATS (General Agreement on Trade In services) and UNCTAD 2002 / 1998 they are

1. Cross border delivery
2. Consumption abroad
3. Commercial Presence
4. Movement of health personal

Globalization and marketing of Healthcare sector is driven by many factors. These include decline in public sector expenditure and rise in private sector participation in Healthcare in many countries, liberalization of economies, increased mobility of consumers and health service providers due to decline in cost of travel, Technological advancement enabling cross border delivery, differences in cost of health across different countries emergence of investment opportunities, aging of populations etc.

This study focuses on identifying strengths of Indian Healthcare sector, and to develop strategies for marketing of healthcare.

**2.1 NEED FOR THE STUDY:**

Globalization caused many countries to re-evaluate their economical strengths and weaknesses as well as re-assess what products or services in which nations can benefit. One such product & service emerged over the past decade is Healthcare sector. Quality of Healthcare is vital for growth of any nation. India has several value propositions to offer effective out comes that compare with the best overseas, Internationally qualified experts, a technology edge that many other South Asian countries are yet to master, very competitive in costs, quality of services that is being constantly upgraded, and the unique offer of a combination of eastern wisdom/ alternate therapies that are increasingly finding popularity world over. A heart surgery that costs $ 30,000 in America can be done for $ 6,000 in India. A bone marrow transplant which costs a mind boggling $ 2,50,000 can be had for $26,000 and
orthopedic surgery can be had as a cost of $ 6,000 against US cost of $ 20,000 with the introduction of *air ambulances* and increase in sophistication of Healthcare delivery system India can make its presence felt by other nations in International health scenario but the proceedings and pace of development, support from Government are not adequate to explore the potential lies in the form of well-trained medical care professionals and multilingual knowledge of the doctors. A CII-McKinsey report estimates a potential of $ 2 billion for Indian in health tourism by 2012. In the light of above the researcher felt the need to study and develop strategies for making India globally competitive in international health sector through medical tourism.

In the era of “new medicine”, resulting from interaction of biotechnology, bioinformatics and health informatics Healthcare in India offers greatest promise to world for achieving more accessible high quality Healthcare for both individuals and groups. But recent statistics of human development index of different countries revealed that India is placed in 135th position in terms of Healthcare delivery standards, which is very sad situation. Inspite of its strengths Indian Healthcare sector suffers from few deficiencies. They are in-adequate infrastructure to meet the rising demand, lack of insurance coverage for Healthcare sector, no measures to supply adequate quality manpower, lack of co-ordination between public and private sector, less active contribution by private insurance sector, No leverage for industry association etc. Hence there is a need to study, analyze potentiality of Indian healthcare sector in height of growing global opportunities and thrust to develop strategies over come various barriers in the path of making Indian globally competitive.

**2.2 OBJECTIVES OF THE STUDY:**

The study aims at developing strategies to make Indian Healthcare sector globally competitive. Globalization has promoted a consumerist culture, there by promoting products that can feed the aspirations. India’s National Health Policy 2002 says “to capitalize on the comparative cost advantage enjoyed by domestic health facilities in the secondary and territory sector, the policy will encourage the supply of services to patients of foreign origin on payment.
Objectives:

1. To study Healthcare sector in India
2. To conduct a study and examine the cost advantage, need for increasing the number of Healthcare personnel, Infrastructure of Indian Healthcare Sector to maximize its share in world healthcare with global perspectives.
3. To develop strategies for Globalisation of Indian Healthcare services.
4. To suggest some measures to policy makers for strengthening of Healthcare sector in India

2.3 SCOPE OF THE STUDY:

The scope of this subject can be attributed to the International Healthcare potential, wherein the implications of globalisation of healthcare were explored. The aim of this research is to understand the impact of globalisation in terms of the Indian Healthcare sector. The scope of study extends to discuss present scenario Healthcare sector in India and different system of Indian medicine. The assumption is that in-spite of vast potential in terms of expertise cost advantage Indian Healthcare Sector has not made attempt to maximize its share in world health picture due to lack of co-ordination among various departments & levels of Healthcare much growth has not been witnessed as it is supposed to be. Since medical tourism is a relatively new concept initiated about 7-10 years ago, adequate data may not be available. Most of data has been country specific.

The study is conducted based on secondary data available at various sources. Only select countries Healthcare system has taken in to consideration. Various published reports, articles have been referred. The study excludes primary data buff considered various opinions with doctors towards making India globally competitive.

2.4 DATA COLLECTION:

This study is an exploratory in its nature. Emphasis is given on the discovery of insights to formulate specific solutions for identified problem. This study established priorities in studying competing explanations of the phenomenon, by organizing specific investigations and has not involved any sampling plans. Majority
of findings are / were based on literature surreys, analysis of select cases reports and their published and unpublished information.

**SOURCES OF DATA COLLECTION:**

The data has been collected from both sources i.e. primary & secondary.

**Primary Data**

Primary data is the original data which is collected at source such as survey data which is obtained in an uncontrolled situation by asking questions (interviews) or making observations and experimental data which is obtained in a controlled situation by conducting experiments (Hussey and Hussey, 1997). In this study, primary data was obtained by qualitative methods via conducting in-depth interviews of the Doctors and senior healthcare managers. They were contacted to hold a face to face interview.

The interviews were semi-structured owing to the investigative nature of the research. It resulted in excessive data but it encouraged the interviewees to answer beyond the scope of the question thus, offering a greater reliability and credibility to the data procured. The themes covered comprise of the advent of medical tourism in these hospitals; major stakeholders; the key growth drivers; opportunities and challenges; business strategies adopted to attract international patients; countries targeted; reasons for reverse brain drain of skilled professionals and flow of medical tourists to a developing country like India.

**Sample:**

Being an exploratory study, a sample of 90 respondents has been taken for conduct of opinion survey through interviews. The sample comprise of doctors & senior managers of Multi-specialty hospitals.

**Sampling Technique:**

Convenience sampling technique has been adopted which in turn adopted quota sampling. But researcher has taken extra care to ensure that the respondent is capable enough to answer the questions. Since the respondents happened to be Practicing doctors & senior managers they are capable of responding with adequate responses.
Data Analysis:
Primary gathered have been compiled in to 35 interpretations. The data has been tabulated in to simple percentages and average of each category has been taken to sum up. The outcome has been tested with Chi square test to test validity of hypothesis. Chi-square test of independence has been used for testing the significance of difference in opinion between Doctors and Senior Managers. Interpretations have been drawn based on the responses of doctors & senior managers.

SECONDARY DATA

It is the data which already exists as books, documents (for example, published statistics and annual reports), journals, business periodicals, documentary films and news releases to supplement the primary data (Hussey and Hussey, 1997). The internet, another significant source of information has been used for conducting exhaustive research for medical tourism since it is a relatively new concept initiated about 7-10 years ago.

