Medical Tourism: Reverse Subsidy for the Elite

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In India, medical tourism is big business. Industry experts estimate that the medical tourism market was worth more than $310 million in 2005–6 and that it could increase to $2 billion by 2012. These estimates represent a phenomenal jump in the inflow of medical tourists, from a little over 100,000 in 2002 to over 1 million in 2012 (Confederation of Indian Industries and McKinsey and Co. 2002). These figures are significant when contrasted with India’s overall health care expenditure—$10 billion in the public sector and $50 billion in the private sector. And government estimates suggest that India’s health care industry could expand by 13 percent annually over the next six years, “boosted by medical tourism, which industry watchers say is growing at 30 percent annually” (Swain and Sahu 2008, 478).

Evidence suggests that India is second only to Thailand in the number of medical tourists that it attracts every year (Deloitte Center for Health Solutions 2008). Apart from the perceived exotica of the orient, and the fact that Indian medical professionals are proficient in English and that patients are familiar with Indian doctors who practice in large numbers in many Western nations, the principal attraction of the Indian medical
tourism industry lies in its cost-effectiveness. For example, hip replacement surgery, which normally costs around $25,000 in the United States, can be performed for $7,000 in India. Heart valve replacement surgery, which costs around $200,000 in the United States, costs $10,000 in India (Discover Medical Tourism n.d.). But there are two other major contributing factors: the sustained growth of corporate hospitals and hospital chains across India and the promotion of medical tourism by the government as part of public policy.

While the private sector has always been prominent as a source of medical care, neoliberal policies have created conditions for its rapid growth. India ranks among the top twenty countries in terms of private expenditure on health as a percentage of gross domestic product (GDP)—around 4.5–5 percent. Importantly, a large proportion of this private expenditure is accounted for by the elite, who make up less than 10 percent of the population but who have prospered as a result of these same neoliberal policies. Although they constitute only a fraction of the Indian population, this elite is larger in absolute numbers than the elite in most countries of the global North. Thus, while national policies have opened the way for the penetration of the corporate sector into medical care, this sector now needs further avenues for its continued growth. The global health care industry—valued at $2.8 trillion in 2005—makes for an obvious target (Sengupta 2008).

Diverse avenues have been opened up for the growth of medical tourism in India. For example, since 2006, the government has issued M (medical) visas to patients and MX visas to the accompanying spouse. In 2009, the Ministry of Tourism extended its market development assistance scheme to cover hospitals certified by Joint Commission International (an international organization that accredits health care facilities) and the National Accreditation Board for Hospitals (the country’s premier institution that provides accreditation to health care facilities). This market development scheme offsets overseas marketing costs for travel companies. Through this program, hospitals will become eligible for financial assistance to cover publicity through printed material, travel and stay expenses for sales-cum-study tours taken by hospital staff, and participation fees for trade fairs and exhibitions.

Another major driver of medical tourism in India is what can be loosely termed reproductive tourism, that is, medical tourism specifically related to accessing assisted reproductive technologies such as in vitro fertilization and surrogate parenthood. Internationally, there is wide variety in the extent to which different countries regulate reproductive technologies. This results in a flow of medical tourists into countries such as India,
Thailand, and China, where reproductive technology regulations are lax and where such facilities are well developed. India, for example, does not have guidelines that prohibit foreigners from hiring Indian surrogates.

The consequences of poor access are felt across gender, class, and community divisions. However, data related to women’s health reflect some of the worst manifestations of compromised access to medical care. Thus, while women from across the world flock to India to take advantage of the booming market for assisted reproductive technologies, a very large number of Indian women are denied basic health care. Women are truly invisible to the public health system in the country—the latest available data indicate that just 17.3 percent of women have had any contact with a health worker. Even when some public health facilities exist, women’s access is compromised: only 17.9 percent of the primary health centers in the country have the services of a female doctor (Ministry of Health and Family Welfare 2007). This is especially important in large parts of rural India, where conservative norms of behavior prevent women from freely discussing their ailments with male doctors. The paucity of women doctors in rural settings is tightly linked to the lack of basic facilities for health personnel, including those related to housing and safety. Lack of health services for women is also reflected in the fact that in 2005–6, only 48.3 percent of births were conducted safely (IIPS and MI 2007). As a consequence of poor public facilities and low health status, more than 120,000 mothers die in childbirth every year. The maternal mortality ratio, or number of maternal deaths per 100,000 live births, is still over 300, an unacceptably high figure. It is considerably higher than the target of fewer than 200 deaths per 100,000 births by the year 2000, set in the National Health Policy of 1983 (see Ministry of Health and Family Welfare 1983). Women’s health, in many situations, is inextricably linked to violence, which they face as a routine part of their lives. Among women ages 15–49, 34 percent have experienced physical violence, and 9 percent have experienced sexual violence. In all, 35 percent of women in India have experienced physical or sexual violence, including 40 percent of women who are or have been married (IIPS and MI 2007).

