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## The Globalization of Health Services: The Impact of Global Medical Travel in India, Brazil and Mexico

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# THE GLOBALIZATION OF HEALTH SERVICES: THE IMPACT OF GLOBAL MEDICAL TRAVEL IN INDIA, BRAZIL AND MEXICO

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Health administration educators in the U.S. have traditionally focused their teaching on domestic healthcare delivery, and this was done for good reason. Healthcare has always been among the most local of all industries: you visit your local doctor and when you need extra care you go to your local hospital. Historically, most actors in the healthcare value chain – employers, insurers, payers, providers, suppliers, and the government – have been local, regional, or at the most removed, national (Starr, 1982). But in fact, many facets of the healthcare value chain have started to globalize, paralleling to some extent the growing globalization of most other industries.

Health administration education programs in the U.S. have begun to add global elements in recent years. A primary example is the topic of comparative health systems, which has been added to curriculums in response to recent health reform legislative efforts. However, we argue that the element of global medical travel – often referred to as medical tourism – also needs to be considered as a topic for inclusion in health administration education programs. This is because the phenomenon of global medical travel has moved beyond an embryonic stage of curiosity and is becoming a major international trend in health services delivery. In one of the most comprehensive analyses of the growth of global medical travel, Deloitte predicted that the number of Americans traveling abroad for treatment would soar from 750,000 in 2008 to 6 million by 2010 and 10 million by 2012 (Keckley and Underwood, 2008).

The frequency of global medical travel has become more advanced in recent years due to the passage of the General Agreement on Trade in Services (GATS) in 1995. GATS emerged from the Uruguayan Round negotiations that created the World Trade Organization (WTO) in 1995. The purpose of GATS

is to create a credible and reliable system of international trade rules; ensure fair and equitable treatment of all participants; stimulate economic activity through guaranteed policy bindings; and promote trade and development through progressive liberalization. Trade agreements can be multilateral such as GATS, regional such as the North American Free Trade Agreement (NAFTA), or bilateral between two countries.

Before making any commitment in the health sector, WTO member nations should consider these factors: whether GATS can help achieve any of the health policy outcomes being sought; how to regulate trade in health services to achieve any of the health policy outcomes being sought; and the level of national capacity required to regulate trade in health services and the measures necessary to prove it. While GATS is broader than conventional trade agreements, it is extremely flexible in application. Participating countries can determine their level of commitment from full, to partial with restrictions, or none at all. Further, developing countries are not obliged to liberalize trade in health services or open up this trade to any and all nations. Indeed, researchers argue that bilateral agreements between nations might be the best approach to ensure quality care for global medical travel (Smith, Alvarez, & Chanda, 2011).

The opening up of international trade in health services has created both new opportunities and challenges for national health systems. For example, trade liberalization of health services by the lowering of custom tariffs is improving access to medical technologies and has made medications available at reduced prices. Further, increased trade in health services will be good for the economic development of those nations that become the most attractive destinations for international patients. At the same time, concerns have been expressed about the potential negative impacts of global medical travel on access to essential health services, on the “brain drain” of health professionals, and on overall equity and access to healthcare. For example, some argue that global medical travel might cause an internal brain drain as health professionals leave the public health system to work for those hospitals that attract medical tourists (Burkett, 2007).

Another concern is that, in an attempt to become a medical tourism destination, a nation might turn its attention and resources to tertiary care in urban settings and away from primary and secondary care for poorer populations who can't afford private-based care (Fried, 2007). There are numerous anecdotal accounts that have brought critical attention to this issue (e.g., Gupta, 2004; Mudur, 2005; Gentleman, 2005; Wilson, 2007; Murugan, 2008; Sengupta, 2008). However, there has been little empirical evidence regarding whether this is happening and to what extent (Smith, Alvarez, & Chanda, 2011).

This research attempts to move beyond anecdotal accounts by providing the first empirical assessment of global medical travel's impact on health resources available to poorer populations. Our analysis is based on a survey of physician providers in eight hospitals: Delhi, India (3), São Paulo, Brazil (3), and Monterrey, Mexico (2). Our focus on the impact of global medical travel is especially salient for these three nations given their recent focus on global medical travel development, despite the limited availability of public-based care for poorer populations. The primary research question asked of survey respondents was whether they feel that global medical travel is good for the care of poorer patients in a nation. Secondary research questions consider why global medical travel might be good for a nation in terms of increased medical education and training, increased use of newer medical technologies, and the potential to lessen health professional brain drain away from a country.