The following keywords have been used for the search strategy: ‘medical tourism, globalisation of healthcare, India and medical tourism, US and UK medical tourists in India, Economic crisis and medical tourism, baby-boomers, why medical tourism?, stakeholders medical tourism industry‘, medical tourism types‘ with‘ in addition to the search criteria in several databases such as Proquest , Thomson Reuters, EMBASE, Pub Med, NBER, Scopus, Ingenta Connect, Elsevier, Medline and the World Wide Web to identify the studies of medical tourism and globalisation. The parameters chosen for the literature review have been time and geography, implying analysis of reports of medical tourism in India from its advent in 2001 to current 2010 (Hussey and Hussey, 1997).

A literature review was conducted to identify multiple sources of secondary data relevant to the topic of globalisation of healthcare and the medical tourism industry. A snowballing or ego-centric approach to literature research has been adopted where one list of relevant references leads to the next (Hussey and Hussey, 1997). The published data was analysed to find out what was already known about this topic, identify gaps in the literature, define areas of weakness, identify trends in
research activity and develop ideas to provide recommendations and draw conclusions (Hussey and Hussey, 1997).

For collection of primary data efforts were made to elicit opinion of medical professionals, and experts in the industry by participating in seminars, symposiums and workshops. The researcher tried to note down the various opinions of participants of above programmes either by listening to their presentations or personal interaction with them. Apart from notes and other written information in depth interview were organized by seeking their appointment as and when they are free and during National Seminar being organised at University of Hyderabad during 18 & 19 October 2011.

The researcher has visited various libraries, sources of information. They include local medical college libraries, Indian institute of management Ahmadabad, Administrative college of India, Apollo hospitals etc. The secondary data play vital role for this study. The reports published by Economic Survey, CII – McKinsey Human development index, World Health Organisation (WHO) for economic cooperation and development, were extensively collected to conclude and summarize information various sites over internet were surfed to download information especially http://indianmedicin.nic.in; enquiries@nao.gsi.gov.uk; www.who.org are of immense use.

2.5 LIMITATIONS:
1. The scope of study is limited. The research was context-specific and limited to Indian Perspective due to difficulty in gaining access to the health organizations abroad.
2. Financial Implications of FDI and Legal aspects of brain drain with reference to Globalisation of Healthcare were not analysed.

2.6 REVIEW OF LITERATURE

For the purpose of this proposed study, through studies of all possible academic and non-academic references were referred. They include various reports published by professional bodies, dissertations; articles published in journals and in newspapers, various conclusions and abstracts kept in websites, information supplied
by different Government organisations etc. In order to gather updated information the researcher has made all attempts to participate various seminars, symposia organized across the country. Various hospitals were been visited to gather relevant data for strengthening study.

In search of data various doctoral theses submitted on various sites over internet have checked. The attempts were made to visit various relevant institutions for the purpose relevant text books and reference books various agencies’ catalogues were referred and identified a handful of books those are suitable for shaping study and were obtained accordingly. A list of these books were given under bibliography for studying the articles published in academic and non-academic journals various sources are identified to take reprographic copy for further reference and study. Documentation centres of various libraries such as administrative staff college of India, Hyderabad. Indian Institute of Ahmedabad; Indian school of Buisiness, Hyderabad, Appolo Institute of health sciences Hyderabad, Guntur medical college, Guntur, library of Acharya Nagarjuna University, Guntur, V S Krishna library of Andhra University Visakhapatnam library of world health organisation New Delhi, Library of APVVP, Hyderabad, Madras University, Chennai were visited and notes were taken refined accordingly.

In the process of surveying literature it has been observed no doctoral theses have been submitted on topic strategies for making India published with limited scope and concluded the lapses in Healthcare sector. Articles published in academic journals of national and international repute also emphasize need for revival of Healthcare sector and to get benefit of potential viable in the world various news items emphasized the importance of Indian medicine and how can score over other streams of medicine. Most of articles are informative at the same time they throw open some issues of debate.

Population ageing occurs when the median age of a country or region rises. This happens because of rising life expectancy or declining birth rates. Excepting 18
countries termed 'demographic outliers' by the UN\cite{20}\cite{21} this process is taking place in every country and region across the globe. In the entirety of recorded human history, the world has never seen as aged a population as currently exists globally.\cite{22} The UN predicts the rate of population ageing in the 21st century will exceed that in the 20th. Countries vary significantly in terms of the degree, and the pace, of these changes, and the UN expects populations that began ageing later to have less time to adapt to the many implications of these changes.\cite{3} With health care costs occupying prime space in the policy arena in the United States\cite{23} and other western economies, a relatively new conduit for the transfer of services from the developed to the developing economies has emerged the growing trend of “medical tourism\cite{24}” where patients travel to low-cost developing countries for health procedures.

Overburdened healthcare infrastructure and high costs in the West are the key drivers for the boom in medical tourism. The healthcare infrastructure in Europe and the United States is under severe pressure\cite{25}. In Britain, the National Health Service (NHS) has a long wait list of patients for surgery. In US the healthcare crisis has different dimensions it has 50 million uninsured citizens while the insured have to pay dearly for healthcare facilities. To add to this the stringent visa regulations imposed by US and European countries after 9/11 episode has led to a growing number of foreign patients from Middle East to visit Asian countries for treatment. All these factors have opened up avenues for hospitals in various Asian countries to promote medical tourism. The Indian Healthcare sector is enjoying support of higher standards of medicine practitioners. The non-invasive treatments, amenities available for faster recuperation and the ambience in leading hospitals are such that resumption of normal

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\bibitem{23} Fried, Bruce J.\cite{1} managing healthcare services in the global market place. “\textit{Frontiers of Health Services Management}”; Winter 2007, Vol. 24 Issue 2, p3-18,
\bibitem{24} http://en.wikipedia.org/wiki/Category:Types_of_tourism
\bibitem{25} Andreas von der Heide et.al, Asia Pro Eco -Europe Aid cooperation office, “India Health Tourism Network report- Sector over view and analysis” SINET 2007
\end{thebibliography}
life style even after critical illness is faster now\textsuperscript{26}. Technology is revolutionizing the every approach of Healthcare professionals, through application of technologies that enable faster and richer (voice, data and images) communication (telemedicine, Video conferences) have expanded the reach of quality Healthcare facilities to remote audiences. In the words of Prof. Dan. E. Detmes, emerging Healthcare would be less hospital-based and more primary and traditional home care based. All those systems should acquire it based application in order to increase the role of medical care spectrum across the world. There are certain barriers like emergence of global standards and financial support to the needy especially in select countries where cost of medical care is non-affordable.

