**“Medical tourism:**

**a snapshot of evidence on treatment abroad”**

**MS prepared for Maturitas**

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**INTRODUCTION**

An earlier review [1] mapped the literature around medical tourism. Medical tourism is a particular form of patient mobility, where patients travel across borders or to overseas destination to receive treatments including fertility, cosmetic, dental, transplantation and elective surgery. There has been much media coverage – of individual patients, of unusual places, of life-saving and life-changing treatments, and medical mishaps and the risks travellers face, spurring academic interest.

The 2010 review discussed *the market for medical tourism* and called for more empirical research on the role, process and outcomes of medical tourism. It noted the lack of information on numbers and key indicators, particularly patient numbers and flows, and patient and consumer profile. Second, the review noted much anecdotal information around *consumer choice*, but that there were also promising explanatory frameworks with potential for further empirical investigation (e.g., the framework of familiarity, availability, cost, quality and legislation suggested by Glinos et al. [2]). Such detail would deepen our understanding of decision making – the interplay of individual and social factors, and the role of education, locality, socio-economic characteristics and information. Third, evidence around *clinical outcomes* was weak with little known about relative clinical outcomes for particular treatments, institutions, clinicians and localities. Fourth, the review identified how *quality and patient safety* knowledge was limited by the lack of comparative quality and safety data, and evidence of infection rates for overseas institutions and reporting of adverse events relatively rare in the clinical literature. Finally, regarding *ethical and legal dimensions* there was relatively little examination of redress and treatment complications, whilst the potential impact on countries that treated patients within their health systems or those countries that were the source of patients was unexplored.

In the intervening period there has been a burgeoning of literature and it is timely to take stock of coverage, emerging themes, and gaps. Within the confines of a brief review article the focus is on out of pocket payments and outsourcing (rather than the EU Patient Directive), and we emphasise evidence and experience relevant to patients in mid-life and beyond wherever possible eschewing those studies with a focus on children. Constant throughout the period is difficulty in defining terms and the ‘essentially contested’ nature of medical tourism, medical mobility, transnational healthcare, medical refugees and medical diaspora. We sought to scope the literature for 2010-2015 using related terms ‘to map rapidly the key concepts underpinning a research area and the main sources and types of evidence available’ [3]. The review aims to contextualise ‘knowledge in terms of identifying the current state of understanding, identifying the sorts of things we know and do not know; and then setting this within policy and practice contexts’ [4]. As we shall see, research evidence is increasingly uneven; some topics are well served, others underexplored.

***Search strategy***

Our approach draws on the framework of Arksey and O’Malley [5] supplemented with additional suggestions [6] with stages of i) identifying a research question ii) identifying relevant studies iii) study selection iv) charting the data v) collating, summarising and reporting results. We examine the extent, range and nature of research activity relating to medical tourism, briefly summarise research findings, and identify research gaps in the existing literature. We searched two databases with a search strategy that incorporated a number of stages/elements, including designated search terms. The search results were then screened to determine which references were relevant to the review. A screening stage was undertaken which involved scanning the titles and the abstract returned in the searches. The screening of abstracts and papers was guided by inclusion and exclusion criteria that aimed to identify relevant empirical literature. Inclusion was work published since 2010 around medical tourism that included some primary data collection or secondary analysis. We undertook a hand search and added relevant articles not identified within the search strategy. We excluded evidence focused on EU crossborder healthcare rights. Our search spans social science and clinical studies and is restricted to material published in English.

Multiple searches were undertaken of each of the two databases used – *Web of Science* and the British Library. Details of the generic search terms used and items identified are provided in Table 1. The searches were undertaken by one researcher, and both the screening of the abstracts and the full papers were undertaken by the same researcher. The team reviewed the selection of the 100 sources contained in the review and sought to clarify emerging themes. The conclusions drawn from the review are based upon an interpretation by the authors of the information included in the publication of the studies.