There is also a deeper logic that drives policies designed to promote medical tourism in India, one derived from neoliberal reforms that were initiated in the early 1990s. These reforms led to severe and sustained cuts in budgetary support for various welfare measures. Between 1990 and 1994, there was a precipitous fall in social-sector spending, including on health care. While there has been some restoration in public expenditure since then, in GDP terms health expenditure (already one of the lowest in the world)
declined from 1.3 percent in 1990 to 0.9 percent in 1999—and it has continued to languish at around 1 percent of GDP to date.

In the aftermath of these reforms, the costs of both outpatient and inpatient care increased sharply. Over the 1990s and 2000s, there has been a substantial increase in the cost of hospitalization in both public and private facilities. While there has been an 82 percent increase in government health expenditure on hospitalization in public facilities, costs in private facilities have increased 120 percent (in both cases adjusted for inflation). For both public and private facilities the increase is higher in rural areas than in urban areas. It is interesting to note that the cost of care in the public sector also rose precipitously—resulting in greater out-of-pocket expenses (in the form of user charges, drug costs, etc.) for patients who access public facilities. The 2002 National Health Policy noted this trend and identified medical expenditure as one of the leading causes of indebtedness among the poor (Ministry of Health and Family Welfare 2002).

As a consequence of these reforms, public health facilities have suffered severely, leading to their virtual dismantling in many parts of the country and also resulting in a severe loss of morale among public health workers. Such a trajectory has caused the public system to fall into disarray and to attract criticism from those who depend on it. Ironically, the same forces that brought about this change (the World Bank, the International Monetary Fund, and even the government) have joined in the chorus in blaming public health services. All this has forced people to look for other options, leading to a boost for the private sector and to its increasing legitimization. The dominance of the private sector not only denies access for poorer sectors of society but also skews the balance toward urban, tertiary-level health services with profitability overriding equity and rationality.

The virtual collapse of the public health system has led to the emergence of a disorganized and unregulated private sector. There is a large spectrum of providers within the private medical sector, ranging from individual practitioners to small dispensaries and nursing homes to large corporate-run hospital chains. This sector thrives thanks to tax subsidies and direct government support through the outsourcing of public-sector functions to private providers. As the private medical sector expanded, the top end of the sector—promoted by corporate entities—needed to diversify into more lucrative areas to further maximize profitability. Diversification into the medical tourism market was an obvious choice.

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1 See Selvaraj and Karan (2009), which is based on National Sample Survey Organisation unit-level data. Government medical expenditure includes expenses on medicines purchased.
There is evidence of rapid differentiation taking place in the corporate-run medical sector, which clearly wishes to target the elite. In an interesting consolidation of industry interests, leading Indian private hospitals, health care providers, and travel and medical tourism industry officials have come together to form an industry association—the Indian Medical Travel Association—that aims to work “together to make India the leading global healthcare destination.” The industry is also promoting the National Accreditation Board for Hospitals, which has granted accreditation to seventy hospitals across the country (Sengupta 2008). What is interesting to note is that such accreditation programs are limited to a few large hospitals. This development is likely to set in motion a differentiation in the private hospital sector, where quality care will be provided through a few high-priced hospitals that target the Indian elite and foreign tourists. This is unlikely, however, to ensure quality care and minimum standards in the overwhelming majority of private hospitals. In fact, to the contrary, the private sector has consistently stalled efforts to regulate and set standards.

As Oxfam International writes with respect to Africa, “the private sector provides no escape route for the problems facing public health systems in poor countries. . . . Evidence available shows that making public health services work is the only proven route to achieving universal and equitable health care. . . . Public provision of health care is not doomed to fail as some suggest, but making it work requires determined political leadership, adequate investment, evidence-based policies and popular support” (Oxfam International 2009, 4). Many of these elements are absent in the policy framework that promotes neoliberal reforms. As Oxfam contends, “to look to the private sector for the substantial expansion needed to achieve universal access [to medical care] would be to ignore the significant and proven risks of this approach and the evidence of what has worked in successful developing countries” (2009, 5).