Over the last two decades there has been a marked shifted in India towards dominating role for private sector in addition to public sector. About 4/5\textsuperscript{th} of country’s expenditure on health (estimated to be 6\% of GDP) earn from private health sector because of cost effective and efficient Healthcare services. A CII McKinsey report estimates a potential of $ 2 billion for India in Healthcare tourism by 2012\textsuperscript{27}. All most international standard of Medicare is now available in private hospitals along with some renowned Govt. Hospitals and are attracting medical tourists who come to India for Cheaper treatments. Advanced techniques such as beating heart surgery (with out heart long machine) and minimally invasive robotic surgery (next only to Japan in Asia) are available in hospitals such as Escorts Heart institute and Research Centre. The initiative of Indian Healthcare federation in approaching credit rating agencies ICRA and CRISIL to grade hospitals is also a step in right direction, which would help to promote interims of comprehensive health insurance coverage which 8 could go hand is hand and was/ is a compulsory

Health services have become increasingly globalized. Healthcare is one of India’s largest sectors, in terms of revenue and employment, and the sector is expanding rapidly. During the 1990s, Indian healthcare grew at a compound annual

\textsuperscript{26} Manisha Dhingra “Medicine without Borders”, The Times of India, Education Times 11th December’ 2006 article

\textsuperscript{27} CII McKinsey report, India Health Report 2007
Globalisation of Indian Healthcare Services

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rate of 16%. Today the total value of the sector is more than $34 billion\(^{28}\). This translates to $34 per capita, or roughly 6% of GDP. By 2012, India’s healthcare sector is projected to grow to nearly $40 billion. The private sector accounts for more than 80% of total healthcare spending in India. Unless there is a decline in the combined federal and state government deficit, which currently stands at roughly 9%, the opportunity for significantly higher public health spending will be limited. According to a joint study by the Confederation of Indian Industry and McKinsey, Indian medical tourism was estimated at $350 million in 2006 and has the potential to grow into a $2 billion industry by 2012\(^{29}\).

Governments are faced with a complex set of factors that continue to make it increasingly difficult to provide health services to their populations\(^{30}\). In the developed world in particular high cost medical interventions combined with an ageing population have made the marginal health returns to many interventions extremely expensive\(^{31}\). The rate of globalization of trade, travel and migration, technology and communications has dramatically accelerated over the last two decades, resulting in gains for some and marginalization for others. Ecological problems have emerged with increased threats to health. The World Health Organization (WHO) reports\(^{32}\) that although improvements in health status, health coverage and access to Healthcare are apparent throughout the world, these improvements have not benefited all. In fact the number of the poor in developing countries has increased, thereby increasing the potential for health status disparities between the developing and the developed world. Projections indicate that there is a great danger that the gains realized cannot be

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\(^{29}\) Finance Wire, July 2006

\(^{30}\) World Health Statistics, WHO report 2010

\(^{31}\) 1 In 1995, the OECD countries devoted, on the average, 10.4 per cent of their GDP to Healthcare (public and private). In the same year, they spent on the average US$ 2,071 per person on Healthcare. In 1970 Medicare, the United States public health-insurance scheme for elderly and disabled, cost the government US$ 6 billion; in 1997 it costs US$ 200 billion. In future it will cost even more: by 2030, Medicare is expected to absorb 7.5 per cent of GDP, up from the current 2.6 per cent. In France total spending on public health has been surging at a real annual rate of more than 5 per cent over the previous 15 years. "A headache", The Economist, 8 March, 1997; "An unhealthy silence", The Economist, 15 March 1997, and "Will Medicare sink the budget?", The Economist, 1 February 1997.

\(^{32}\) World Health Statistics, WHO report 2010
maintained in the future\textsuperscript{33}. It is increasingly being recognized that there is a significant impact of economic policies on health status. New policies tend to reduce government spending on social sector programmes. Healthcare infrastructure market in India is expected to grow and reach Rs 1,420 crore by 2013 according to KPMG\textsuperscript{34}. This is an increase of 50\% from 2006. The main factors responsible for this growth are the steadily increasing middle class due to rising income levels and a change in profile of illnesses. There is a shift from chronic to lifestyle diseases. A study by Ernst & Young and FICCI revealed that 1.75 million additional beds will be needed by end 2025. The public sector will be able to contribute only 15-20\% and the rest is open to the private sector. If not counterbalanced, these policies can lead to detrimental effects on health status. Considerable concern has been expressed in recent years about the impact of economic development, and in particular the structural adjustment process, on both the environment and on social progress in general, especially education and health\textsuperscript{35}. The increased acceptance of the multiplicity of factors that contribute to health status has resulted in attempts to develop inter-sectoral approaches. The health sector is seeking to interact with other sectors such as agriculture, education, economic, trade, and the environment.

As finances become more limited globally, the need to seek cost-efficient and cost-effective strategies for health systems strengthening and Healthcare interventions is becoming more urgent\textsuperscript{36}. Competition between sectors can be expected to become more intense. Understanding the relevant benefits of an inter-sectoral approach and engaging the other sectors in developing coordinated programmes are necessary steps in the development of effective actions. The environment within which health systems and health policy are being developed has changed dramatically. In previous decades

\begin{itemize}
\item \textsuperscript{33} http://www.blonnet.com/2007/04/02/stories/2007040205221500.html stated that the number of medical tourists visiting Kerala was close to 15,000 in 2006 and is expected to reach 100,000 by 2015
\item \textsuperscript{34} “India Health Report”2010
\end{itemize}
governments looked forward to long periods of independence, national reconstruction, economic growth and a wider sharing of prosperity. "Redistribution with growth" was the theme for development. Economic orthodoxy and development thinking has changed. The redefinition and reduction of the role of the state are now being seen on all continents.

Market mechanisms\textsuperscript{37}, rather than public intervention, are increasingly being used to drive national economies. The health sector is also experiencing these changes. There is growth in private sector participation in the financing, production and delivery of health and Healthcare services. In some countries public institutions are being sold off to the private sector and new private institutions are replacing or augmenting them. Insurance schemes and community financing are being encouraged, as well as private providers. However, a new challenge will be for governments to continue to steer and regulate the health sector, including private providers, for the benefit of public health.

The issues discussed above affect different countries in different ways. The capacity to address them depends in part on the socioeconomic and political environment of the country\textsuperscript{38}. The key issues facing a number of poor developing countries include shortages of resources: financial, material and human\textsuperscript{39}. This is aggravated by adverse economic conditions and the loss of trained personnel to other countries. There is also a shortage of technology in many countries, and in others a concentration of high technology that serves only a small part of the population. Countries are searching for opportunities that will provide foreign capital and strengthen their ability to meet the needs of their populations. Among the opportunities being examined is a greater attention to opportunities for trade within the health sector. Countries are seeking areas in which they have a comparative advantage and using this as a basis for the development of services for export.

\textsuperscript{38} The Global Health Observatory is a WHO portal that provides access to data and analyses for monitoring the global health situation and trends. www.who.int/gho  
\textsuperscript{39} Healthcare in India- Emerging Market Report 2007, Price Water Coopers
The competitive position of a health service will depend on many factors:

The cost structure, the availability and skill level of human resources, service differentiation, and availability of technology and health facilities. These comparative advantages are reinforced by other factors such as geographical proximity, cultural and linguistic affinities, natural endowments, and the ability to market the advantages effectively.

