Rajagiri Journal of Social Development
Volume 6, Number 2, December 2014

Medical Tourism and Medical Tourists: A Conceptual Analysis

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Abstract

Medical tourism based on transnational journeys for healthcare, cure and well-being is widely discussed in the literature. As an upcoming and fast developing phenomenon there are different views and perspectives on the concerns of medical tourists. This paper discusses the significance of medical tourism in the present global scenario and examines the practical difficulties faced by medical tourists from information search to after care. The concerns of the medical tourists such as the need for accreditation, patient risks, malpractices and legal issues, and after care issues are examined here in detail. This article establishes that the medical visa and medical attendant visa concerns are important in policy formulation in this area. The concerns discussed in this paper need to be addressed if it needs to be sustained in any economy.

Keywords

medical tourism, aftercare, India

Introduction

Media, practitioners, researchers and healthcare industry are optimistically viewing the new niche, medical tourism (MT). It has been noted that for the past few years, people seeking healthcare are inclined to travel from the advanced countries to developing countries such as India, Mexico and Thailand. It is a paradigm shift from the earlier pattern of medically motivated travel. This new trend has been referred to as MT which is emerging as a unique and readily identifiable form of tourism. According to Solomon (2011), MT is a boon for the desperate and needy who suffer from serious ailments and hindering situations. Medical tourists (MTs) travel mainly for cheaper and quicker treatment options which are equal to or better than that of their home country / destination (Horowitz and Rosensweig, 2007; MacReady, 2007). The main motivations for MT can be classified as better quality care, quicker access, cheaper cost, qualified doctors and staff and tourism options. However, the subsequent medical tourism survey (2013) found out that 80 per cent of the demand for MT is aroused solely by the cost effective factor.

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MT has grown on a greater pace and has become an important segment of the health care industry and is promoted by the stakeholders with its competitive advantages. All over the world, MT has found new niche and has become a prominent portfolio for many in the tourism industry and other related sectors directly and indirectly. It is more of a business opportunity for the stakeholders than ever before and so they seek to cash in on every available opportunity. MT includes primary, secondary and tertiary care and may include surgeries, transplants, health check-ups, psychiatry, fertility evaluations, curing lifestyle diseases and dental care.

Medical Tourism: Present Scenario

MT attains national industry status in more than 50 countries (Gahlinger, 2008). The average contribution of MT is accounted as $45-95 billion to global Gross Domestic Product for six million patients (Medical Tourism Survey, 2013). The Medical Tourism Survey (2013) has found out that the prominent areas of MT are Latin America and Asia. The highly popular in demand and favuored destinations are India and Mexico. In 2006, out of 10 million tourists in Singapore, 410,000 (4%) were medical tourists and 89,000 were their accomplice (Voigt et al., 2010). The highest sought procedure is cosmetic treatments having 38 per cent of the total market. Average spending of a medical tourist is higher than that of a leisure tourist (Bennet et al., 2004) which is between $7,475 and $15,833 per medical travel trip (Medical Tourism Survey, 2013). World Travel and Tourism Council (2011) accounted the average spending of a medical tourist is US$12,000 while a leisure tourist spends only US$6,383 which means a medical tourist spends approximately twice as much money in the chosen country of its destination. Viewing this financial aspect, both the governments and stakeholders are increasingly interested in MT activity with policies, corporate tertiary care multi-specialty hospitals, MT networks and collaborations, and insurance portability concerns. Though there is a vacuum in the collection and dissemination of statistical information of MTs' volume, the UK provides some statistics which help to assume that the phenomenon is growing faster. The outbound MTs in UK estimated as 63,000 in 2010 while inbound MTs are 52,000 (Lunt et al., 2014) and outbound travel has been increasing tremendously for the past few years.

