

ANALYSIS OF MEDICAL TOURISM POLICY: A CASE STUDY OF THAILAND, TURKEY AND INDIA

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ABSTRACT

Background: Medical tourism has gained popularity for the past 15 years and formulating the best medical tourism policy is challenging. This article performs a comparative analysis of health policies related to medical tourism in three developing countries which are India, Thailand and Turkey. Health policy triangle is used to better understand the policy studied and the potential implications of medical tourism policy to the aforementioned countries identified by the analysis are presented.

Materials and Methods: A scoping review was done related to medical tourism policies frameworks and their implications in India, Thailand, and Turkey. The primary search was conducted using public and journal search engines. Articles were screened for relevant titles and abstracts, followed by a detailed examination of the full texts, applying defined inclusion and exclusion criteria. Articles that fulfilled those criteria were used in this comparative analysis study.

Result: Based on the analysis, these countries formulated their policy plans to address their continuously growing medical tourism sector. In the formulation process, the actors aimed for the policies to exert influence at a local, national, regional or international level. In India, Thailand and Turkey, economic drive is one the major factors that have driven them to be actively promoting medical tourism industries. Each policy needs were forecasted and targets were defined in the process of formulating the health policies. The policies were then implemented accordingly. All the essential components of the health policy development process and the impact of the policies are discussed in depth in this article.

Conclusion: The medical tourism policy processes in Thailand, Turkey and India are well developed in terms of problem definition, policy formulation and implementation of policies. However, there is no appropriate platform to evaluate in order to identify the effectiveness and pitfalls throughout the stages of a health policy cycle. These policies have generated national incomes but not necessarily add value for local people whereby the return investment may not be invested to improve local healthcare system.

Keywords: Medical Tourism, Implications, Health Policy, India, Thailand, Turkey

1.0 Introduction

An effective health policy is essential to improve public health. Lee and Mills (1982) defined a health policy to be authoritative statements adopted by a government to improve the welfare and quality of life of a population. Formulating the right health policy is desirable by every organisation when considering the ultimate implications to the general public. This is particularly important in newly-developed areas such as medical tourism. Accurately defining the framework and providing the necessary support will ensure such areas can flourish and be beneficial to the general population. However, accurately deciding the best health policy is challenging. Hence, it is important that a health policy is examined using a structured framework to provide a systematic analysis. The framework used in this article is explained in the next section.

1.1 Health Policy Triangle.

The framework used in this article is the Health Policy Triangle as depicted in Figure 1. This framework analyses the content of a policy, the processes of policy making, actors of the policy maker and context of the policy.

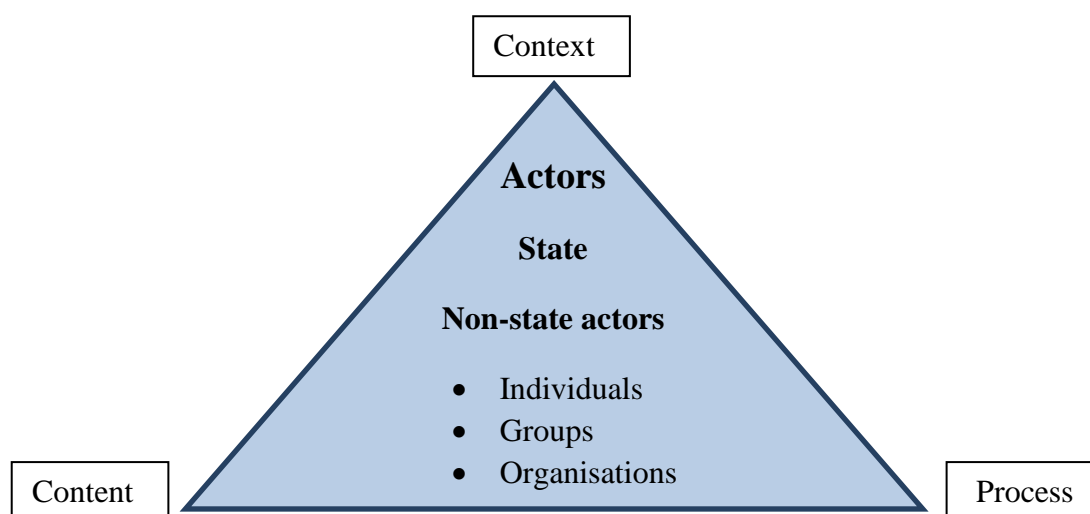


Figure 1: Health Policy Triangle

Based on the framework, the content of a health policy is the policy statement of the policy whilst the process is how the policy is formulated. Actors of the policy maker are placed at the centre of the framework. They can be denoted as an individual (such as a President) or organizations (such as a government) which are categorized as state actors. The framework also defines the role of the state, nationally, internationally and the groups that influence and interact with the public in forming the health policy (Buse, Mays, & Walt, 2005). The individual or organization can also be a non-government entity such as social groups, in which they are referred to as non-state actors. Finally, context in the framework refers to the

systemic factors that may have an impact on a health policy. The Health Policy Triangle allows policy makers from different countries with different economic and social background to systematically analyse areas that have been overlooked, for example due to politics, when a health policy is formulated (Buse et al., 2005). Therefore, by using this framework, we are able to identify key aspects to be considered in a health policy, providing a better understanding of the development of health policies in medical tourism.