The benefits that may accrue from the development of trade opportunities must be weighed against the potential negative effects. For example, the development of a private facility with state-of-the-art technology to provide services for the wealthy or foreign persons will increase the technology available in the health system. From a competitive point of view, the availability of technology is an important element to make a specific country/health establishment appealing. From a public health point of view, a right balance should be found between the need to invest in technology to guarantee a modern and effective level of Healthcare, and the avoidance of overspending. It is clear that as countries explore opportunities in trade in health services there must not only be the corresponding regulations that enable this to take place, but more importantly legislation and regulations that support values of the national health policy such as equity and sustainability.

The General Agreement on Trade in Services (GATS) is the first multilateral agreement to provide a framework for regulating trade in services according to principles similar to those for trade in goods. It defines trade in services by the way in which they are supplied: by personnel providing services abroad, by consumption in other countries, through foreign direct investments, and across borders. In terms of GATS, health services include the general and specialized services of medical doctors; deliveries and related services, nursing services, physiotherapeutic and paramedical services; all hospital services; ambulance services, residential health facilities services, and services provided by medical and dental laboratories. In the multilateral

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41 Asia’s growth industry: Medical tourism, April 09, 2009
negotiations, professional services of doctors and nurses were differentiated from those of hospital services and negotiated separately. Global perspective of Healthcare Services:

Globalisation by some analysts is considered as a process of closer interaction of human activities across a range of spheres including economic, political, social and cultural occurring globally along three dimensions: spatial, temporal and cognitive (Lee, 2000). However, Labonte et al. (2002) contends that this description fails to address the drivers of contemporary globalization, namely the changes in global capitalist organization and associated macroeconomic policies that are a source of rising global inequalities. Robertson (1992:8) contends that there is a broader view and description of globalization; globalization as a concept refers both to the compression of the world and intensification of consciousness of the world as a whole; both concrete global interdependence and consciousness of the global whole in the twentieth century. This is a useful conceptualization of globalization for the purposes of understanding Healthcare in an era of diminishing national, technological, mental and physical boundaries in the delivery of Healthcare services. Stiglitz (2002:9) describes globalisation as closer integration of the countries and people of the world which has been brought about by the enormous reduction of costs of transportation and communication, and the breaking down of artificial barriers to the flows of goods, services, capital, knowledge and people across borders. Widely accepted theoretical frameworks of Giddens (1990), Appadurai (1990) and Woodward et al. (2001) have been used to understand the expanse of globalisation and analyse the link between globalisation and healthcare.

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42 The services sectoral classification adopted in GATS broadly corresponds to the United Nations Central Product Classification, for which a new version has recently been adopted.
On one hand, Appadurai (1990) outlined five-scapes to provide a rudimentary framework for analysis of globalization. These are: Ethnoscapes (the flow of people—tourists, refugees, immigrants, guest workers, etc); Technoscapes (the export of technology); Finanscapes (global capital transfer); Mediascapes (mass media images); and Ideoscapes (images invested with political-ideological meaning). GATS has a complex ‘top-down’ (mandatory) and ‘bottom up’ (optional) provisions which allow countries to specify which services to liberalise, under what conditions and in which of the four ‘modes’ (Spiegel et al. 2004). The GATS agreement with Mode 2 of consumption abroad of medical services (medical tourism) embodies three of the scapes identified by Appadurai (1990), the movement of people, the export of technologies, and the global capital transfers.

**Movement of natural persons**

The temporary movement of personnel to provide services abroad is relatively more significant as a mode of trade in health services due to the essentially labour-intensive nature of these services, the fact that shortages of personnel exist in many countries and the fact that health services unlike many other professional services (e.g. legal, accounting services), are largely based on universal scientific knowledge.

Health professionals move to seek improved living and working conditions and more lucrative remuneration, often shifting from the public to the private sector. They also may wish to acquire higher professional qualifications or to expose themselves to new techniques not available in the home country. The employers seek to purchase skills that are in short supply domestically. The movement of health professionals can remove shortages in the receiving countries, and remittances can improve the standard of living in the countries of origin. Thus, while the permanent emigration of

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48 UNCTAD report 1998
health personnel can result in a brain drain from developing countries, the temporary movement can contribute to a general upgrading of skills when the returning persons resume their activities.

Developing countries are estimated to supply 56 percent of all migrating physicians and receive less than 11 percent\(^{51}\). The direction of flows has changed over time. Whereas, in the 1960s, doctors working abroad were mostly from developed countries, they now come predominantly from developing countries and particularly from Asia\(^{52}\). Many countries experience both an outflow and inflow of health personnel. For example, the United Kingdom exports junior nurses to the United States and in turn imports nurses (e.g. from India and Ireland) to meet domestic shortage; Jamaica exports nurses to the United States and imports them from Myanmar and Nigeria. Thus, the lowest income countries are the ones most affected by the "brain drain" as they are unable to attract replacements\(^{53}\). For example, South Africa has witnessed an exodus of medical personnel to Canada, United Kingdom and United States, and also a migration from the public to the private sector within the country. The resulting shortage in the public sector was first met by personnel from neighboring countries; however, as this was producing an unacceptable brain drain from its poorer neighbours, the South African government entered into contracts with Cuba to obtain medical personnel to work in more remote areas. In order to halt brain drain, an arrangement has been made for doctors from Mozambique to work part of their time in South Africa (while resident in Mozambique) so as to supplement their income. Often health professionals from developing countries are providing a great deal of the unskilled labour in the health sector in the developed world, despite the qualifications they may have\(^{54}\).

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\(^{54}\) International Trade in Health Services: A Development Perspective UNCTAD report Geneva, 1998
Some recent studies draw attention to the saturation of developed country markets, especially the United States and the European Union, for certain categories of health professionals\(^5^5\). However, new openings may still be available in specific sectors, such as nursing care for the elderly and for people with disabilities or for patients suffering from drug or alcohol addictions, and medical services in remote areas. Cultural affinities and geographical proximity facilitate the movement of health personnel abroad.

**Actual or potential Health trade barriers**

Restrictions to movement of health personnel may arise from economic needs test requirements, discriminatory licensing, difficulties with accreditation or recognition of foreign professional qualifications, nationality and residency requirements, state and provincial requirements, immigration regulations, access to examinations for completion of qualifications, foreign exchange controls affecting the repatriation of earning, or discriminatory regulation of fees and expenses.

Economic Needs Test (ENT) condition, is a temporary entry upon a determination that no resident/national of the host country is available and qualified to carry out the same assignment. In the GATS commitments, ENT, defined as a barrier to market access under Article XVI, frequently appears as a qualification to commitments relating to the movement of natural persons, including intra-corporate transferees and independent contracted professionals\(^5^6\).