Medical Tourist's Muddles

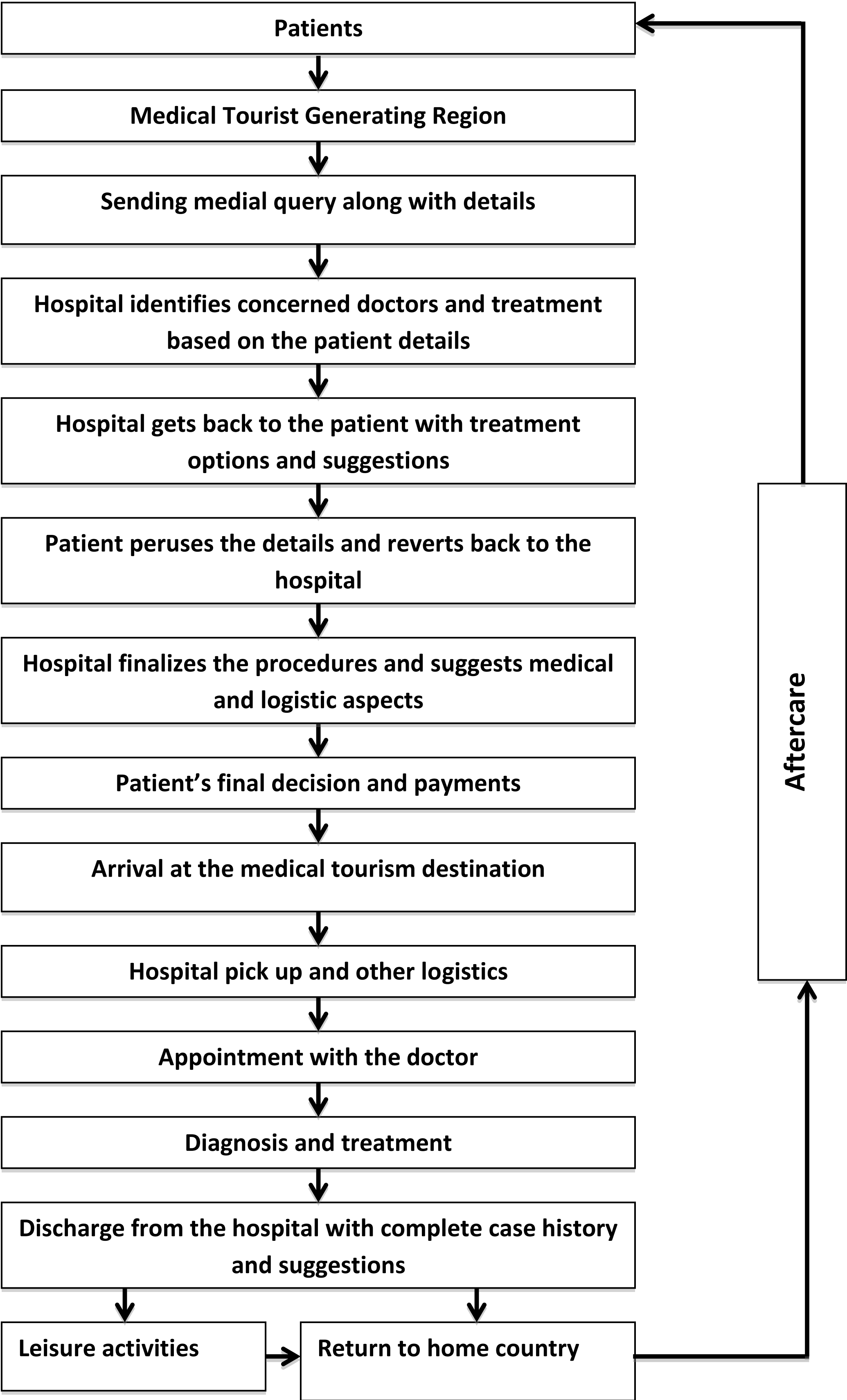
Now along with its fast development phase, the industry witnesses many arguments favouring and criticizing Medical Tourism (MT). Many are mere speculations based on little evidence and some are serious issues which must be debated but often ignored. The available literature on MT falls into both categories, yet these issues remain as it is because of the peculiar nature of this phenomenon. MT system itself is a bit muddled due to conceptual flaws and disintegrated activities. There are many challenges faced by the MTs themselves and many impacts directly or indirectly affecting the economic and social aspects of the country chosen as its destination.