1.2 Medical Tourism

According to Bookman & Bookman (2007), medical tourism is described as an economic activity involving the trading of services that merges at least two sectors which are medicine and tourism. Medical tourism has been on a substantial rise in popularity for the past 15 years in which people travel internationally for medical treatment. The activity has gained popularity in several countries with stable socioeconomic and political status that can provide high quality medical services at a competitive price. Changes in population dynamics such as a growing of number of ageing population and advancement of technology have caused the rise in demand for medical services beyond geographical boundaries for the betterment of quality of health. Since medical tourism involves interaction between commercialization, commodification and internationalization of health care, health policy in medical tourism can be affected by the adherence to the agreements signed and enforced by the governments. Internationally, the provision of medical services as trade which includes medical tourism is officially under the General Agreement on Trade in Services (GATS). Governments have the option to either be part of the GATS or practice outside the legal jurisdiction of the agreement. This agreement focuses on four modes of supply which are the cross border supply of services, consumption of services abroad, foreign direct investment and movement of health professionals (Carrera & Bridges, 2006). Regionally, the Association of Southeast Asian Nations (ASEAN) has developed the Framework on Agreement on Trade in Services (AFAS) in 1995 which provisions for flexible decree in services for non-GATS members (Pocock & Phua, 2011). The established agreements provide a platform for several developing countries to expand their services related to medical tourism to the international level for the benefit of economic development such as India, Thailand and Turkey.

1.3 Medical Tourism in Developing Countries

According to Clements Worldwide (2017), India, Thailand and Turkey are among the top five destinations for medical tourism. These countries are classified as developing countries by the International Monetary Fund (IMF) from the World Economic Report. The IMF uses a flexible system that evaluates three domains in determining the status of developing countries which are per capita income level, export diversification and degree of integration into the global financial system (International Monetary Fund, 2017).

Thailand, located in the heart of Southeast Asia's mainland, covers an area of 514,000 square kilometres (Royal Thai Embassy, 2018). Its population is approximately 63.9 million with an official national language of Thai. However, English is a mandatory subject in public schools

and is widely spoken in Thailand (Royal Thai Embassy, 2018). In comparison, India has a population of approximately 1.2 billion and its land covers 3.3 million square kilometres (Government of India, 2018). Geographically, India occupies a major portion of the south Asian subcontinent and is surrounded by the Bay of Bengal in the east, the Arabian Sea in the west and the Indian Ocean to the south (Government of India, 2018). Hindi is the official language in India but English is widely spoken among the citizen. Turkey is a transcontinental country in Eurasia. Turkey's Anatolia region is located in Western Asia whilst a smaller portion of its Balkan peninsula is located in Southeast Europe (International Model United Nations Association, 2018). The land area of Turkey covers 783,562 square kilometres whilst the first language of Turkey is Turkish. However, the younger Turkish generations are fluent in English language (International Model United Nations Association, 2018).

India, Thailand and Turkey are among the top five destinations for medical tourism. Turkey is well known for its strategic geographical location in which Turkey is part of Europe whilst India and Thailand are easy to access internationally. Besides that, English is widely spoken in all of the aforementioned countries which give them an advantage in trading services related to medical tourism. Hence, these three developing countries were chosen in this article for further analysis in medical tourism policy.

The aim of this article is to perform a comparative analysis of health policies in medical tourism in three developing countries which are India, Thailand and Turkey by using the Health Policy Triangle as a basis for a systematic analysis. This article also aims to analyse the potential impact of medical tourism policies to the countries.

2.0 Materials and Methods

A scoping review was done to search for articles related to medical tourism policy frameworks and their implications in India, Thailand, and Turkey. The primary search was conducted using public and journal search engines including science direct.com, PubMed and Google scholar. For searching, we placed exact phrases like "medical tourism", "health tourism", "wellness tourism", and "developing countries". Those phrases were combined by the Boolean operator "and".

A primary screening of the articles was done by reviewing the titles and abstract of the articles. Those articles with duplicated information or not focused on medical tourism policies in developing countries. A secondary screening was done by examining the full texts of the articles and identifying articles that meet the inclusion and exclusion criteria. The reports and articles later were selected based on top 3 developing countries popular destination for medical tourism with establish medical tourism policy which are Thailand , India and Turkey

As the inclusion and exclusions criteria, the date of publication of the journals, articles, reports and books were limited to only those published in the last 15 years when the electronic databases were searched. Besides that, only articles in English language with full texts were included. Articles that fulfilled those criteria were used in this comparative analysis study.