ENT acts as a quota restriction and may be qualitative or quantitative. ENT takes into account current population characteristics and Healthcare service capabilities. Licensing provision can impede entry of foreigners through non-recognition of their professional qualifications or by imposing discriminatory, more stringent and more costly standards on them. Licensing and recognition of qualifications is particularly complicated in cases where no national licensing body

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\(^5^5\) The United States Council on Graduate Medical Education has recently determined that by the year 2000 the national supply could exceed the need by more than 100,000 physicians. Quoted by Shalala Foreign Doctor Letter, 7 February 1997. Internet site: http://www.telalink.net/~gsiskind/docs/shalala.html.

\(^5^6\) International Trade in Health Services: A Development Perspective UNCTAD report Geneva, 1998
exists and granting of the license to practice medicine is the responsibility of the
individual state or provincial authorities, each of which has a medical licensing board.
The requirement of registration with, or membership of, professional organizations
could also constitute an obstacle to the person wishing to provide the service on a
temporary basis\textsuperscript{57}.

In the United States, for instance, the requirements for obtaining a licence to
practice medicine for those with qualifications obtained outside the United States vary
from state to state, some of which allow graduates of foreign medical schools to
practice subject to a written examination. Candidates must also pass the qualifying
examination of the Educational Commission for Foreign Medical Graduates, and then
undertake a period of graduate medical education at a hospital in the United States.
Many states grant a license to practice medicine by endorsement to graduates of
accredited Canadian medical schools\textsuperscript{58}.

In Canada, the requirements for physicians with foreign qualifications to obtain
a license to practice medicine vary from province to province. Foreigners must also
obtain the agreement of the relevant provincial ministry that their professional services
are needed. Registered nurses must have been granted a provincial license to practice
in Canada before they can be granted entry as professionals. An employment
authorization issued at the time of entry can have a maximum duration of one year.
Extensions may be granted in one-year increments, at the discretion of an immigration
officer. Under the North American Free Trade Agreement, provision is made for
temporary movement of health professionals.

Proposals have been made to provide for examining the problems of nationals
of the European Union (EU) with third-country medical qualifications\textsuperscript{59}. Council
the equivalence of university diplomas in order to bring about the effective freedom of
establishment within the EU. However, where major structural differences between


\textsuperscript{59} Commission of the European Communities, Report to the European Parliament and the Council on
the state of the general system for the recognition of higher education diplomas. Brussels 15.02.1996, COM(96) 46 final.
training courses exist, the host Member State would be entitled to require compensation, namely the adaptation period and the aptitude test\textsuperscript{60}. Although professional associations are crucial in maintaining standards and quality of service, they have often attempted to dampen price competition and restrict new entrants. For example, the American Medical Association used to provide for contract practice rules that made it unethical for a physician to treat patients under a salaried contract with a hospital or health maintenance organization (HMO) that was controlled by non-physicians. Association rules also considered it unethical for a physician to accept compensation that was inadequate in light of the usual fees in the community. Professionals have used control over medical plans or insurance firms to discriminate against potential competitors in the domestic market and abroad. However, restrictions imposed by professional associations are being eroded by market forces. It should be noted that some joint actions are legitimate and aim at maintaining standards and quality.

**GATS commitments**

Most GATS commitments on temporary entry and stay of natural persons are not sector specific and therefore it is hard to evaluate how they will affect Healthcare personnel\textsuperscript{61}. The commitments on the movement of natural persons normally include entry requirements for three main categories of personnel - business visitors, personnel engaged in setting up an establishment presence, and intra-company transferee - and, a fourth category, namely personnel in specialty occupations. The fourth category could provide some limited access for health professionals, e.g. in the area of management consulting, research and development, or health educational services. Only a few countries, thus far, have made commitments in the area of personnel in specialty occupations.

\textsuperscript{60} Some Member States have implemented legislation setting up rules on licensing and recognition of qualifications obtained in non-EU countries.

\textsuperscript{61} For an overview on temporary movement of natural persons see: *Information on the temporary migration regime (laws and implementing regulations) in force in selected developed countries*. Note by the UNCTAD Secretariat, UNCTAD/SDD/SER/7, 25 September 1995.
Some of the trade barriers mentioned above are evident from the market access and national treatment limitations contained in GATS commitments\textsuperscript{62}. Moreover, temporary entry and stay of independent Healthcare personnel are generally not covered by GATS commitments. A few commitments do provide for movement of natural persons in the medical and dental services, e.g. the EU under the sub-sector relating to professional services has scheduled commitments relating to (I) medical, dental and midwifery services (CPC 9312, 93191); (ii) veterinary services (CPC 932); (iii) nurses, physiotherapists and paramedical personnel (CPC 93191); and (iv) pharmacists. The commitments relating to (I) are covered both by the modes of supply relating to commercial presence and movement of persons. Under foreign commercial presence, some Member countries limit access to natural persons or professional associations among natural persons. Under the mode of supply of natural persons, residence or nationality requirements, ENT or limited authorizations apply\textsuperscript{63}. The specific commitments on this mode of supply demonstrate that few countries have bound their existing immigration laws and regulations; there is some margin for improving the concessions without actually modifying the relevant legislation. In fact a number of countries have introduced provisions in their immigration legislation to facilitate the temporary entry of certain categories of medical personnel. In the United

\textsuperscript{62} International Trade in Health Services: A Development Perspective UNCTAD report Geneva, 1998

\textsuperscript{63} Under foreign commercial presence it is provided that access shall be restricted to natural persons only in Germany and Spain. In Italy and Portugal access is also restricted to natural persons, however, professional associations among natural persons are permitted. In Ireland access can take place only through partnership or natural persons. In the United Kingdom the establishment for doctors under the NHS is subject to manpower planning. Under the mode of supply of natural persons, Denmark provides for limited authorization (for maximum 18 months) to fulfil a specific function and imposes a national treatment limitation providing for residence requirement in order to obtain necessary individual authorization from the National Board of Health. Italy also requires residency in the country. Greece, Portugal, Germany and France impose the condition of nationality. In France, however, access to non-nationals is possible within annually established quotas, while in Germany a waiver may be granted in cases of public health interest. Access for services provided by nurses, physiotherapists and paramedical personnel is provided for mainly through commercial presence and movement of natural persons. Under commercial presence, the EU schedule provides that in Austria, Italy, Portugal and Spain access for nurses is restricted to natural persons. Under movement of natural persons mode of supply, Denmark provides for limited authorization (maximum 18 months) to fulfil a specific function, Greece and Portugal provide for condition of nationality, and Italy for residence requirement and an ENT subject to regional vacancies and shortages. The abovementioned limitations apply to non-EU citizens.
States, for instance, an H1A visa is granted to foreign nurses who are not immigrants and who occupy permanent positions temporarily; this visa does not require certification from the United States Department of Labor. A 1994 Act authorizes each state's department of public health to grant waivers for up to 20 physicians per year to work in areas having a shortage of Healthcare professionals\textsuperscript{64}. In Australia, of the 24 major classes of temporary resident visas and entry permits at least nine are relevant to the temporary entry of specialty personnel, including educational personnel, visiting academics, medical practitioners, and public lecturers. In Japan, in addition to persons setting up a commercial presence and intra-company transferees, employment permits temporary working visas to be issued to 13 categories of persons, including professors for research and teaching at the college-level; providers of medical services, and researchers.