Availability of Reliable Information and Treatment Concerns

There is a course of action for MT process, which starts from the tourist-generating region and ends at the destination region. The process is initiated by the search for information for a suitable treatment resort as shown in Figure 1. The current source of information for treatment options overseas is by word of mouth, referrals of doctors and most importantly websites. Being a bi-product of globalization and IT enabled industry; information on MT is mainly available

through websites. Current Google search for ‘medical tourism’ (as on 5 December 2014) gives 36,500,000 results. It is absolutely based on this information on which the decision for it and where to go for medical treatment is being made.

Figure 1: International Patient's Service Cycle



As MT is a highly profitable business activity, the websites are designed to impress like any other type of promotion. It is absolutely illogical to perceive that all patients have enough expertise to navigate and access the required information and then evaluate the quality and suitability and quite often are confused with the language and health systems which are not similar to theirs (Legido-Quigley et al., 2008). To make the appeal favourable to the patients, the websites will give guarantee for their services and competencies of healthcare which are not reliable as it is not regulated (Lunt et al., 2012) and are purely a marketing venture. Many research results show that the patients rely mostly on this information and are prone to be dissatisfied by some factor or the other as the entire system of MT is highly risky and consists of many interconnected components.

Many websites are functioning as 'ghost agencies. ' Sometimes the search for 'contact us' on the website ends up in chaos. Many Medical Travel Facilitators (MTFs) are working without an office and it has become a mere business just like real estate or any other commercialized activity. Very often there is only one contact number and if it vanishes the condition of MTs will be a distaster.

A research conducted by Turner (2011) found out that a total of 25 medical tourism companies that were based in Canada are now defunct. Given that an estimated 18 MT companies and 7 regional, cross-border (MTFs) now operate in Canada, it appears that approximately half of all identifiable MT companies in Canada are no longer in business. Penney et al. (2011) studied 17 websites and found that Canadian MT broker websites varied widely in scope, content, professionalism and depth of information. Third party accreditation bodies of debatable regulatory value were regularly mentioned on the reviewed websites, and discussion of surgical risk was absent on 47 per cent of the websites reviewed, with limited discussion of risk on the remaining ones (Penney et al., 2011). Terminology describing brokers' roles was somewhat inconsistent across the websites (Penney et al., 2011). Mainly, brokers' roles in follow up care, their prices, and the speed for surgery were the most commonly included business dimensions on these reviewed websites (Penney et al., 2011).

Accreditation System

As there is no standard cost and quality for treatment, the only means for its reliability and authenticity is its international accreditation. Though it does not seem to be an important parameter for the developing nations, accreditation like JCI (Joint Commission International), QHA (Quality Healthcare Advice) has a direct influence on the decision making process of people from the advanced countries like the US and Canada. To them, due to the intangible characteristics, the slogans or promotional material has no value for them if it is not accredited. Due to the intangible nature of the MT product, accreditation is the one and only factor which gives them an assurance on the physical and mental risk that may come across. This makes the comparison and assessment easier for the common patient with regard i to safety and quality and puts them at par with the advanced countries. It is perhaps absolutely true in the case of cosmetic, ophthalmic, dental and other less risky treatments, which are practised by doctors even without much expertise and qualification, and they may not disclose the potential problems that the patient may come across eventually.

On the contrary, Bies and Zacharia (2007) challenged that there are chances for errors even in accredited hospitals due to the heterogeneity in training and experiences of doctors. Sengupta (2011) observed that accreditation programmes will pave the way for a two-tier medical system where the private sector will have more interest as they have abundant resources and will target

the elite and foreign tourists. However, accreditation is the only one mechanism to ensure the quality of care in a totally unregulated global environment.