Table 1: Search strategy

|  |  |  |
| --- | --- | --- |
|  | Web of Science | British Library  Advanced Search |
| Search term | Number of hits generated | Number of hits generated |
| *Medical tourism* | 560 | 370 articles (and 112 books) |
| *Medical travel* | 1618 | 270 |
| *Treatment abroad* | 479 | 201 |
| *Treatment overseas* | 235 | 126 |
| *Cosmetic surgery overseas* | 6 | 3 |
| *Cosmetic surgery abroad* | 19 | 11 |
| *Surgery abroad* | 138 | 70 |
| *Fertility tourism* | 43 | 17 |
| *Cosmetic tourism* | 49 | 20 |
| *Cross-border fertility* | 43 | 25 |
| *Transplant tourism* | 139 | 60 |
| *Dental tourism* | 27 | 30 |
| *Medical vacation* | 76 | 26 |
| *Cross-border health* | 567 | 274 |

**WHAT HAS CHANGED?**

The burgeoning of research and scholarship over the past five years has seen a number of sole authored volumes on medical tourism [7-9], and edited collections addressing topics, places and treatments [10-14]. Such books and collections are, to a greater or lesser degree, underpinned by empirical research, and there is a body of research studies funded by national policy or research council sources including in the UK [15-17], Australia [18-20], Canada [21-23] and United States [24]. There are published reviews [25-28] each guided by distinct questions and search strategies.

***Challenging industry boosterism***

Given medical tourism is underpinned by private provision (commercialization and competition) this has made it difficult to produce clear information on patient numbers and provider activities, allowing the growth of industry boosterism where numbers are produced by commercial companies with no evidence or source, and these are subsequently echoed in academic sources and grey literature. There have been greater attempts to understand numbers involved in medical travel (definitional difficulties notwithstanding) and debunk wider soothsaying and extrapolations [29-30, 24]. Whilst we are some way from a definitive figure globally – there are country-level estimates of patient numbers that involve impartial data collection. For example, the upper bound in Johnson and Garman [24] suggests 121,000 Americans leave the US for healthcare. Detailed investigation at the level of hospital in Thailand [31-32] provides a more nuanced understanding of Westerners travelling for treatment. A study of Canada during 1970-2010 concludes that medical tourism activities grew when there was a fall in private investment in medical facilities [33]. Undoubtedly, there is still work to do around critically assessing numbers, trends and markets but both country-focused and broader critical investigations [34] are important contributions.

***Re-conceptualising medical travel as regional***

Together with growing criticality about *who* is counting up numbers has been a rethinking around *what* counts. Putting aside confusion about whether expatriates or those requiring treatment whilst on vacation should be included in counts of medical travel there is growing awareness that marginalized groups of medical travelers have been overlooked [35-36]. Initial phases of medical tourism scholarship focused on government agencies and private providers pursuing an identical high-end, costly and complex patient market primarily from the Middle East, North America and Western Europe and preferably one that is funded by insurance and public health system financing. What was previously unusual – patients travelling from west to east or east to west – was seen as increasingly commonplace. Since 2010 there is growing empirical acknowledgement of the diversity of medical travelers and a range of drivers. Diaspora, regionalism, and south-south exchanges are emerging themes [29, 14, 36-37]. The importance of familiarity and cultural similarity is emphasized in services utilized by diaspora populations, for example, Korean healthcare services to those first- or second-generation populations within the United States, Australia and New Zealand [37-38]. Similarly, the colonial connection between the UK and India appears to have encouraged a medical market between the two countries [39-40]. The Turkish diaspora has been a group travelling to receive services offered by providers within Turkey [41]. Dangor et al. [42] explore travel of Indian-South Africans to India. Explanations of medical travel are increasingly located in a wider context of transnationalism, diaspora and migration including medical returns of Mexican-Americans who engage in border crossing from the United States to Mexico and Latin American intra-mobility [43-44, 35].

A body of Asianography has identified cross-border exchanges between near-neighbors, including patients travelling from Indonesia to Malaysia [45-49], Laos to Thailand [50], and Burma to Thailand [51]. Looking across East Asia there are many examples of regional exchanges, including mainland Chinese medical tourists to Hong Kong [52-53], and travelers to South Korea from Japan and China [54, 37]. Similarly, analysis of India as a treatment destination identifies its importance as a regional hub for Afghan, Pakistani and Nepali patients [40, 55].