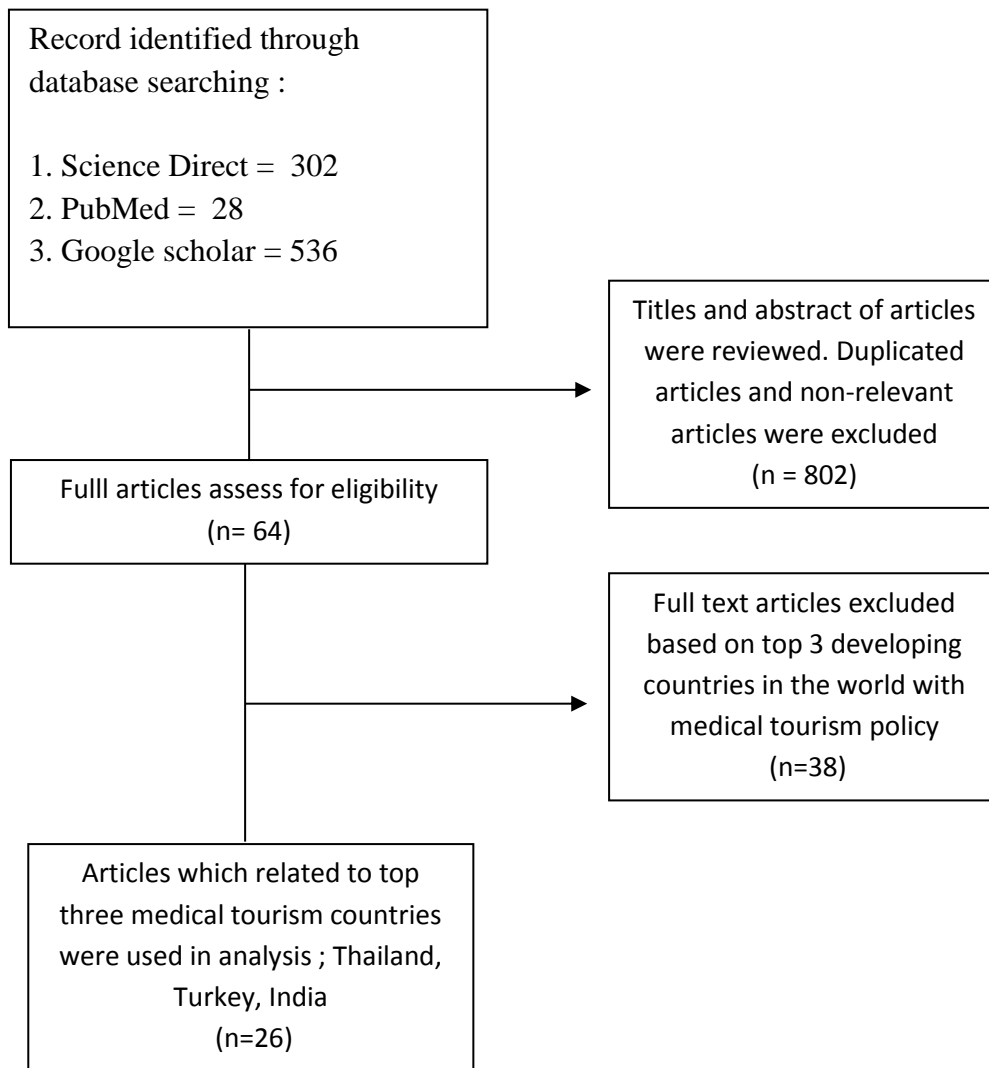


Figure 2.1 : Prisma Flow Diagram of systematic review for analysis of medical tourism policy.

3.0 Results and Discussion

From our literature review, we were able to compare the medical tourism policies of India, Thailand and Turkey using the Health Policy Triangle framework model that examines the policy contents, actors that are involved in policy making, context of the policies that drive the medical tourism policies, the process of policy making and the implications of the medical tourism policy of each country.

3.1 Policy Contents

The content of medical tourism health policies includes the constituent of its policy which is the related documents, laws and guidelines. This part of the policy framework also tries to look into the main motivation for the countries to trade their medical proficiencies, along with the implications of the medical tourism health policies (Lehmann, 2016). The mentioned developing countries all came up with policy plans for their continuously growing medical tourism. Thailand, a self-claimed world class health care provider, held their first five years transformation national strategic plan on medical tourism in 2003 (Pitakdumrongkit, 2017a). The government continued a second phase of the policy in 2012 which extended until 2018 to strengthen the global competitiveness of the kingdom's healthcare providers. The second strategic plan had a policy statement that stated their aim of "turning Thailand into a medical hub in four major areas: medical treatment, health promotion, traditional Thai medicine and alternative medicine, and health products" (Kamoltham & Sorprung, 2016).