The United Kingdom has a regulatory regime for non-EU nationals that allow the issuance of work permits to licensed professionals, administrative and executive staff, highly qualified technicians with specialized experience, key workers with expert knowledge, and hospital auxiliary occupations. These categories are subject to a labour market needs test and, in the case of hospital auxiliary occupations, to quotas\textsuperscript{65}.

**Movement of Patients (consumers)**

Trade in health services under this mode includes primarily health services provided to foreign patients; however, educational services provided to foreign students can also be considered as trade in health services. Patients seeking Healthcare in foreign countries could include (i) those who travel abroad looking for specialized and surgical treatments that employ advanced technology which may not be available at home or for prestigious health institutions; (ii) those who travel for convalescence care; (iii) those who travel to specific places to benefit from natural endowments - such as hot springs and spas - and are willing to link medical treatment with other activities, such as recreational tourism; (iv) those who travel for medical and dental


\textsuperscript{65} Trade in Labour Services and Temporary Movement of Persons as Services Providers, Note by the UNCTAD Secretariat, TD/B/CN.4/24, 3 September 1993.
outpatient treatment, looking for a treatment of similar quality to that they can receive at home, but less expensive or for specific services not available in the country of origin. Emigrants living abroad and border patients are important groups of clients; (v) elderly persons who move to countries where costs are lower and the climate is better than in the home country, and returning nationals who have lived many years abroad and who are able to retire in their country of origin. Retirees are regarded by many as the biggest potential market for developing countries; therefore the Healthcare these countries are able to provide will affect their ability to attract the elderly. However, a major barrier to retiring abroad is the lack of portability of health insurances\(^{66}\).

Elements such as well-developed transportation, common or similar language and culture, friendly doctor-patient relationship, readily available information on health facilities abroad, established links with health institutions in the home country contribute in all cases to making the option of Healthcare in a foreign country more attractive. On the other hand, visa requirements, foreign exchange restrictions or the need to obtain authorization for medical expenditures may limit many patients from seeking services in foreign countries. Countries which have traditionally attracted foreign patients are the developed countries which can offer health providers of international reputation, specialized treatment, and state-of-art technology. However, developed countries also compete among themselves on the basis of the fees they charge\(^{67}\). A number of developing countries are actively seeking to attract foreign consumers relying on their ability to offer good Healthcare at prices significantly lower than in the developed countries. Others are trying to penetrate the international health service market on the basis of the uniqueness of the treatment they can offer or

\(^{66}\) It is estimated that, by the year 2015, 15% of the United States' population, 24% of Japan’s population and 17% of Europe’s population will exceed 65 years of age. By 2015 the United States, Japan and Western Europe will have a combined population older than 65 years of age of more than 100 million. L. Martin, *The Graying of Japan*. Washington, D.C., Population Reference Bureau, 2009.

\(^{67}\) Some world-renowned hospitals in Canada, for instance, have started targeting American patients. They can offer a service as good as the one provided in the United States at a fraction of US costs. This is because of cheaper administrative costs, much lower doctors’ salaries, and a low Canadian dollar. "A Special Report with Radical Surgery". *Maclean's*, 2 December 2006.
relying on their natural, geographical and cultural characteristics; however, these elements are usually combined with price advantages\textsuperscript{68}.

Until some years ago, the movement of patients was expected to expand, under the assumption that patients would increasingly request highly specialized care and that the number of health institutions able to provide it would be limited. However, the trends in other modes of supply, especially commercial presence and cross border trade, as discussed below, may be reducing the motivations for patients to travel abroad, or may shorten the length of their stay in foreign countries. On the other hand, the global trend of increasing medical costs and decreasing public Healthcare budgets, with the consequent reduction of Healthcare coverage, may encourage a larger number of patients to look for health treatment in countries where the ratio price/quality is more advantageous than at home. The effort to keep health costs under control may prompt HMOs in developed countries to include in their network developing country health institutions which can provide medical treatment at competitive prices. The reduction of public health coverage is leading to the expansion of private insurances, which may include treatment abroad\textsuperscript{69}. The overcapacity in hospital beds in certain countries, notably the United States, has prompted major marketing efforts to reach potential foreign patients. Efforts by medical institutions, in countries where state-controlled medicine was previously the rule, to attract high paying foreign clients are beginning to have their impact.

\textsuperscript{68} In the case of Mexico, for example, geographical proximity to the United States represents the major comparative advantage, along with lower costs, for developing health services exports. In addition, cultural factors in the border area - such as language and the special characteristics of the doctor-patient relationship - attract patient of Mexican descent and other Spanish-speaking patients who reside in the United States. In the case of Jamaica, an area of comparative advantage for the country is that it shares a common language with its main potential markets, the United States and several neighboring Caribbean countries. In the case of India, most foreign patients come from countries having a large population of Indian origin.

\textsuperscript{69} In the United Kingdom, for instance, the number of people covered by private health insurance has quadrupled in the past 25 years to more than seven million, corresponding to 12 per cent of the population. The private health market is expected to continue to grow at 5 per cent per year and treat 16.5 per cent of the population by 2000. "An unhealthy silence", \textit{The Economist}, 15 March 1997.
There is an accompanying flow of patients as some citizens of developed nations choose to bypass the care offered in their countries and travel to less developed areas of the world to receive a variety of reasonably priced medical services (Horowitz, 2007). As a result, regional and national governments in India, Thailand, Singapore, Malaysia, Philippines and Indonesia regard MTI as an important resource for economic and social development (Mudur, 2004a; Kuan, 2006). The difference in treatment costs can be considerable; for example, the cost of an elective coronary artery bypass graft surgery is about $60,400 in California, $25,000 in Mexico, $15,500 in Bumrungrad, Thailand, $10,000 in Wockhardt, India and only $6,500 in Apollo, India (Milstein, 2006b). Hence, cost-conscious patients choose to accept the inconvenience and uncertainties of offshore healthcare to obtain service at prices they can more comfortably afford (Lancaster, 2004; Arnold, Appleby and Kher, 2006).