In fact, evidence in India points to the increasing brunt of unequal access that is borne by the most marginalized sectors of Indian society. Neoliberal policies have created a creamy layer of Indian elite whose consumption patterns parallel those of the global elite. They seek care today in world-class facilities built to cater to the elite—both Indian and foreign. In contrast, the poor are being denied basic health care. Data available indicate that “financial constraints” are increasingly cited as the reason for not accessing medical care. In rural areas, lack of adequate finances was cited by 15 percent of people as the reason for not accessing medical care.

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in 1986–87. This rose to 28 percent in 2004. The corresponding figures are 10 and 20 percent, respectively, in urban areas (NSSO 2006).

Recent data suggest that Indian hospitals treated 450,000 foreign patients in 2007, second only to Thailand with 1.2 million foreign patients treated every year (Deloitte Center for Health Solutions 2008). The Indian government sees this as a win-win situation. For example, the 2002 National Health Policy states: “To capitalize on the comparative cost advantage enjoyed by domestic health facilities in the secondary and tertiary sectors, [the policy] strongly encourages the providing of . . . services to patients from overseas” (Ministry of Health and Family Welfare 2002). Such services, the policy goes on to explain, will be “deemed exports” and will be made eligible for all fiscal incentives extended to export earnings.

Implied in the government’s promotion of medical tourism is the promise that the revenues it earns will strengthen health care in the country. But as I have written, evidence to date is to the contrary: “corporate hospitals have repeatedly dishonoured the conditions for receiving government subsidies by refusing to treat poor patients free of cost—and they have got away without punishment” (Sengupta 2008, 5). Many top specialists in corporate hospitals are drawn from the public sector, thereby promoting a brain drain of health professionals into private corporate hospitals (Sengupta 2008). Urban concentration of health care providers is widely documented: 59 percent of India’s practitioners (and 73 percent of allopathic practitioners) are located in metropolitan centers. Medical tourism intensifies the trend of health professionals moving to large urban centers and, within them, to large, corporate-run specialty institutions.

Clearly there is a disjunction between the government’s perceived need to support medical tourism and the state of public health services for ordinary Indians. If services related to medical tourism were taxed sufficiently to support public health, the revenue that medical tourism generates could benefit health care throughout India. Instead, the medical tourism industry receives tax concessions. The government grants private facilities that treat foreign patients benefits such as lower import duties and increased depreciation rates (from 25 to 40 percent) for life-saving medical equipment, among other breaks. Valuable land is set aside for private hospitals, and at reduced rates. As I have argued elsewhere (Sengupta 2008), India’s medical tourism industry also receives a significant subsidy that few acknowledge: a pool of medical professionals. Most physicians train in public hospitals and then go on to work in private facilities, representing an indirect support for the private sector at an estimated $90 to $110 million annually (Sengupta and Nundy 2005). Thus, the com-
petitive edge that has enabled the medical tourism industry to move aggressively into the international market is actually paid for by Indian taxpayers, who receive nothing whatsoever in return.

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References


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**Medical Tourism in the Backcountry: Alternative Health and Healing in the Arkansas Ozarks**

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People traveling in search of effective health remedies have become commonplace throughout many communities in the rural Arkansas hill country. For patients unsatisfied with conventional medicine, the services provided by unorthodox practitioners in Arkansas mountain communities offer hope and promise where conventional therapies have failed. Medical tourism in rural Arkansas has promoted access to folk health systems, preserving them by incorporating them into tourists’ health care services, and also has attracted new forms of alternative medicine to the region and encouraged the transformation of some forms of traditional medicine. Ultimately, the blend of alternative, folk, and conventional medicine in the Arkansas highlands is evidence of globalizing forces at work in a regional culture. It also serves to highlight a renewed appreciation for the historic continuity and efficacy of traditional knowledge in the upper South.

To many eyes, a mythic sense of a bygone, simpler, moral, homogeneous, and untouched age appears to be preserved in the Ozarks (Blevins 2002; Ketchell 2007). Tourists travel there to experience, appreciate, and consume multiple aspects of otherness, including sacred sites and pristine

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