The policy statement for Medical Tourism in Turkey is more or less similar to the strategies followed by the government of Thailand but has a longer time frame. Their medical tourism policy was stated as, "enhancing and applying promotional strategies in order to create a consistent, significant and attractive brand for Turkey at international level". Turkey has defined a strategic target to become a regional centre of attraction in the field of health in their Ministry of Health in Health Tourism Development Program for the period 2014-2018. The 2023 strategic plans also aim to position Turkey as the centre of health tourism by exploiting its geographical location: in the middle of Africa, Asia and the Middle East (OECD, 2016; Tunaligil, Cicek, & Resat Dabak, 2015).

However, in India, the medical tourism policy strategies are "to capitalize on the comparative cost advantage enjoyed by India's domestic health facilities in the secondary and tertiary sectors". The policy encourages the supply of services to patients of foreign origin to pay with their own currency. The interpretation of such services on payment in foreign exchange will be treated as 'deemed exports' and will be made eligible for all financial incentives extended to export earnings (Qadeer & Reddy, 2013).

The main purpose of medical tourism in Thailand is to establish a source of foreign currency earnings from foreign patients which brings financial benefits to the country (NaRanong & NaRanong, 2011). The revenue stream is used as a tool to propel Thailand's economic prosperity and development (Alberti, Giusti, Papa, & Pizzurno, 2014). Similarly, in Turkey, the aim is to enhance the quality of the tourism sector by spreading and developing tourism activities all year long and across all regions of the country by diversifying tourism types, particularly health tourism. (OECD, 2016a). The ideological underpinnings of the Indian State itself are reflected in the policy shifts towards commercialisation and growth of medical tourism that transforms health services into a source of trade, gross domestic profit, and foreign exchange (Qadeer & Reddy, 2013). India is one of the top medical hubs in Asia mostly because their price for treatments and procedures are 60-80% lower compared to developed countries for the same procedures, shorter waiting list and the fluency in English language of the medical staff. Additionally, their medical visa is easier to obtain compared to developed countries and can be extended for about a year after initial approval (Shetty, 2010). The main common purpose of health tourism of the three countries is for economic development, made possible by the generation of additional incomes. The countries support

growth in the medical tourism sector by making it affordable and more attractive by offering numerous types of services such as organ transplant, herbs, traditional medicine, and spa.

3.2 Actors Involved in Policy Making

Policy actors are those who prevent problems that are worthy of attention, who can shape and develop strategies and design policies in order to ensure their implementation. In many countries, the ministry of health is involved as the main stakeholder in policies that are related to health (Lehmann, 2016). Actors may try to influence the policy process at the local, national, regional or international level. Often, they become parts of networks, sometimes described as partners, to consult and decide on policy at all of these levels (Buse et al., 2005).

The governmental stakeholders for India, Thailand and Turkey are more or less the same: The Ministry of Health, the Ministry of Tourism, the Ministry of Finance, the Ministry of Foreign Affairs and the Ministry of Economy are some of the main common actors. The Ministry of Commerce in Thailand is the main ministry that gives the economic and financial report of the country whereas, in India, the National Accreditation Board for Hospitals is the additional governmental sector that makes every hospital involved in the health tourism (Qadeer & Reddy, 2013). Private hospitals are the non-governmental stakeholders in addition to other international non-governmental organizations. The strong involvement of the governmental ministries indicates that there is full support and ensure the success of the policy. For instance, the travel visa by the governmental sectors for the international travellers make it feasible for them to perform the journey.

The ministries involved in other sectors such as hotel and hospitality enterprises, travel agencies, trade service institutions, governmental authorities, tourist information centres, and representatives of civil societies are also important parts of this policy process which can directly or indirectly have an enormous effect on health tourism in these three countries. These stakeholders are additional support for the full success of the medical tourism policies.

3.3 Context of Policy

In the late 1960s and early 1970s, healthcare accessibility is a government responsibility as stated in the Declaration of Alma Ata 1978 (Benavides, 2002). Besides that, healthcare services was still not seen as a profitable market although international trade already existed (Benavides, 2002). However, an increasing need for healthcare services especially in developed countries have lead healthcare consumers to seek treatment overseas (Pocock & Phua, 2011). Furthermore, factors such as rising healthcare costs, demographic changes, epidemiological transition and a long waiting list for surgeries at their home country also contribute toward health seeking behaviour at the other countries. Moreover, the availability of cheaper alternative treatment in other countries especially developing countries also becomes a catalyst for consumers to seek treatment abroad (Pocock & Phua, 2011). Many factors can drive a country to adopt a medical tourism policy such as politic, economy, environmental and also availability of facilities.