For Africa there is similar evidence of cross border activity and regional hubs. Crush and Chikanda [36] explore patient movement into South Africa, drawing on secondary data analysis to show that South Africa is both an emerging destination of medical tourism patients from developed health systems, and that South-South movement of patients to South Africa for treatment is particularly significant. South Africa has entered into bilateral health agreements with 18 African countries [56]. Other research identifies how Africa’s middle class women present opportunities for South Africa’s medical tourism relating to breast treatment [57].

Outsourcing has received greater attention in the literature. Patients are funded by national governments, Ministries or third party payers to receive treatment abroad with block contracts and government-to-provider reimbursement [19-20, 58-59]. A major focus has been on patients from oil rich countries of the Middle East. Al-Hinai et al. [59] collected data from patients who had travelled from Oman for treatment; two-thirds were male and they most commonly travelled as a result of orthopaedic diseases. Patients funded to travel overseas bring individual benefits but also points to perceived weaknesses in domestic health systems. One study concludes that for some ‘outsourcing represented a betrayal of the obligations of their states to its citizens’ [20].

One corollary of outsourcing is awareness that patients continue to travel *into* developed health systems for treatment. In the UK NHS providers have received encouragement for such activity given the pressure of public resourcing of healthcare [58]. Johnson et al. [60] draw on national and supranational data sources to examine factors (such as health and healthcare system, economic and wider travel patterns) that explain inwards medical travelers to the United States and such evidence underpins viable export strategy, including promotion and outreach for providers and policy makers.

Forms of medical travel are diverse with medical travel often a bilateral business rather than a global one. A regionalism challenges the Anglophone focus so prevalent in earlier debates. Coverage continues of emerging destination including Caribbean [61-62], Greece [63], Japan [64], Turkey [65], Middle East [66], and Iran [67]. There is increased attention to why places have *failed* to live up to expectations of becoming major treatment hubs in spite of national strategies that have involved significant political and financial support.

Beyond transnationalism, diaspora and border-crossing there are out of pocket medical travelers from western countries who – whilst fewer in number and pursuing lower cost and low tech procedures than earlier anticipated – continue to attract attention. One typology suggests that decisions about treatment may not always be taken before travel, complicating marketing strategies [68]. Interest continues around identifying characteristics of American and European consumers who are more and less likely to participate in medical tourism [69-70]. A survey of international consumers sample using qSample’s international traveler panel on their experiences and views of medical tourism suggests previous experience of international travel was an important factor in propensity to travel for treatment [71].

***On-line information and support services***

A key support in the commercialization of medical tourism is the platform provided by the internet for gaining access to healthcare information and advertising. A range of studies focus on the role and function of the internet including types of information provided, information provenance and reliability, and privacy protection. Lunt and Carrera [72] systematically interrogate the range and quality of medical tourism sites using quantitative and qualitative assessment tools [also 17, 73]. Mason and Wright [74] examine how medical tourism websites convey information about benefits and risks of medical procedures and how they frame credibility of providers. A review websites of medical tourism facilitators from a wide range of countries, noted differences are associated with whether the business is based in a Western or an Eastern country [75]. Studies examine the benefits and risks featured in medical tourism broker websites, as well as the types of persuasive appeals of websites [76] and material distributed at a medical tourism trade show [77]. Holliday et al. [78] analyse the marketingof **c**osmetic surgery tourism and in particular gendered construction of cosmetic surgery tourism in different of destination websites. What is consistent across all these studies is that websites downplay risk and despite offering complex procedures websites display little information on treatment process, postoperative care, or issues of redress.

Medical tourism facilitators, intermediaries and brokers emerged to help travelers locate appropriate destination hospitals and clinics and to help manage their travel (translation, transfers and concierge). There is now a greater understanding of the role of facilitators [22, 17, 79-80]. Gan and Frederick [81] identify how business differentiate their activities – including countries and providers that are referral points, the treatments, and the role of medical professionals within the process, and broader range of services.Research on service convergence and service integration in the medical tourism industry includes in-depth study of Thailand’s Bumrungrad International Hospital initiatives that integrated medical and hospitality to enhance customer focus [82]. A study of medical hotels examines international patients’ attitudes, desires and perceived outcomes, discussing financial saving, convenience, medical service, and hospitality product [83].