### THE PUSH AND PULL OF GLOBAL MEDICAL TRAVEL

Historically, developed nations such as the United States and the nations of the European Union were considered popular global medical travel destinations because these wealthy nations had the education and technology to provide first-class medical services unavailable in many developing nations. However, the direction of travel for health services has started to go both ways in recent years. Access and cost problems in developed nations, in conjunction with improved quality of care in developing nations, is leading an increased number of patients to seek healthcare in developing nations. Deloitte predicts that the number of Americans traveling abroad for treatment will soar from 750,000 in 2008 to 6 million by 2010 and 10 million by 2012 (Keckley and Underwood, 2008).

Much of this increased demand for health services in developing nations is driven by cost savings. In India, medical treatments may be as low as a tenth of the price of comparable treatments in the U.S. or U.K. For example, a preventive health screen that costs about \$574 (U.S.) in the U.K. is \$84 in India (Marcelo, 2003). However, costs have long been much higher in America than in poor countries, so this alone does not explain the new exodus. Two other factors are now at work. First, the quality at the best hospitals in Asia and especially Latin America now rivals many hospitals in wealthy nations, as evidenced by the dozens of hospitals around the world that meet the stringent requirements for accreditation by the respected Joint Commission International (JCI). Gaining the Commission's seal of approval has become the price of entry into the serious market for global medical travel.

Second, the health insurance safety net in the U.S. continues to fray. Over 47 million Americans are uninsured and many millions more are severely un-

derinsured. Also, insured Americans sometimes find it cheaper to fly abroad and pay for an operation out-of-pocket rather than pay the required deductibles or copayments for the same procedure at home. For example, Hannaford, a New England-based grocery chain, now offers its 27,000 employees the option of having a number of medical procedures done in Singapore at a savings to the employee of \$2,500 - \$3,000 in copayments and deductibles (Sengupta, 2008).

**POTENTIAL BENEFITS TO A NATION FROM GLOBAL MEDICAL TRAVEL** Government ministries, private hospital associations, and tourism agencies in countries like India, Brazil, Turkey, Malaysia, South Africa, and Mexico have worked together to develop comprehensive national strategies to expand the international patient market (Mudur, 2005). For example, India's national health policy recognizes care of international patients as an export. Special zoning laws, reductions on tariffs for imported medical devices, lowered corporate taxes, and government investment in transportation all support India's national policy of promoting trade in health services (Sengupta and Nundy, 2005; Gawande, 2003). The rewards of such initiatives can be profound since medical tourists are among the most profitable visitors to a nation. Singapore's Tourism Board estimates that the average spending for regular tourists is \$144 (U.S.) per day compared to \$362 per day for medical tourists (Travel Smart-Asia Watch, 2006). Proponents of medical travel also point to the advantages of economies of scale (Sengupta and Nundy, 2005). For example, it helps hospitals chains and health ministries to negotiate better contracts with companies selling medical devices, hospital supplies, and pharmaceuticals.

In order to attract patients from industrialized nations, medical facilities are being upgraded to meet world-class standards. Many hospitals in India today have the infrastructure and equipment to match the best centers in the world, be it for transplants, cancer treatment, neurosurgery, angioplasty, or cardiac surgery (Mudur, 2005). Most global medical travel hospitals offer specially designed packages for patients that include treatment along with accommodations for their pre- and post-hospitalization stages. Global medical travel has also been praised by some as reversing, or at least slowing, brain drain of professionals from poor to wealthy nations offering better salaries and working conditions (Turner, 2007). The argument is that, through the development of a global medical travel industry, a host nation may lessen the propensity of local health providers to emigrate elsewhere; and, in some cases health providers who have emigrated to wealthier nations might return back to their native countries to work (Wibulpolprasert et al., 2004).

## CONCERNS ABOUT GLOBAL MEDICAL TRAVEL'S IMPACT ON CARE FOR POORER POPULATIONS

Supporters of global medical travel argue that revenue generated from treating international patients can be used to subsidize publicly funded healthcare. Rather than harming local patients by hampering their access to services, the expansion of the market for international patients is supposed to lower the overall cost of providing publicly funded and privately purchased medical care to residents. As such, global medical travel provides a long term economic justification for building infrastructure, permits expansion of the private and public healthcare sector, and thus serves the interests of even the poorest members of society as it generates additional revenue for publicly funded healthcare.

