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trade from different viewpoints, with Qadeer bringing the argument back from national concerns and legislation to the necessity of international ethical debate and action.

I hope these forum contributions, together with the articles in this issue, help to make the case for further focus on ethical and global regulatory context in this area, which extends from addressing poverty and destitution and the necessities of health systems to fundamental ethical problems inherent as part of this trade. If poverty and regulatory differences between countries are the driving force for this trade, it is unlikely that a solution will be reached without a further focus and assessment of the ethical and normative basis on which current efforts to promote health care tourism and trade in health services reside.

Biographical note

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Trade in health services: Can it improve access to health care for poor people?

Chantal Blouin

In the last 10 years, we have seen a growing interest for cross-border trade in health services. Health tourism, that is a patient traveling abroad to receive health care, has received most of the attention, both in research and policy circles. Trade and economic ministries in Thailand, Malaysia, India, Singapore, in the Caribbean, to name only these, have promoted health tourism as the promising export industry of the new services economy, offering economic diversification, increased incomes and foreign exchange. Health ministries in these same countries are sometimes less enthusiastic, concerned with the risks such endeavors posed to the national health systems. For instance, health tourism has meant an internal brain drain and strain on human resources available for local patients in Thailand; policies for nursing and medical schools to increase their enrollment were adopted in response to the rise of health tourism.

Researchers have also raised a number of concerns regarding the quality of care received by patients traveling abroad to receive treatment and surgery, the legal issues related to malpractice law, and ethical considerations, especially regarding reproduction services and organ transplantation. On the other hand, economists have examined how to facilitate this rising form of international trade in services, especially by improving cross-border health insurance portability (the capacity of insured patients, either from public or private insurance, to be reimbursed for non-emergency care received abroad).

One policy question that remains unanswered and under-explored is the capacity of trade in health services, including health tourism, to have a positive contribution to the capacity of poor people in developing countries to access health care services. The first channel for such positive contribution is that some of the revenues from health

tourism be harnessed to improve access. Typically, advocates of health tourism will recommend that government in developing countries 'put in place universal access policies that require private providers to contribute to a health care fund' (Mattoo and Rathindran, 2006: 367).

Have the countries promoting health tourism adopted such mechanisms? In the last six years of monitoring the literature and the institutional frameworks related to health tourism, I have failed to identify such a mechanism. Neither in the more established health tourism destinations like India, Jordan, Thailand nor in countries that have been more recently involved in this form of service exports (the Caribbean, Mexico, Costa Rica), has an explicit mechanism to allocate some of the additional income generated from health tourism been used to increase access to health care services for local patients. The only country found to have mentioned a specific tax on health tourism is New Zealand, where the government was considering in 2009 to apply a specific levy on private hospitals catering to foreign patients that would contribute to the Accident Compensation Corporation, a public agency which provides a comprehensive, no-fault injury insurance to all New Zealanders and visitors.

General income, corporate or property taxes on the providers of health tourism, if not waived to create incentives for greater investment, can create some additional income for the public purse. However, specific programmes through which these additional funds to the general government revenues would be allocated to improve access to health care for the local population has not come to attention. In a country like Malaysia where public expenditures on health are relatively high (99 dollars per capita in 2005) and access to health services tends to be good and equitable (e.g. 100% of births are attended by a skilled health worker), a specific allocation of the income generated by health tourism may respond to a less urgent need. But in a country like India, with low government expenditures for health (seven dollars per person), limited and inequitable access to health services, health tourism appears as one of the greatest expressions of health inequity in access to health care; not to harness the revenues it generates to improve the local health system, is a failure of ethics.

As health tourism becomes more established as a regular component of the private health care industry, the issue of the regulation and oversight of this industry should be added to the list of policy concerns. Public health officials may be put in a difficult position in some countries where they will be asked to both regulate this growing industry and be its promoter on the global scene. For instance, last year, the government in Malaysia created the Malaysia Healthcare Travel Council, an agency of the Ministry of Health, whose mandate is to promote the 'the healthcare travel industry and to position Malaysia as the healthcare destination of choice in the region'.

Therefore, researchers studying the policy and public health impacts of health tourism will continue to have a full programme ahead of them. Documenting the actual level of health services being traded (number of patients, revenues generated) itself remains a difficult task, as few countries have done like Thailand and established reporting requirements for hospitals regarding the number of foreign patients being treated in their establishment; data collection tends to be limited in most countries. Beyond this descriptive task, exploring what policy mechanisms (regulation, taxation) work best to mitigate the risks associated to trade in health services and harness its potential benefits for the

population of destination countries is a key challenge for the growing community of researchers investigating this new form of globalization.

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Global health regulations should distinguish between medical tourism and transplant tourism

Alireza Bagheri

Medical tourism has been defined as traveling across international borders to obtain healthcare. It also refers to the practice of healthcare providers traveling internationally to deliver healthcare. Many countries, in the developed and developing world, for different reasons, have been trying to develop medical tourism programmes to attract patients from around the world. In the current situation, organ shortage is a worldwide problem and patients have to be registered on the waiting list if they need an organ for transplantation. Given the fact that there is no single country to achieve self-sufficiency in organ procurement so far, the number of organs available for transplantation is still not enough to address the need of the patients. As a result, many patients have to travel beyond geographical borders to receive transplants. The question is whether travel for transplantation, known as ‘transplant tourism’ should be considered the same as ‘medical tourism’, in which a patient travels for a knee replacement surgery or cosmetic surgery? In medical tourism, the parties involved are: healthcare providers, healthcare facilities and patients who seek medical care abroad. However, medical tourism is not free of criticism; there are ethical concerns, especially when the resources (medical doctors, nurses, and medical facilities) devoted to providing medical care to patients from outside of a country undermine the country’s ability to provide the same services for its own population.

The Istanbul Declaration on Organ Trafficking and Transplant Tourism defines travel for transplantation as ‘the movement of organs, donors, recipients or transplant