Medical Tourism and Patient Risks

MT is highly risky and vulnerable as it handles the life of those who are in a dilemma and extremely anxious especially due to the sudden overseas travel, unfamiliar environment and chronic conditions. Normally they will be confused with regard to the risk factors, complications that may arise even though the cost information is the only aspect provided with. Authors like Crooks et al. (2010), Riezman (2010) and Priya (2010) classified the MT risks into three types as patients' risk, travel risk and pre- and post- operative care risk. Long distance travel after the procedures is often prone to lung diseases and thrombosis and unattended leisure activities after surgery will have serious fatal repercussions like pulmonary embolism or blood clots (Steven, 2010). Comparatively less risky procedures such as cosmetic surgeries may have serious adverse effects due to the exposure of direct sunlight and environmental pollution. Cosmetic and dental procedures may also be problematic if it is not done properly and then the patients will eventually be forced to meet the doctors at the home country there by spending extra money (Turner, 2008). There may be unwillingness by the doctor at home to 'take over the case' (Riesman, 2010) and it will be worse if the case history and documentations are not clear and complete and this creates both an economic and an ethical burden on the physicians of their home countries, even to an extreme degree when some of the home country patients are fatally deprived of an organ transplant and the donor organ goes instead to a returning "transplant tourist." At times due to an emergency the need arises for a second transplant surgery (Steven, 2010). Riezman (2010) also discussed other diseases one might contract due to the unfamiliar food, air or water of the other countries. Outward-bound UK MTs are subsequently being treated by the National Health Service (NHS) for complications arising from poor care provided overseas (Birch et al., 2007; Jeevan and Armstrong, 2008). Furthermore, the out break of contagious diseases in the destination countries will be life threatening for tourists and is more aggressive for MTs in their post treatment period. Patients usually have no idea about the potential chance for infectious and non- infectious complications from MT, the trade-off between saving money on medical expenses and obtaining potentially life-prolonging medical care that the patient could otherwise not afford, and sacrificing potential legal remedies should medical negligence occur (Steven, 2010).

An observational study conducted from 2007 to 2009 on patients presenting complications of cosmetic tourism surgery to a tertiary referral plastic surgery practice identified 19 patients where operations performed in Europe or Asia (primarily breast augmentation procedures), 11 patients were reported to have received NHS treatment, at a cost of £120,841 (Miyagi et al., 2011). Similarly, Turner (2012) provided brief descriptions of 26 reported cases of mortality in individuals who travelled abroad and underwent cosmetic surgery or bariatric surgery at international medical facilities from 1993 to 2011. Of the 26 reported deaths 25 of the individuals were women. Eleven individuals died after receiving health care in Mexico, four died after receiving care in the Dominican Republic, two died after undergoing surgery in Hungary, and single deaths were reported to have occurred in Brazil, Colombia, Cyprus, India, Malaysia, Panama, Spain, the United Arab Emirates (Dubai), and the US. Identified surgical interventions included 13 liposuction procedures, four tummy tucks, three breast implants / breast lifts, three breast reductions, two face lifts, two injections of fat into buttocks or calves, two lap bands, one gastric bypass, one gastric reduction duodenal switch, one vaginal surgery

with the specific type of procedure unspecified, one facial surgery with the specific type of surgery unstated, one plastic surgery with the specific procedure unspecified, and one patient reported as having surgery done to her nose, chin, lips, and eyelids. Krishnan et al. (2010) observed that Indo-Asian patients with diagnosed renal failure seeking transplant abroad via commercial kidney transplants have poor clinical outcomes compared to the comparator groups of local transplantations (including high rates of infection and with over 30 per cent of cases resulting in patient death or graft loss). For the growing phenomenon of 'fertility tourism', a UK-based 11-year follow-up study of high order multiple pregnancy found that 26 per cent of mothers had their fertility treatment performed overseas (McKelvey et al., 2009). These complications present difficult issues that remain unresolved and merit further investigation and discussion to better establish the true economic benefit of MT for patients (MacReady, 2007).