For India, Thailand and Turkey, economic drive is one the major factors that drive them to be involved in medical tourism industries. Thailand was involved in medical tourism extensively after the Asian Financial crisis in 1997-1998. Prior to this event, Thailand's private medical

facilities have grown to serve an increasing demand from local consumers. This financial crisis brought an economic crisis and caused the country's private health sector to lose their local customers (Pitakdumrongkit, 2017b). Besides that, the 9/11 terrorist attack that took place in New York, America also stirred Thailand's medical tourism industry as America and other western countries began to tighten their entrance security and imposed entry restrictions to visitors from Middle East countries. This caused Asian countries to become their new alternative place to seek treatment including Thailand (Pitakdumrongkit, 2017b).

Turkey has a long history in healthcare. Historically and geographically, Turkey has been the region's health centre since ancient times as it is located at the meeting point between West and East Culture (Book, 2014). Turkey is ranked 8th worldwide by tourist inflow and 9th by tourist income. Furthermore, Turkey has ranked among the "World best 10 countries for foreign countries" (Book, 2014). This advantage has driven Turkey to embark in medical tourism industries aggressively in 2010 (Tunaligil et al., 2015). According to TURSAB, Turkey's total health tourism income in 2013 was \$2.5 billion and they target to attract 2 million international patients and earn \$20-25 billion by 2023 in health tourism (Tunaligil et al., 2015).

India is the second largest country in the world, hosting 17% of the world population. Their healthcare sector is considered one of the largest in terms of both revenue and workforce employment in South Asia (Kumar Gupta, Rajachar, & Prabha, 2015). Besides that, India's rich cultural heritage, diversity of tourism destinations, presence of world class hospitals, large number of skilled health professionals of international reputation and patronage of age old therapies have made India as a preferred destination for medical tourism (Kumar Gupta et al., 2015). Recognizing their advantages in this arena and its potential in boosting their economic development, their current government gave special exemptions to attract foreign direct investment (FDI) to invest in this country. By minimizing the bureaucratic hurdles and granting exception to certain rules, all the players in the healthcare industries were able to become competitive in this industry (Bhaidkar & Goswami, 2017). Moreover, states in India itself noticeably changed their policy to promote commercialisation and growth of health tourism which converted healthcare services into a form of trade, providing gross domestic profit and foreign exchange (Qadeer & Reddy, 2013).

Medical tourism is expected to continue to grow in the upcoming years and generate more income to those countries that are involved in the industry. Although it is a profitable industry, not all countries are involved in medical tourism. Many factors must be taken into account such as human resources, skilful health professionals and advancement in health facilities. For India and Turkey, they are popular destinations for tourism and this makes them as a destination for holidays as well as for seeking treatments. Providing an additional economic activity to conventional tourism can increase their annual income multiple times. As for Thailand, progressing towards a medical tourism country is an excellent move to prevent their private healthcare sector from collapsing. Taking advantage from the events that occurred in America, Thailand was able to stay among the top medical tourism countries with high quality service, modern and advanced equipment, synergistic strategic partners and with reasonable cost of treatment.

3.4 *Process of Policy Making*

In the process of formulating a health policy, each policy need is forecasted and targets are defined. In Thailand, the medical tourism sector was grown to help the unthriving private sector where domestic private patients were shifting to the publicly funded system. In this case, a rising number of foreign patients was more or less a net benefit to the private health system, generating significant income to the system with little real opportunity cost (Lunt et al., 2011). Meanwhile, both Turkey and India have a huge potential as medical tourism centers as their quality of health services are at an affordable cost, provided by many internationally accredited hospitals which has an effect of lifting their economies (Bhaidkar & Goswami, 2017; Yilmaz & Erdogan, 2012). With Turkey's geographical location of east meets west, almost 300,000 international patients are treated in Turkish hospitals annually. Turkey's Ministry of Health (MOH) has started to keep the records of health-care services provided to foreign patients on a regular basis (Yilmaz & Erdogan, 2012). In India, an astounding majority (90%) of physicians in the private tertiary sector and 74.3 per cent in the public tertiary sector provide a colossal scope for medical tourism in the private tertiary sector (Bhaidkar & Goswami, 2017). In relation to medical services, Thailand and India specialise in orthopaedic and cardiac surgery, whereas Eastern European countries are hotspots for dental surgery (Lunt et al., 2011).

In Thailand, a policy change in medical tourism was tabbed as one of the agenda of the National Health Assembly in 2010. Resolution on 'Medical Hub Policy' was adopted by the National Health Assembly on 17 December 2010. The resolution was endorsed by the Thai Cabinet on 12 April 2011 (Dedmon, 2009). Policy formulation in Turkey commenced through the country's Health Transformation Program. Medical tourism was generally involved in the 10th development plan of Turkey. It was deliberated as one of the imperative objectives in the strategic action plan 2013-2017 of MOH. In India, the formulation drew from recommendations to the corporate sector specifically from the "Policy Framework for Reforms in Health Care", drafted by the prime minister's Advisory Council on Trade and Industry (Venkata & Prasad, 2011). Generally all three nations have similar concepts where the agenda item is translated into authoritative decision.