Critics of medical tourism argue that the increased number of international patients has an adverse effect on local patients and healthcare facilities (Gupta, 2004). While countries make significant investments to become global medical travel hubs, public resources might better spent on publicly funded healthcare rather than on promoting for-profit initiatives intended to generate trickle-down effects through the larger economy. Further, global medical travel has the potential to cause an internal brain drain as health professionals leave the public health system to work for hospitals that attract medical tourists.

Whether medical tourism revenue ultimately bolsters public-based care is partially up to how governments distribute the additional resources from global medical travel and whether a country is successful in becoming a destination for medical tourists. India, Thailand, and Singapore are well-positioned to attract patients from other countries (Sengupta and Nundy, 2005). It is unclear whether other countries such as Brazil and Mexico will benefit from similar national economic strategies. Investing public funds into preventive medicine, public healthcare, and basic social infrastructure might generate more predictable population-level benefits. Directing public funds toward specialized medical centers and advanced biotechnologies is a particularly questionable decision in countries where most citizens lack access to basic healthcare and social services.

The phenomenon of "crowding out" is another problem associated with drawing international patients to global medical travel destinations. Large numbers of international patients could drive up the cost of healthcare for local patients. Salaries of physicians, nurses, and other healthcare providers would probably increase and healthcare would become less affordable to local patients (Turner, 2007). The problem could disappear if economic benefits ripple through society and entire populations benefit from national economic development. However, if the majority of benefits are captured by

socioeconomic elites and never reach the poorest members of society, some local citizens could have even worse access to healthcare than they had prior to the arrival of medical tourists.

With appropriate financing, auditing, and regulatory mechanisms, perhaps revenues generated from international patients could be used to improve access to care for local citizens. However, if medical tourism profits are not used to subsidize and improve care for local patients, an already large health-equity gap could widen in countries like India, Brazil, and Mexico. Access to the best medical facilities would be limited to the wealthiest local citizens and paying patients from other countries. Instead of contributing to broad social and economic development, the provision of care to patients from other countries might exacerbate existing inequalities and further polarize the richest and poorest members of society.

### DIFFERING LEVELS OF GLOBAL MEDICAL TRAVEL SECTOR MATURITY: INDIA, BRAZIL, AND MEXICO

In the race among nations to attract medical tourists, India arguably has one of the most developed global medical travel infrastructures in the world. Brazil has had independent hospital investments in global medical travel for over a decade. Mexico is a more recent entrant into this global marketplace (Black, 2008). The JCI, an independent, nonprofit group based near Chicago, evaluates and certifies healthcare organizations around the world that meet a set of quantifiable standards. The JCI determined in 2008 that 15 hospitals in India met its standards of care, as did 9 in Brazil; Mexico only had 2, both in Monterrey.

#### *India*

At least two thirds of Indians rely on private care, and 80 to 85% of healthcare expenditures are borne by the patient (Sengupta, 2008). The government covers 12 to 15% and the remainder, a mere 2 to 3%, is covered by the insurance sector. Overall, only 0.9% of the country's Gross Domestic Product (GDP) is spent on public-sector health programs, whereas 4.2% is spent on private care. Accordingly, India ranks 171 of 175 countries in percentage of GDP spent in the public sector on health and 17 in private-sector spending (Singh and Mukherjee, 2004). As a result, health services are in short supply in India. There are, on average, 4 doctors for every 10,000 people. In Britain, by contrast, there are 18 per 10,000. Also, India has less than one hospital bed for every 1,000 people (World Health Organization [WHO], 2005). Especially in rural India, state hospitals have little money for basic medical equipment or for maintenance of buildings, which are often filthy and overcrowded. In 2008, the Planning



Commission of India found that in government-run health centers, 45% of gynecologist posts and 53% of pediatric posts went unfilled (Murugan, 2008).

Despite increased government support of the health system in recent years (e.g., a 21% increase in government funds for healthcare in 2007), the base from which they are starting is very small. Increased investment and modernization initiatives would create opportunities to rebalance the system and offer more career options for allopathic physicians to remain in India and engage in private- and public-sector work. Fortunately, the number of nonresident Indian physicians returning to India has been increasing in recent years with the development of the global medical travel industry (Mullan, 2006).