***Motivations and decision-making***

A range of studies since 2010 have explored motivation and decision making of medical tourists. Interviews with 77 returning UK medical tourists who travelled for treatments including fertility, dental, cosmetic and bariatric identify availability, cost, expertise and cultural and familial reasons as most significant [17]. Most papers reference push and pull factors determining patients’ decision to travel. A study of 27 patients travelling to Thailand identify: high costs and the deteriorating conditions of health care in developed countries, and pull factors such as innovation, efficiency, service quality and patient‐doctor relationships [84]. Alsharif et al. [85] examine medical travellers to India, China, Jordan and the United Arab Emirates with the most important reasons for travel being cost, physician and facility reputation and hospital accreditation. Domestic waiting lists and lack of access to treatment were important push motivations. Snyder et al. [86] conclude medical tourists are motivated to travel abroad by a number of factors, including the affordability of care abroad, access to treatments not available at home, and wait times for care at home [also 87]. For some treatments patients are seen as informed and active decision makers – and procedures as necessary and urgent [21, 17].

Reproductive or fertility tourism is better documented than other forms of medical tourism. A study showed the complex motivations for travelling abroad [88, 15], but concurred with other research that cost of treatment and the greater number of gametes available abroad or more easily accessible gametes played a part in decision-making. Van Hoof et al. [89] explore how legal restrictions on treatments can be evaded by going abroad. Rozée and de La Rochebrochard [90] explore travel among French patients who were eligible treatment in France but who went abroad to obtain oocyte donation due to inadequate availability of medical care and to oocyte shortage in France.

Motivations are often complex and may vary according to the treatment for which a patient travels. A patient travelling for cosmetic surgery, for example, may enjoy the anonymity of a destination far from their country of origin, whereas migrants may prefer to travel to their country of origin to feel more comfortable with the language or type of care provided.

Decision-making involves a range of information sources and the internet plays a key role in addition to information from informal networks of friends and peers. It would appear that medical tourists often pay more attention to ‘soft’ information than ‘hard’ clinical information, be it hard or soft, online or overseas. Objective, third-party information sources were limited [17, 23, 91]. One student notes fertility travellers obtain information online or from stories of friends who also travelled for treatment with donor sperm [89]. Many studies seem to suggest a well-presented and clear website and, more importantly, a feeling that people were receiving a personalised service were deemed much more important than hard information such as success rates. The literature is replete with suggestions that facilitators and brokers play an important; however, studies point to a rather mixed use of such services. A number of studies identify the role of networks as key [16-17, 29, 37, 89, 91].

***Satisfaction, outcomes and complications***

While motivations are heterogeneous and differ across treatments, what is common to all treatment choices is the expectation of effective and safe treatment. Little is known about the relative clinical outcomes for particular treatments, institutions, clinicians and localities. There is scant evidence on long or short-term follow-up of patients dispersing to home countries following treatments at the range of destinations. Only within clinical trials is randomisation feasible and the possibility of standard outcomes design studies [92]. Commercial providers reporting results may not undergo robust verification and cross-national comparison of surgeons offering similar treatments are difficult because the caseload composition differs. A systematic review (that excluded organ transplantation) [28], identified ten studies mentioning longer term health outcomes of patients (including fertility travel and dental tourism) but there were few attempts at systematic design. With regards to obesity no evidence exists relating to bariatric surgery abroad.

Musa et al. [93] explores inbound medical tourists’ satisfaction from 137 respondents sampled using purposeful and convenience samplings in five private hospitals in Kuala Lumpur.  Hospital facilities and doctors were reported as the two most important considerations but it identifies significant differences in the levels of satisfaction within demographic profiles. Abd Manaf et al. [48, 49] report experience and overall satisfaction and future intention among medical tourists again treated in Malaysian private hospitals, drawing primarily on self-administered questionnaire. The most important dimensions of medical tourism service quality were those relating to medical staff, supporting services and administrative services. A study of German patients receiving planned and emergency (unplanned) dental care abroad found both are mostly satisfied with their experience, although some concerns arise with regard to continuity of care [94].