**Actual or potential barriers for Internationalisation of Healthcare services**

In the case of movement of patients, the most important barrier is the emotional insecurity of persons who are ill who do not wish to be far from their families and are particularly sensitive to cultural and linguistic differences. For those persons willing to travel to receive Healthcare, an additional deterrent is the fact that in most cases the public health systems and the private insurance policies do not cover health treatment abroad (with the exception of some "deluxe" private insurance which include treatment abroad, but charge very high premiums, and of some insurances which cover Healthcare received abroad in case of an emergency during business trips or vacations). This limits the current market for trade in the form of movement of patients to certain categories of consumers. Patients might, therefore, look for Healthcare abroad if the treatment needed is not covered or not available, or is only partially covered by their health insurance. Since they have to pay for it, they

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74 Peter, R. Datamonitor: Open market for offshore presence in healthcare. (2005)
may consider going where the ratio quality/price is more favorable than at home\textsuperscript{75}. Insurance coverage may be less of a factor when there are long waiting lists to have access to cover medical services, or when the patient feels that the quality of the health services provided by foreign institutions is significantly better than that provided by national institutions and is able and willing to pay regardless of insurance coverage.

The European Union has dealt with the problem of the non-portability of public Healthcare insurance by a system under which sickness benefits in kind are provided according to the legislation of the country where a EU\textsuperscript{76} citizen resides or stays as if he or she was insured in that country\textsuperscript{77}. These benefits may be more or less advantageous than those provided by the country where the citizen is actually insured. After delivering the service, a bill is submitted to the health insurance of the home country for payment\textsuperscript{19}. In some other countries (e.g. Costa Rica, Egypt, Jordan) patients can be authorized to obtain treatment abroad at the cost of the national health system (NHS) when the NHS are not in a position to provide the required treatment. However, procedures for authorization can be long and cumbersome. Some countries, including EU Member States, have signed bilateral agreements which allow a total or partial portability of the public health insurance.

In the GATS commitments related to trade in health services, consumption abroad is usually allowed without limitations. However, some countries (i.e. Bulgaria, Poland and the United States) have indicated restrictions on the coverage of public insurance schemes outside the country\textsuperscript{78}. As students prefer to study in their own country to avoid future problems in certifying diplomas and obtaining licenses to practice their profession, this kind of movement of consumers takes place mainly for specific reasons\textsuperscript{79}. It seems that the most important criteria for choosing a foreign

\textsuperscript{75} Kathleen DeVries and John McKeever, “Constructing Better brand through service”, MHS Report, American Marketing Association, 2011
\textsuperscript{76} Rupa Chanda, “India-EU relations in health services: prospects and challenges” (2011) http://www.globalizationandhealth.com/content/7/1/1
\textsuperscript{78} "Assessoria de Asuntos Especiais de Saude" Report by the Ministry of Health in Brazil in January 1997.
\textsuperscript{79} Rupa Chanda, “India-EU relations in health services: prospects and challenges” (2011) http://www.globalizationandhealth.com/content/7/1/1
institution are its reputation, the cost, and the availability of funding. Other factors, such as language and cultural affinities and geographical proximity, also play a significant role. In certain cases it is the uniqueness of the training which attracts Foreign students, such as the case of traditional Chinese medicine. The choice to go to abroad for education and/or training is also influenced by the extent to which the foreign diplomats are recognized by the home country.

**Foreign commercial presence**

This mode includes the establishment of a commercial presence in a foreign market to provide health-related services to clients in that market. It can be split into the following categories: (i) foreign commercial presence in the hospital operation/management sector; (ii) in the health insurance sector; (iii) in the educational sector; and (iv) on an ad-hoc basis. In most countries foreign investment in the health sector has faced considerable restriction, if not prohibited. However, many countries have started opening their markets to foreign presence in various forms and favoring competition as a means to achieve better health services, reduce price escalation, and take pressure off the public sector.

Under Foreign commercial presence in the hospital operation/management sector, Hospital management companies usually try to establish themselves in countries which have liberal investment laws, are open to joint ventures, and have either high per capita income or a sufficiently large share of the population which can afford private health treatment. It appears that most providers of health services have established themselves in foreign countries through joint ventures with local partners or triad ventures with local and third country investors. Acquisition of facilities is one technique of commercial presence but is restricted in many countries, management contracts and licensing are becoming a preferred means of commercial establishment for hospital services. The involvement of local partnership is usually sought so as to have access to certified and adequately

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80 Economic Times, 29 July. (2005).Great Indian Hospitality Can Be Biz Too
82 Apollo acquisitions in South East Asia, Economic post, February 2009
Medical Tourism & India:

Medical tourism is viewed as the next big service sector boom in India following on the lines of the call center and the software services industries. Just as the call center industry was fueled by the presence of a large body of English speaking professionals, the main selling point for the medical tourism industry in India is the large number of trained medical professionals available in the country\(^83\). Firstly, India has been chosen as a target country due to the favourable estimates provided by leading consultants like McKinsey which revealed that medical tourism in India could become a US $2 billion industry by 2012 (from US $350 million in 2006)\(^84\). Likewise, a study by Credit Suisse, FICCI-Ernst and Young, estimates medical tourism to be growing at 25-30% annually primarily due to: the low treatment cost in India (20% of the average cost incurred in the US, Singapore, Thailand and South Africa); rising consumerism; globalisation and changing lifestyles (AHEL, 2009). Despite slowing down of economy, Indian Healthcare will grow at a rate of 10 to 12 percent\(^85\).

India, which has now emerged as a major destination (U.S. Senate 2006) lacks universal health coverage for its own citizens. It earned the very low rank of 112 in the World Health Organization’s ([WHO] 2002) survey of global health systems (the U.S. rank is 37), which ranks countries according to the availability of accessible and reliable Healthcare for citizens. In addition, India also ranks very low in the United Nations Human Development Index, which ranks countries based on health outcomes such as life expectancy and infant mortality. A New York Times article by Somini Sengupta on June 1, 2008, evoked some of the paradoxes of this situation by comparing the five star resort style hospitals where foreign patients are treated, to the conditions at a public hospital where Indian patients die waiting for treatment. In such a scenario it is unlikely that a foreign health sector and an ailing domestic health sector can coexist without any feedback. Indian Government now started expanding Healthcare horizons by getting in to Bi-lateral agreements like EU. The health sector

\(^84\) Healthcare in India: The Road Ahead, CII-Mckinsey study report PSM 2009
\(^85\) Indian Healthcare market will grow: McKinsey “The Hindu” News paper 27 May 2009
has also come under focus in bilateral and regional trade and cooperation agreements. One such prospective accord is the India-European Union (EU) Trade and Investment Agreement (TIA) currently under negotiation\(^{86}\).

However, the analysis of medical tourism in academic and policy literature is generally limited to two streams. Some studies, such as Milstein and Smith (2006), Wachter (2006) and Ernst (2006), consider medical tourism from the perspective of the foreign patients (mostly from the United States), focusing particularly on issues of safety. Others, such as Mattoo and Rathindran (2006), Teh and Chu (2005) and CII and Mckinsey & Company (2002) that examine the impact of medical tourism on the host economies focus mainly on the income effect.