The National Health Policy of India declares that the medical treatment of foreign patients is legally an export, eligible for all fiscal incentives extended to export earnings. Critics of this policy, like Dr. Amit Sen Gupta of the People's Health Movement (2004) ask, "Where is the logic of the government spending energy and effort to attract foreign patients for the private sector when an overwhelming majority of patients in India have inadequate access to healthcare?" Also, the Indian government has devised a policy that combines both private and public interests by having private revenues partially reverted back to the public sector. For example, Narayana Hrudayalaya Heart Hospital in Bangalore, which attracts patients due to its excellent reputation for quality care, uses the fees from medical tourists and high-income private patients to offset the costs of treating poorer people for free (Khanna, Rangan, & Manocaran, 2005).

### *Brazil*

Compared to India and Southeast Asian countries (e.g., Thailand and Singapore), Brazil is a latecomer to global medical travel. Historically, government efforts in Brazil have focused on programs for the poor. This sensitivity by the government might be in response to United Nations reports that 50% of the citizens are still unable to meet their medication needs (WHO, 2005). In particular, there appears to be concern on the part of the government about moving the focus away from the *Servico Unico de Saude* (SUS) national program of universal health coverage for all Brazilians. Three quarters of the nation's population relies exclusively on the SUS, and the remainder uses the supplemental, or private, medical care system (Brazil Ministry of Health, 2010).

There is reason to believe that global medical travel could grow quickly in Brazil, thanks to high-quality services, excellent medical infrastructure, and the latest technologies. Further, there has been international recognition in several areas including a large supply of U.S. board-certified physicians, as well as many hospitals accredited by the JCI, International Organization



for Standardization, and other regulatory bodies. Also, the Brazilian government is finally starting to support the development of global medical travel, as indicated by a government-led international conference on Brazil as a global medical travel destination in August 2010.

Most global medical travel to Brazil started with cosmetic plastic surgery and dental work. The number of medical tourists in Brazil has been increasing. Medical tourists accounted for just 2% of all plastic surgeries in 2004, increasing to 54,000 in 2006 and about 60,000 in 2009 (De Vettori, 2010). In São Paulo, there are five hospitals involved with global medical travel, all accredited by JCI, and all with an active international department. Recently, they derived 5% of their total revenue from international patients (De Vettori, 2010).

### *Mexico*

Health spending in Mexico in 2005 was about \$49 billion (U.S.), or 6.4% of Mexico's GDP (WHO, 2005). Although public care predominates in Mexico, there has been extensive development of private care in recent years. For example, the number of private hospital beds in Mexico rose 28% from 27,015 in 2000 to 34,576 in 2005. During the same period, the number of private-care doctors more than doubled from 21,565 to 55,173, and surgery rooms in private hospitals jumped 46% from 3,115 to 4,545 (Black, 2008). Private financing for healthcare expenses in Mexico is done mostly out-of-pocket, as only 3.1% of total healthcare expenditures are funded through private health insurance (Squires, 2010).

For decades, Mexico has attracted U.S. residents looking for cheap, basic healthcare. Border cities such as Tijuana and Ciudad Juarez are dotted with clinics advertising bargain dental braces or discount eye exams, and pharmacies that sell prescription medicines over the counter. In the last few years, global medical travel in Mexico has expanded into interior cities and has started to cover all types of medical procedures, including hip replacement, spinal fusions, knee surgery, and angioplasty. This new demand for health services is primarily due to Mexico's close proximity to the U.S., as well as lower costs. For example, an angioplasty costs around \$10,000 (U.S.) in Monterrey, Mexico, compared to \$50,000 to \$80,000 in an American hospital (Veguiest and Valdez, 2008). As a large northern, industrialized city, Monterrey is considered a primary global medical travel destination. Cultural differences for U.S. citizens are less there. Most speak English and there are a wide variety of accommodations and restaurant chains owned by Americans primarily as a result of NAFTA.

## METHODS

A survey of health providers was conducted at three hospitals in Delhi (two private, one public), three hospitals in São Paulo (two private, one public) and two hospitals in Monterrey (both private).

The three Delhi hospitals that participated in this study were Santosh University Hospital, Paras Hospital, and Escorts Hospital. Santosh only offers public care and does not support global medical travel. Paras is a new private hospital that is not involved in global medical travel. Escorts Hospital is a private hospital with a focused global medical travel strategy.