The relative importance of patient satisfaction compared with other outcomes is however complex. Fenton et al. [95] reporting results of analysis of data from over 50 000 domestic patients argued emphasis on patient satisfaction measures could lead to overtreatment, overprescribing of antibiotics and over-diagnosis which may deliver patient satisfaction but are not clinically necessary. Holliday et al. [16] conducted interviews with 105 travellers receiving cosmetic surgery abroad and found 97% of them were happy with the outcomes of surgery and would recommend the surgeon to a friend. However, 17% of the sample experienced complications and 9% received further treatment from NHS or Medicare when they returned from abroad.

The literature contains some reported cases of infection resulting from patients travelling to receive medical treatment [96-8]. The outbreak of NDM1 bacteria following patients receiving treatment in India highlighted some of the dangers of medical tourism and microbial resistance. Rogers et al. [99] discuss the management of patients with a history of healthcare contact in multiple countries. These travellers may be both vectors and victims of healthcare-related infection with multiresistant bacteria. There is a retrospective review of two patients who presented with M. abscessus SSI after cosmetic surgery overseas [98] and a case report of disseminated mycobacterial infection after fetal stem cell infusion [100]. A better system is needed to ensure broad access to high-quality health services, continuity of care, and surveillance for complications.

The evidence base for transplantation outcomes is stronger than for other treatments. A UK study concluded that Indo-Asian patients who choose to travel overseas for kidney transplantation have poor clinical outcomes (graft survival and major infection rates) and should be counselled on this basis [101]. Experience of Bahrainis [102] suggests receiving a kidney from a paid living donor at a commercial transplant centre abroad carries great risks for the recipient. Cha et al. [103] compare patients receiving kidney transplants overseas with patients who received kidneys from local donors. Biopsy-proven acute rejection, infectious disease, and hospitalization were more frequent in those traveling abroad for transplantations and overseas transplantation connoted risk factors that may negatively affect the long-term graft outcome. Alghamdi et al. [104] report transplant tourists having a higher rate of acute rejection in the first year compared with local transplantation and a higher incidence of infectious complication. Anker and Feeley [105] undertook a meta-analysis of odds ratios comparing the risks of domestic and overseas kidney transplant. Comparison across 12 medical outcomes (including likelihood of contracting hepatitis B, HIV, post-transplantation diabetes mellitus, and wound infection) was less favourable for overseas transplantation. Domestic kidney transplant recipients experience significantly higher one-year patient- and graft-survival rates.

Idowu and Adewole [106] undertook a single institution prospective study for 23 neurosurgical cases. India is the most common country visited by Nigerian patients. Nine patients died from various complications on arrival in Nigeria.

Determining the appropriate measures and timeframe are problematic when judging outcomes. Some treatments militate objective outcomes (e.g. cosmetic treatments), and some, such as fertility may become skewed by more immediate outcomes that do not acknowledge longer term risk and complication, and there are both complex technical and ethical issues [15, 88, 107].

***Health system implications***

Beyond individual decision making and motivations the actual volume of trade (the flow of medical patients) was referred to in many papers but investigated in few. Studies calculated the total volume of trade in health services (for countries in the Eastern and South-Mediterranean region), including the actual costs and effects on recipient country health systems [108-9]. Loh, [110] found the import and export of medical tourism 2003 to 2009 rose among countries with a high volume of such activities but not among those with a low volume. However, the growth in total import of medical tourism was slower than population growth, implying that overall the population’s take-up of medical tourism was static. NaRanong and NaRanong [111] calculate the contribution of medical tourism to the Thai gross domestic product (GDP) (0.4%), with medical tourists with their higher purchasing power likely to increase the cost of health services and lessen access in the public sector. Martínez Álvarez et al. [39] analyse the potential for countries to adopt a regional or bilateral perspective (rather than a multilateral) on trade in health services, finding there is scepticism because of political ‘cost’ involved. The potential cost savings and benefits of sending UK patients abroad have been calculated [112].

Miyagi et al. [113] conclude costs to NHS of complications of cosmetic tourism concluding costs are substantial and under-estimated by central funding agencies. Hanefeld et al. [107] cost three types of treatments for which patients commonly travel abroad: fertility treatment, cosmetic and bariatric surgery. Inbound medical tourists treated as private patients within NHS facilities may be especially profitable when compared to UK private patients. The impact of patients travelling for aesthetic procedures presenting to the UK NHS with concerns or complications on their return is examined [114]. Over one-third of surgeon responding to a survey had seen such patients in their NHS practice, most commonly following cosmetic breast or abdominal procedures. A quarter of these patients underwent emergency surgery, a third out-patient treatment and a third elective surgical revision [also 115].