One of the most important aspects of India's healthcare system is the significant role of the private sector, which accounts for over 75 percent of India's total healthcare spending. Private players account for 75 percent of dispensaries, 80 percent of all qualified doctors, and an estimated 95 percent of new hospital beds in recent years. Public health expenditure accounts for less than 1 per cent of GDP. Government spending on healthcare infrastructure (excluding land) is projected to rise only marginally, by 0.12 per cent of GDP and the private sector is expected to provide 88 per cent of investment requirements over the medium term\(^{87}\).

A series of articles in newspapers and magazines have documented individual stories of patients traveling abroad due to cost reasons. As Joshua Kurlantzick reported in a *New York Times* article dated May 20, 2007, insurance carriers such as Horizon Blue Cross Blue Shield and United Group Programs in Florida are offering plans that reimburse overseas procedures. The United States Senate Special Committee on Aging held a hearing in 2006 to examine whether medical tourism can contribute to lowering the cost of Healthcare in the United States. The committee noted that various Fortune 500 companies are considering plans to outsource non-emergency surgeries for their

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\(^{86}\) Rupa Chanda, “India-EU relations in health services: prospects and challenges” (2011) http://www.globalizationandhealth.com/content/7/1/1

\(^{87}\) Raman & Mavalankar Dileep, Health system in India: opportunities & Challenges, IIM-Ahmedabad, W.P No. 2005-0703
employees (U.S. Senate 2006). Like the rest of the world, the US is an ageing society. Between 2000 and 2050, the number of older people is projected to increase by 135%\textsuperscript{88}. Moreover, the population aged 85 and over, which is the group most likely to need health and long-term care services, is projected to increase by 350%. In this context US citizens may look for alternatives for cost effective Healthcare services. Over this time period, the proportion of the population that is over the age of 65 will likely increase from 12.7% in 2000 to 20.3% in 2050; the proportion of the population that is age 85 and older will increase from 1.6% in 2000 to 4.8% in 2050. The important dimension is that the ‘affordability’ of any government programme depends not just on its costs but on the nation’s willingness to contribute to the support of government programmes and the extent of other spending obligations\textsuperscript{89}. These factors will give Asian counties to explore the potential in International Healthcare markets\textsuperscript{90}. India will have more edge than its neighboring countries due to cost advantage & skilled man power\textsuperscript{91}.

CII says that India has the potential to attract 1 million medical tourists per annum and this could contribute (\textit{Venkata Krishna Prasad} 2007) around us $ 5 billion to the economy\textsuperscript{92}. In many developing countries it is being actively promoted by the government's official policy. India's national health policy 2002, for example, says: "to capitalize on the comparative cost advantage enjoyed by domestic health facilities in the secondary and tertiary sector, the policy will encourage the supply of services (Rakesh Goswamy 2007) to patients of foreign origin on payment\textsuperscript{93}. At the same time Healthcare delivery in India presents many unique challenges for healthcare

\textsuperscript{88} Joshua M Wiener and Jane Tilly, Population Ageing in United States of America: implications for public programmes http://ije.oxfordjournals.org/content/31/4/776.full
\textsuperscript{89} White J. \textit{Is Aging Relevant?} Discussion Paper for Four-Country Conference on Aging and Health Policy, Gananoque, Ontario, Canada, 12–14 July 2001
\textsuperscript{90} Zahera kazemi, “ A study of effective factors for attracting Medical Tourism in Iran”, 2007 Lulea University of Technology, 2008-o21 ISSN 1653 0187 ISRN LTU PB EX 08/21 --SE
\textsuperscript{91} Jyothsna Mal, “Globalisation of Healthcare: Case studies of Medical Tourism in Multi-Specialty Hospitals in India” Dissertation for MS, University of Manchester, 2010
\textsuperscript{92} C.B. \textit{Venkata Krishna Prasad}, “ Medical Tourism Industry - Advantage India”, IIMK
\textsuperscript{93} Rakesh Kumar Goswami, Facts for you, January 2007, “medial tourism: the next best thing”
professionals\textsuperscript{94}. The country’s lack of regulatory framework in quality results monitoring. It’s high time for Indian Hospitals to go for accreditation from JCI & NABH which will position in the minds of International Medical Tourists. The striking feature of India’s healthcare system is the significant and growing role of the private sector in healthcare delivery and total healthcare expenditures. India’s foreign investment policy is very liberal for hospitals which enable 100\% investment in the form of FDI\textsuperscript{95} under the automatic route.

As per a study by an industry body and Ernst & Young, India would require another 1.75 million beds by the end of 2025. Surprisingly the public sector however is likely to contribute only around 15-20 per cent of the required US$ 86 billion investment. The corporate India is therefore, leveraging on this business potential and various Healthcare brands have started aggressive expansion in the country who have even expanded their horizons in to abroad markets. Some of the companies that plan to increase their footprints include Anil Ambani’s Reliance Health, the Hindujas, Sahara Group, Emami, Apollo Tyres and the Panacea Group. Sahara Group is planning several healthcare projects such as a 200-bed multi-specialty tertiary care hospital at Gorakhpur in Uttar Pradesh, a 1,500-bed multi super-specialty, tertiary care hospital at Aamby Valley City and 30-bed multi-specialty secondary care hospitals across all the 217 Sahara City Homes Townships.

It’s high time for Health insurance sector to witness better days and with what is on the anvil. With a population as strength, even the present two per cent penetration to a five per cent penetration would mean millions and billions in business. The projected penetration of Health Insurance Sector in the next five to 10 years is 20 per cent of the population, because the earning population of 15 to 64 year age group comprises of more than 60 per cent of the total population who may afford health

\textsuperscript{94} Ratan Jalan and Vinay Kumar, “Eye on Indian Market”, American Marketing Association, MHS Spring 2009
\textsuperscript{95} RBI note on Foreign Investments in India (April 1, 2007).
insurance\textsuperscript{96}. With quality standards coming on even in AYUSH and alternative medicine, and India's rich heritage already attracting a lot of tourists, medical tourism will see a marked boom in years to come. Health cities with an aim to woo medical tourist is on the rise, and the healthcare players will leverage on the integrated medicine model by providing Ayurveda, Homeopathy, Unani, Yoga and others along with the modern medicine.

India is considered the leading country promoting medical tourism and now it is moving into a new area of "medical outsourcing," where subcontractors provide services to the overburdened medical care systems in western countries\textsuperscript{97}. This holistic approach will attract patients from far lands further, because the cost of care is almost one tenth the western worlds’ costs. Technology will play a major role in bringing quality in healthcare, be it better nursing communication systems, patient monitoring devices or telemedicine to provide low cost diagnosis to remote patients etc. More over Multi-language skill\textsuperscript{98}, which is one of the prominent interfaces while availing healthcare as also the tourism services abroad, is another advantage for India. In addition to proficiency in English, Indians are proficient in speaking Hindi, Urdu, Bangla, Arabic, Tamil, which are widely spoken in neighbouring countries of West Asia, South and South East Asia\textsuperscript{99}.

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