Some patients expressed regret that their isolation in hospital rooms meant that there was little opportunity for them to critically assess everyday life and illness outside the hospitals' walls (Solomon, 2011). The relationship between tourist leisure and therapy was not without conflicts, for example, Spa doctors frequently mistrusted the commercial propensities of proprietors and doubted their commitment to medicalized therapy. They complained bitterly about the heavy meals frequently served in expensive spa hotels. Above all, they feared becoming mere tourist sites (Weisz, 2011). There is little comparable information with regard to the quality and safety of care provided by many of the destinations visited by UK MTs (Lunt et al., 2012). There is a need to address both the management of post-operative complications occurring after a patient leaves a foreign medical facility, and also the resulting financial costs associated with such care (MacReady, 2007).

Malpractices and Legal Issues

MT has become a complex phenomenon by its nature itself and there are chances that clinical errors and malpractices will be aggravated in an unregulated environment. There are many evidences of errors and mistakes occurring bat the hands of the healthcare people in advanced countries (Hurwitz and Sheikh, 2009). According to Riezman (2010), about 90,000 patients have died primarily due to the medical negligence and errors. Ben-Natan et al. (2009) pointed out that safety and appropriateness of treatment is a real problem for MT. However, there are many obstructions which make the foreign patients reluctant to complain against these issues in another country. Sometimes, it is maimly due to the weak legislation especially in developing countries which keep them away from litigation and eventually this makes the situation a real muddle where they cannot sue or succeeding in suing the culprits. Steven (2010) called attention to cases of surgical negligence without any exisiting meaningful legal recourse and the usage of medical devices which are not on par with the US. The FDA (Food and Drug Administration) or equal standards for safety are not available and it is worse when I these deficiencies are not informed to the patient. Currently, there are no reliable, or comprehensive sources for patients to learn about what legal recourse to take for malpractice committed in [foreign] jurisdictions (Steven, 2010). According to World Health Organization, the data collected in 2006 from 132 countries demonstrated that 31 countries (or 23.5%) have less than 100 per cent screening for at least one of the four common infection markers: HIV (Human Immunodeficiency Virus), HBV (Hepatitis B Virus), HCV (Hepatitis C Virus) and syphilis and many countries cannot provide complete information related to the screening process; even with testing of blood products, the testing process may often be incomplete or lack a quality assurance mechanism (Steven, 2010). Thus, patients risk becoming sicker through their travel to another

country, rather than gaining an improved state of health (Ben-Natan et al., 2009). Patients may be offered procedures and techniques in foreign countries that are illegal for the patients in their home countries (e. g., abortion and euthanasia) or illegal both in their home countries and the destination countries as well (Steven, 2010).

If something goes wrong with the medical treatment, it is extremely difficult to successfully sue the health care provider and obtain justice (Bookman and Bookman, 2007; Carrera and Bridges, 2006; Horowitz and Rosensweig (2007). Ormond (2011) observed that the usage of the terms 'outsourcing' and 'off-shoring' in relation to 'medical tourism', for example, implicitly assumes that control is in the possession of those entities 'sending' patient-consumers abroad and not those 'attracting' them.

According to Steven (2010), various forms of experimental, often scientifically invalidated treatments, including stem-cell therapy, that are allegedly marketed to desperate patients who can afford the tourism involved, have been the subject of ethical criticism and yet are a growing part of the medical tourism sector. The ethical issues with regard to these therapies include (1) providers making inaccurate medical claims in their direct-to-consumer promotional materials; (2) patients not receiving adequate and appropriate information and thus shouldering inordinate risks; (3) clinics contributing to public expectations that exceed what the field can reasonably achieve; (4) patients subjected to excess financial burden; (5) clinics not following international or national guidelines for the provision of stem cell-based treatments; and (6) inadequate patient informed consent, including patients suffering serious treatment side effects that allegedly were not disclosed in advance.