In São Paulo, two private hospitals in the city participated in this study, Hospital Israelita Albert Einstein and Hospital Alvorada Moema, along with one public hospital, M'Boi Mirim Hospital, which serves the poor on the city's southern side. In 1999, Albert Einstein Hospital became the first Brazilian hospital to receive JCI accreditation and has since become very active in global medical travel. Alvorada Moema Hospital is not active in global medical travel. The public hospital, M'Boi Mirim, serves public patients only and is a key hospital in the Brazilian Unified Public Healthcare System.

The two private hospitals from Monterrey to participate in this research were CIMA Monterrey and Hospital Conchita. CIMA recently received JCI accreditation and focuses on global medical travel, especially for American health travelers. It is owned by the International Hospital Corporation of Dallas, Texas. Hospital Conchita is part of the partnering health systems of Christus Mugeurza and Catholic Health System Christus Health of Irving, Texas and has recently begun to develop its global medical travel capacity.

The survey used in this research was approved by the Institutional Review Board of the University of Colorado at Denver. Each participating hospital approved the survey prior to its distribution to their physician providers. The survey was conducted in 2008 and 2009. Participation was voluntary and the responses were confidential. Results were analyzed using SAS software, version 9.1. A total of 170 physicians responded to the survey for an overall response rate of 32.8%. Of these, about 58% were male and 42% female. Also, 40% of respondents indicated that they see no global medical travel patients. Of those providers who see medical tourist patients, 30% reported that medical tourists comprise more than 5% of all patients.

## RESULTS

### *Attitudes Toward Global Medical Travel*

Based on anecdotal information from various media accounts, we expected that health providers would be critical of global medical travel, especially the impact of global medical travel on the care of poorer populations. However,

our findings indicate the opposite (Table 1). Physicians in India, the nation with the most advanced global medical travel industry in this research project, think highly of global medical travel's impact on the nation. This is an important finding because India has had enough time to get beyond the initial honeymoon phase of the global medical travel industry's development to make a more informed decision about the benefits and costs of global medical travel.

The results from India are further corroborated by the results from Brazil and Mexico. In both of these cases, there is strong support for global medical travel. Also, Brazilian and Mexican physicians do not think that healthcare resources will be diverted from poorer populations. Note that these results do not differ when comparing physicians who see global medical travel patients with those who do not. One might expect health providers not involved with global medical travel to be especially critical of global medical travel and its impact on poorer populations, but that was not the case in this study.

Table 1: Physicians' Perceptions of the Impact of Global Medical Travel: India, Brazil, & Mexico

	India		Brazil		Mexico	
	Sees GMT patients (n=86)	No GMT patients (n=24)	Sees GMT patients (n=65)	No GMT patients (n=27)	Sees GMT patients (n=51)	No GMT patients (n=37)
Global Medical Travel has been good for the nation	4.42	4.62	4.01	4.19	4.50	4.37
Global Medical Travel decreases care for poorer populations	2.75	3.14	2.40	2.42	2.38	2.10

Questions are based on a Likert scale of 1 to 5 with 5 being "strongly agree."

### *The Benefits of Global Medical Travel*

Physician providers in India, Brazil, and Mexico believe that global medical travel is bringing advantages to their respective nations in at least two areas: economic growth and medical education and training (Table 2). Most prominent is the belief that global medical travel is enhancing the economic growth of a nation. For example, foreigners coming to India, Brazil, and Mexico for medical care often bring family members and spend considerable time and money outside of the healthcare arena on traditional tourism activities.

Whether this expectation for economic development is realized or not is open to question, but there have been reports from some advanced global medical travel nations, like Thailand, which indicate that global medical travel has brought substantial economic benefit to the nation.

Further, in the more mature global medical travel market of India, there is greater appreciation for other potential benefits, including improvement of medical technologies, as well as medical education and training. Being part of the global market for health services appears to be pushing India to move beyond competition locally to compete globally for patients. As a result, Indian providers perceive that such global competition is having positive benefits for the nation. For example, India’s efforts to upgrade technology, adopt western protocols, and to offer prompt services at lower prices have all been linked to India’s successful medical tourism industry (Madur, 2005). Considering Brazil and Mexico, it is quite possible that these newer global medical travel markets are aimed at economic growth as an initial investment motive. Secondary benefits, such as improved medical education and training, may come later.