In terms of the implementation of medical tourism policies, governments of medical tourism destinations such as India and Thailand give attention to medical tourism and they established national medical tourism agencies to support medical tourism. On the other hand, Turkey is one of the countries supporting medical tourism industry by governmental regulations and incentives (Yilmaz & Erdogan, 2012). There is a range of ways that a national policy can directly foster the domestic medical tourism industry which includes supporting trade fairs: many of which include government support (through tourism, airlines or health) (Lunt et al., 2011). Meanwhile, besides the introduction of medical visa, 'M' and 'MX' categories which led to a rise in the number of medical tourists to India from 56,129 in 2013 to 134,344 by 2015 and incentives and tax rebates to numerous healthcare and pharmaceutical companies involved in promoting medical tourism in India, individual states have made diversified efforts. The state of Karnataka is in the process of setting up Bangalore as a healthcare city called the Bangalore International Health City. The state government of Maharashtra has put up efforts to introduce Medical Tourism Council of Maharashtra (MTCM) and the government of Gujrat has introduced a policy to promote medical tourism with an aim to generate an integrated medical tourism package based on the location of the hospital, local

culture and its heritage. Medical Tourism in Kerala grew without any efforts because of its popular Ayurveda therapies. Primary hospitals in Kerala have joined hands with the government to promote Medical Tourism in the state (Bhaidkar & Goswami, 2017). Similarly in Thailand, the new visa categories were set up for medical travellers and foreign retirees, who were understood as consumers of medical care. In 1999, the Tourism Authority of Thailand (TAT) started supporting medical tourism through its 15 offices abroad. Government-sponsored promotional campaigns whereby prominent among them, the 'Amazing Thailand' campaign, highlighted "the attractions of spas, hospitals and herbal products" (Alberti et al., 2014).

However, both research and evaluation have not kept pace with the development of medical tourism and there is a need for national governments and potentially international bodies (e.g. EU, OECD, WHO) to invest in research in this area (Lunt et al., 2011).

3.5 Implication of Health Medical Tourism Policy

The economic prospect drives these countries to develop their own policies that are related to the medical tourism services. The implications of having a structured medical tourism policy can also be discussed in terms of the governance of policy making, the regulation on providers, the delivery of services and human resources distribution, and health financing.

3.5.1 Economic benefits

Most developing countries value medical tourism as a prospect to generate more national income and hence support it strongly (NaRanong & NaRanong, 2011). The same implies to the three countries studied; India, Thailand and Turkey. For Thailand, the value added from medical tourism was projected to be between USD 1.96 to 3.67 billion in 2012 (NaRanong & NaRanong, 2011). In comparison, Turkey, due to its geographical advantage, generated USD 2.5 billion in 2013 in total health tourism income (Market, Innovation, & Viewpoint, 2016). In their Vision 2023 policy, Turkey targets to attract 2 million international patients and earn USD 20-25 billion, just from health tourism (Market et al., 2016). In India, one of the well-recognized medical tourism hubs, the medical tourism market was estimated to be USD 333 million in 2004 and it is predicted to become a USD 2 billion a year business opportunity in 2012 (Hazarika, 2010). The Indian healthcare industry is growing at a rapid pace and is expected to become a USD 280 billion industry by 2020 (Mishra & Shailesh, 2012).

3.5.2 Governance and policy making at international, regional and national level

As discussed earlier, medical tourism service involves interaction between commercialization, commodification and internationalization of health care. Therefore a health policy in medical tourism can be affected by the adherence to the agreements signed by the governments. Internationally, the provision of medical services as is officially under the General Agreement on Trade in Services (GATS). Governments have the option to either be part of the GATS or practice outside the legal jurisdiction of the agreement. India, Thailand and Turkey had become the member of GATS since 1995 (World Trade Organization [WTO], 2018). Regionally, Thailand have joined the Framework on Agreement on Trade in Services (AFAS)

for provisions for flexible decree in services (Pocock & Phua, 2011). In addition, Turkey had signed the Health Cooperation Agreements with 53 countries in 2014 (Book, 2014). In these agreements they agree to exchange healthcare staff and experts, exchange of information and experience in all matters concerning health, and technology with many countries, foremost being Sudan, Yemen, Afghanistan, Palestine, Balkan countries, Central Asian and Caucasian countries (Book, 2014). As a consequence, these three countries are able to properly provide medical tourism services at an international level.

The governance of policymaking involves quite a number of ministries in the countries as the governmental stakeholders for medical tourism in Thailand, India and Turkey are more or less the same: the Ministry of Health, Ministry of Tourism, Ministry of Finance, Ministry of Foreign Affairs and Ministry of Economy are some of the main actors. Take Turkey as example, multi-ministries initiatives were carried out, such as the Ministry of Foreign Affairs signed agreements for the abolition of visas with many countries, the Ministry of Finance has adopted several incentives like tax allowance, the Ministry of Economy supported market entry in terms of reducing the flight costs of medical tourists up to 50% (Yilmaz & Erdogan, 2012).