According to Marsek and Sharpe (2009), regulatory, administrative, public perception, continuity of care and liability issues are all restricting insurance companies from covering patients abroad. Concern is thus generally focused on the transnational regulation of private health-care to ensure (Western) patient consumer protection and future global industry growth. Another set of ethical concerns surrounds what has been labeled "transplant tourism," those countries (identified in the past as China, Colombia, India, Pakistan, and the Philippines) offering organ transplants to international patients under circumstances in which the source and circumstances surrounding the procurement of donor organs has been criticized (Steven, 2010). Skeptics raise concerns about quality of care and patient safety, information disclosure to patients, legal redress when patients are harmed while receiving care at international hospitals, and harm to public health care systems in the destination nations (Turner, 2012). Reizman (2010) pointed out the malfunctions and risks associated with the medical tourism where people have been given inappropriate medicines or drugs, resulting in erroneous test results or abnormal reaction. In many countries, the doctors try to cheat the patients by suggesting to them to undergo a series of unwanted tests which are not at all related to the patient's illness (Riezman, 2010). By doing so, they earn money and assure the patient a guaranteed successful outcome of their surgery (Reizman, 2010). Henderson (2004) suggests that there is the need for a strict control on advertising for such patients, ensuring safeguards and accountability to protect patients, and the legal machinery to deal with malpractice and grievance procedures. There is a lack of governmental safeguards ensuring the quality of healthcare generally and specifically the safety and effectiveness of certain procedures and also there is no international governmental body for accrediting hospitals, physicians or other health professionals (Steven, 2010).

Aftercare Issues

Aftercare is the main factor, which can create favourable and sustainable image for the MT destination. In the absence of a governing mechanism for MT, a standard system of aftercare is neither endorsed nor monitored globally. A review of 100 internet websites under a search for "plastic surgery abroad" and covering services offered in Asia, Eastern Europe, and South America, it was found that there is a distinct lack of information for potential patients, particularly with regard to complications and aftercare (Steven, 2010). In the current situation, the MTs are sent back with aftercare advice and here effectiveness of communication with them and their home health care provider also matters. Thereafter various complications, side effects, and post-operative care usually become the responsibility of the patient's home country's medical services following their few days of stay in a foreign hospital (Whittaker, 2008). In some cases, a schedule of follow up care is provided to foreign patients, but this would require further travel and many patients may not be prepared to follow through with the extra cost (Reddy et al., 2010; Whittaker, 2008). Further, providing only limited follow-up care and monitoring with no continuity of care if complications arise and revision surgery is required—the costs may not be covered by health insurance in the patient's home country (Steven, 2010). Once they have returned to their home country, if the foreign patient experiences any problem with the medical care they had received, extensive legal protection may not be available within all the foreign countries. Although most post operation complications occur within the first few days after surgery (Marsek and Sharpe, 2009), if a complication should arise later on, it becomes very difficult for that person to seek immediate medical attention (Reddy et al., 2010). Foreign physicians may promise to provide follow-up care to medical tourists using telemedicine, but there are serious limitations in the consistency of law and regulations governing the practice of tele-medicine in foreign countries (Steven, 2010).

Cosmetic tourism has also been blamed for adding burden on local plastic surgeons for complications following private cosmetic surgery undertaken outside the patient's country (Steven, 2010). Ben-Natan et al. (2009) suggested that appropriate follow-up care, adequate communication between providers and patients, provisions to assure the quality on long-term and provide for the cost of this care need to be considered before the patient decides in undergoing procedures in other countries.

M-Visa and MED-X Visa Concerns

Viewing the importance of MT, Indian Government issue two types of visa for MTs and accomplice namely Medical Visa (M-Visa) and Medical Attendant Visas (MED-X Visa) and if the validity period is less than 180 days, they are required to be registered. If any admitted patient and attendant is having a Medical and Medical Attendant visa of more than six months' validity, it is mandatory to get himself / herself registered with FRRO (Foreigners Regional Registration Office), within 14 days of his / her first arrival, irrespective of the duration of his / her stay with the treating Consultants Certificate (separate certificate for both Patient and Attendant). If the patient and attendants are not having M-Visa and Med-XVisa (only having other types, e. g. Tourist VISA), they should be guided to FRRO with the treating Consultants Certificate for converting their visa type to Medical and Medical Attendant. If any patient and attendant need visa extension for treatment, they should report directly to the FRR Office with the treating Consultant's Certificate (separately for both patient and attendant). Here the big paradox is that the medical tourists may not be in a position to do so due to health conditions. For obtaining M-Visa, many procedures and processes are involved which naturally require more money and time. For some countries, visa processing is delayed by more than two weeks and