The results of economic development and increased medical education and training are consistent with Turner (2007), who argues that global medical travel’s development will improve health training and technique as JCI-accredited hospitals raise standards of education and care in a region. However, our results diverge from Turner’s suggestion that the development of global medical travel will lessen brain drain of physicians. As shown in Table 2, there is little evidence to suggest that foreign medical graduates in America are starting to migrate back to native countries to take advantage of global medical travel’s development. If this situation changes, then a poorer nation might consider investing in global medical travel to entice physicians and other health professionals to stay in the country (Ghatak, Hazlewood, & Lee, 2008). Note that foreign medical graduates (FMGs) comprise about one quarter of all physicians in the United States, and Indians are the most highly represented group within the U.S. FMG population (Mullan, 2006).

Table 2: Physicians’ Perceptions of Positive Impacts of Global Medical Travel

	India (n=110)	Brazil (n=92)	Mexico (n=88)
Economic Growth of the Country	3.92	4.27	4.24
Availability of Medical Technology	3.71	2.47	2.80
Improvement of Medical Education and Training	3.18	3.29	3.09
Lessening Problems of Brain Drain	2.78	2.31	2.78

Questions are based on a Likert scale of 1 to 5 with 5 being “strongly agree.”

*The Impact of Medical Travel on Physicians' Practice Environment*

Table 3 shows how global medical travel may provide benefits to participating physicians. As illustrated, respondents in India and Brazil believe that global medical travel will increase physicians' incomes. Respondents in all three nations believe that participation in global medical travel enhances physicians' professional reputations.

Of further interest is the differing perception of benefits by those physicians who are involved in medical travel versus those who are not. Physicians who do not see medical tourist patients appear to have a higher perception of the benefits of global medical travel in terms of higher income and reputation compared to physicians who already participate in global medical travel. This finding suggests public-oriented physicians may not be drawn away from public care, but instead might be willing to supplement their incomes with a few global medical travel patients.

Table 3: Global Medical Travel's Effect on Physicians' Income & Reputation

	India		Brazil		Mexico	
	Sees GMT patients (n=86)	No GMT patients (n=24)	Sees GMT patients (n=65)	No GMT patients (n=27)	Sees GMT patients (n=51)	No GMT patients (n=37)
Physicians who treat GMT patients have higher incomes	3.51	3.86	2.98	3.65	2.65	2.24
Physicians gain in reputation for treating GMT patients	3.12	3.43	3.50	3.52	3.70	3.42

Questions are based on a Likert scale of 1 to 5 with 5 being "strongly agree."

## DISCUSSION

The increasing ease of traveling and communicating internationally, combined with the expanding network of highly qualified hospitals around the world, have made foreign travel for healthcare a choice for many. Accordingly, health administration educators should consider key issues about the global marketplace for health services in their classroom teaching. One key issue is whether nations that turn their attention to infrastructure development to attract foreign patients are doing so at the expense of providing resources for the access of health services to their poorer populations.

The survey results in this paper provide a first empirical analysis of the impact of global medical travel across nations on three continents. Of these nations, India has the longest standing and most advanced global medical travel industry, while Mexico has the most recent and least developed global medical travel industry. We expected that physicians in public hospitals would be sensitive and critical of global medical travel's impact on the care of poorer populations. However, survey results indicate the opposite. Physicians in both private and public hospitals share the perspective that global medical travel is good for a nation and does not compromise healthcare for poorer populations. Our analysis also provides some indications about why this is the case. The surveyed physicians believe that global medical travel enhances a nation's economy and leads to health infrastructure development through investments in new medical technologies and medical education. Also, surveyed physicians believe that global medical travel adds to physicians' income and helps them gain recognition among their peers. If these results hold true in future research, one could expect that national policies limiting trade in health services might be relaxed in coming years and that health services development nationally could benefit from policies that include both private and public health strategies.

There are shortcomings in this study that can hopefully be addressed in future research. First, the positive benefits of global medical travel as indicated in this research do not rule out the need to be concerned regarding access to care for poorer populations. This research merely suggests that the benefits might outweigh the concerns, at least from health providers' perspective. Second, our research describes the perceptions of physician providers regarding global medical travel. It would be very helpful if a financial accounting of the benefits and costs of global medical travel for a nation were known. Third, it would be helpful to explore the perceptions of other key stakeholders involved in global medical travel.

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