Such active policymaking will definitely encourage the cooperation and participation of other stakeholders which will give their input for better medical tourism services. These stakeholders include private hospitals, hotels and hospitality enterprises, travel agencies, trade service institutions, governmental authorities, tourist information centers, representatives of civil societies and many more.

3.5.3 Regulation of services providers

As the services become more globally recognized, India, Thailand and Turkey have set several regulations and standards for both public and private service providers in terms of safety and quality controls. For this purpose, the Joint Commission International (JCI) conducts the accreditation process of public and private health organizations from different countries. JCI accredited approximately 550 healthcare organizations in 52 countries (Yilmaz & Erdogan, 2012). Accreditation has great importance in the selection of medical tourism organization and country. This is because by increasing the number of internationally accredited organizations, the negative image associated with developing countries that is a barrier to growth in medical tourism can be solved (Yilmaz & Erdogan, 2012). In India, there are 20 organizations accredited by JCI, while there are 53 and 49 accredited organizations in Thailand and Turkey respectively (Market, Innovation, & Viewpoint, 2016).

3.5.4 Delivery of services – private sector growth & Human resource distribution

However, despite the positive economic implications, without proper management, medical tourism can become a heavy liability for the healthcare systems of these countries. As medical tourism is predominantly provided by the private health sector, and as promises of more

income and incentives are given to health personnels, this leads to the ‘brain drain’ from the public health sector. In Thailand, this aggravated the shortage of manpower in the public health sector and thus affected the healthcare quality to the local people. Since private hospitals for medical tourists have attracted many highly skilled physicians and specialists from public hospitals, the majority of Thais will likely receive health-care services of lesser quality compared to their private counterparts. To counter this effect, in 2008, the Ministry of Public Health drastically improved its compensation scheme by practically doubling physicians’ dentists,’ pharmacists’ and nurses’ total pay in all community hospitals (NaRanong & NaRanong, 2011). In Turkey, the same situation happened and this adversely affected the local population, who have low purchasing power. Similarly in India, the disproportionate of public-private healthcare services is even more pronounced. While the public sector is burdened with inadequate manpower, it has been estimated that over 75% of the human resources and advanced medical technology, 68% of the estimated 15,097 hospitals and 37% of 623,819 total beds in the country are in the private sector (Hazarika, 2010). Further growth in medical tourism could worsen the internal ‘brain drain’ that is already happening in India (Hazarika, 2010).

The potential for earning revenue through medical tourism to a country could become a key argument for these private hospitals to demand more subsidies from the government in the long term. This could potentially lead to usage of public funds and subsidies, thus diverting resources and further worsen public sector health services. This may cause ‘cream skinning’, whereby those who need less but can pay more are served at the expense of the poor and more deserving (Hazarika, 2010).

3.5.5 Financing – more out of pocket expenditure

As with any emerging sector, medical tourism has a number of negative aspects. For example, in most cases, national health services and many medical insurance companies are reluctant to compensate citizens/clients for medical procedures performed abroad, meaning that patients must pay out of their own pockets. For example in Thailand, in 2008, medical tourists have contributed 71.1% of private health expenditure (Pocock & Phua, 2011) while in Turkey, treatments implemented in medical tourism destinations are usually beyond the healthcare coverage and medical tourist have to pay out of their pocket (Yilmaz & Erdogan, 2012).

It can be argued that for these countries, if the revenue earned from medical tourism doesn’t added value for local people, medical tourism couldn’t be beneficial and achieve its objective. Therefore, medical tourism shouldn’t be reason for disregarding local people of the destination countries. The providers should put efforts to establish or strengthen the mechanisms that can promote partnerships between the public and private sectors. It is vital to establish these partnerships, since this could potentially help boost the financial capacity of the public health sector, improve the overall availability and quality of services for the public at large, and lessen the gap in standards and working conditions between the two sectors.

4.0 Conclusion

The analysis of medical tourism policies of India, Thailand and Turkey, showed that medical tourism policy processes are well developed in terms of problem definition, policy formulation and implementation of policies. However, there is no appropriate platform to evaluate the development and implementation of medical tourism to identify the effectiveness and pitfalls of the policies relevant to medical tourism which is essential for improvement throughout the stages of a health policy cycle. Furthermore, these policies have generated national incomes but not necessarily add value for local people whereby the return investment may not be invested to improve local healthcare system.

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Declaration

Authors declare that there is no conflict of interests. This manuscript has never been published in any other journal or duplicated in any mean concerned.