Sheppard et al. [116] examine cost impact of overseas bariatric surgery on a public healthcare system. Conducting primary bariatric surgeries domestically was modelled as costing less than treating medical tourists returning to Canada. A study assessed the burden of medical treatment overseas on the Maldive government and households with 43% of households of medical travelers suffering from catastrophic health spending. Annually, an estimated 5% of country GDP was spent to obtain treatment for Maldivians overseas [55]. Alongside such system costs there is discussion in the literature [47] that ‘consumption’ and consumerist identities must be situated in the political and social context of inadequate health systems and human resourcing [18-20].

**Research gaps**

The past five years has seen greater research and publication around medical tourism. Looking forward we formulate what we see as the most pressing issues for ongoing research in the field.

1. Qualitative and quantitative evidence on patient decision-making

There is growing evidence of the range of medical tourisms, and awareness of the differing drivers and motivations that facilitate travel overseas. The studies reviewed indicate that motivation is complex. Further information is needed to fully understand this decision-making process across different settings and treatment groups. It is especially relevant to gain insight into why patients from countries with public health-care systems such as the UK choose to travel abroad. There is still a lack of information on the background of patients and the numbers of patients travelling abroad for treatment. This limits insights into why some patients travel and others do not and restricts evidence about the possible costs and benefits of medical travel. The absence of information on patients’ social, economic and demographic backgrounds hampers the ability to understand patient decision-making and determinants of travel. Understanding both the volatility and endurance of different travel patterns is required.

1. Engagement with risk and patient safety

It is apparent that patients do not fully understand the scale and nature of risk associated with seeking treatment abroad. Across studies there are relatively few that examine issues of risk, liability or even aftercare at the level of provider and national system. Discussion by Vick [117] notwithstanding there is relatively little case reporting of how disputes have been resolved concerning complications and redress.

1. Industry characteristics and logistics

The wide range of clinical, ancillary and support services involved in medical tourism complicates efforts to understand the full service delivery supply chain. Too little is still known about the industry beyond reviews of information materials and websites – relatively low-hanging fruit. Further research, especially qualitative and survey-based research, is needed to better understand how the sector operates and what its motives are to ultimately understand how it drives or affects trade in health services. Moving beyond hyperbole, it is time for detailed studies to retrospectively examine the reasons why provider, places and national strategies have under-delivered on anticipated growth.

1. Attention to costs

Although case studies of patients returning from treatment abroad with complications were reported, these did not quantify the potential cost of medical travel to the patients’ ‘home’ health systems. Given the evidence of an increase in medical travel such research is urgently needed. Beyond transplantation studies there is scant attention to long-/short term follow up of patients dispersing to home countries following treatment at the range of destinations. Relatively limited empirical research has been carried out with data from patients that focus on outcomes or self-reported health status. This is likely due to difficulty in getting access to international patients, and patients’ reluctance to participate. Further qualitative and quantitative research is needed to truly understand the effect of medical travel on patients and its cost to the health system.

1. Health systems: north, south, east and west

The body of literature focusing on medical tourism as a trade in health services indicates that further research investigating levels of such trade is needed. Data on costs and benefits of medical tourism are rare and this limits accurate assessments of its effects to inform policy decision-making. Studies are also needed to empirically observe the effects of medical tourism in practice.

The literature emphasizes qualitative social science rather than health systems or clinical studies. Much early academic coverage of medical tourism was written with a strong American accent. Frequently absent from debates were voices, experiences and concerns of the global South. Whilst much of the emphasis has been on patients from high-income countries travelling to lower-costs destinations, cross-border flows within South America, South East Asia, Southern Africa require still further empirical investigation.

To conclude on an epistemological point: following the ‘discovery’ of modern medical travel, a second wave of scholarship since 2010 includes more detailed empirical investigations of particular aspects and local development. Perhaps a third wave of scholarship is more nascent – informed by empirical work but identifying wider theoretical linkages of broader cultural, political, economic and social changes associated with globalisation.

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