Authors contribution

Author 1: Information gathering, preparation and editing of manuscript

Author 2: Information gathering, preparation and editing of manuscript

Author 3: Information gathering, preparation and editing of manuscript

Author 4: Information gathering, preparation and editing of manuscript

Author 5: Information gathering, preparation and editing of manuscript

Author 6: Review and editing final manuscript

Author 7: Initiation of idea, review and editing final manuscript

References

- Alberti, F. G., Giusti, J. D., Papa, F., & Pizzurno, E. (2014). Competitiveness policies for medical tourism clusters: government initiatives in Thailand. *International Journal of Economic Policy in Emerging Economies*, 7(3), 281.
- Benavides, D. D. (2002). Trade policies and export of health services : a development perspective. *Trade in Health Services: Global, Regional, and Country Perspectives*.
- Bhaidkar, A., & Goswami, A. (2017). Medical tourism in India and the Health policy of the NDA government: An overview. *A Peer Reviewed Research Journal*, XXII(1), 122.
- Book, P. (2014). *Turkey Health Tourism Pocket Book*, (Md).
- Bookman, M. Z., & Bookman, K. R. (2007). *Medical Tourism in Developing Countries*.
- Buse, K., Mays, N., & Walt, G. (2005). *Making Health Policy*.
- Carrera, P. M., & Bridges, J. F. (2006). Globalization and healthcare: understanding health and medical tourism. *Expert Review of Pharmacoeconomics & Outcomes Research*, 6(4), 447–454.
- Clements Worldwide. (2017). *Top 5 Countries for Medical Tourism*.
- Dedmon, R. E. (2009). The future of primary care in Thailand in the context of a global financial crisis. *Asian Biomedicine*, 3(4), 345–350.
- Government of India. (2018). About us | National Portal of India.
- Hazarika, I. (2010). Medical tourism: Its potential impact on the health workforce and health systems in India. *Health Policy and Planning*, 25(3), 248–251.
- International Model United Nations Association. (2018). Turkey MUN Country Profile | IMUNA.
- International Monetary Fund. (2017). *World Economic Outlook*.
- Kamoltham, T. & Sornrung W. (2016). Study on the development of international Herbal Hub of Thailand with Good Governance.. *The IIER International Conference, Saint Petersburg, Russia*, (September), 38–43.
- Kumar Gupta, M., Rajachar, V., & Prabha, C. (2015). Medical tourism : A new growth factor for Indian healthcare industry. *International Journal of Research in Medical Sciences International Journal of Research in Medical Sciences Gupta MK et Al . Int J Res Med Sci*, 3(9), 2161–2163.
- Lehmann, U. (2016). Understanding and Analysing Health Policy. *Schooll of Publci Health University Fo Western Cape*, 110.
- Lunt, N., Smith, R., Exworthy, M., Green, S. T., Horsfall, D., & Mannion, R. (2011). Medical Tourism: Treatments, Markets and Health System Implications: A scoping review.

- Market, M. T., Innovation, F. R., & Viewpoint, G. (2016). www.econstor.eu.
- Mishra, R., & Shailesh, K. (2012). Making Indian Healthcare Market a Global Medical Tourism Destination. *IOSR Journal of Business and Management*, 2(4), 23–28.
- NaRanong, A., & NaRanong, V. (2011). The effects of medical tourism: Thailand's experience. *Bulletin of the World Health Organization*, 89(5), 336–344.
- OECD. (2016a). Tourism in the economy: Turkey. *OECD Tourism Trends and Policies*, 218–223.
- OECD. (2016b). Turkey. *OECD Tourism Trends and Policies 2016*, 218–223.
- Pitakdumrongkit, K. (2017a). Participatory Policymaking, The Crafting of Thailand's Medical Hub Policy *Policy Report*, (March).
- Pitakdumrongkit, K. (2017b). The crafting of thailand's medical hub policy, (March).
- Pocock, N. S., & Phua, K. H. (2011). Medical tourism and policy implications for health systems: A conceptual framework from a comparative study of Thailand, Singapore and Malaysia. *Globalization and Health*, 7(table 2), 1–12.
- Qadeer, I., & Reddy, S. (2013). Medical tourism in India: perceptions of physicians in tertiary care hospitals. *Philosophy, Ethics, and Humanities in Medicine : PEHM*, 8, 20.
- Royal Thai Embassy. (2018). Country Profile | Royal Thai Embassy.
- Shetty, P. (2010). Medical tourism booms in India, but at what cost? *The Lancet*, 376(9742), 671–672.
- Tunaligil, V., Cicek, Y., & Resat Dabak, M. (2015). Medical Tourism on The Rise in Istanbul. Investing in Regional Development: Role of Local Government in Health Tourism, (341).
- Venkata, C. B., & Prasad, K. (2001). Medical Tourism Industry -Advantage India.
- Yilmaz, E., & Erdogan, S. (2012). Medical Tourism : An Assessment on Turkey