most of the MTs are not in a position to wait so long and this wait time is the very factor, that forced them out of their country to seek treatment somewhere else. For obtaining M-Visa, medical report from recognized / specialized hospital / treatment center specifying the period of treatment with patient details, treating doctor's name and signature with hospital seal and nature of illness are mandatory. If any Pakistan national gets admitted, they should report directly to the FRR Office within 24 hours of their arrival and prior to 24 hours of their discharge with the treating Consultant's Certificate, apart from the online Form C submission. And we should also intimate the FRR Office over phone at the time of their arrival (before online submission of Form C. All these factors compel the MTs to take a tourist visa which is actually a serious offence. If everything is perfectly all right there will be no serious repercussions but in the case of death or other legal issues it becomes a serious matter But the government is not eager to look into this policy issue as yet and so the MTs, hospitals and MTs are conveniently neglecting this aspect.

Other Industry Level Concerns

A general lack of insurance portability hinders prospective patients from travelling abroad for health care (Bookman and Bookman, 2007; Porter et al., 2008; Steven, 2010). The industry positively views the changes that are happening in the medical insurance sector which may absolutely result in insurance portability in the coming years. George Eapen, Chief Executive Officer of Apollo Hospitals, India, said that "most western patients we get are covered by insurance or pay out of their own pocket. Canadian patients now get 75 per cent of their expenses reimbursed after treatment in Apollo Hospitals" (Mudur, 2014: 1).

A study of the problems and challenges faced by medical tourists in India by the Ministry of Tourism found that tourists find the overall cost of the treatment far more than what they had initially expected at the pre-procedure stage (Ministry of Tourism Report, 2011). Again, inadequate infrastructural services like roads and accommodation facilities, garbage and visual pollution and high noise levels are often big concerns for medical tourists. The congested rooms of hospital give a tough time to the medical tourists and accommodation of the accomplice is often ignored. A tourist in Kerala came from Washington D. C expressed her frustration to the author with the Indian toilet facilities and was anxious about his 4-year old daughter and his constant worry was "…if she gets sick?'' Poor hygienic conditions, hygienic and ethnic food, Waiting time for procedures, overcrowding at the hospital, traffic problems, incidents of robbery, rape and harassment of tourists, cultural and language problems, political problems like demonstrations, strikes, and terrorism will give a very poor impression to the visitor and his experience and satisfaction will not be favourable.

Ben-Natan et al. (2009:4) identified the following challenges associated with MT.

- Cultural barriers and language, including medical jargon, may be problematic, even with the assistance of interpreters. Serious misunderstandings may occur on both the part of the patient and the provider.
- Quality of the hospital environment: Patients should carefully assess the quality and the standards that they expect and have been promised. This assessment should include the environment outside the hospital. In some countries the quality of the water and the air, as well as hygienic standards, may be quite different from patients' expectations and may compromise their convalescing situation.

- Selecting the best possible destination for the specific service(s) needed. It also remains a daunting task for patients considering medical care abroad to differentiate between desirable destinations from those that have incompetent practitioners working in unsafe facilities. Some help may be gained from medical tourism agents who have backgrounds in healthcare, and who are knowledgeable regarding the quality and outcomes of care achieved in different countries and by different medical institution abroad.

Conclusion

There should be a patient-focused approach which can ensure proper caring and after care of the patient without any legal problems. Cross cultural sensitivities must be handled with utmost care. Service quality of the hospitals and infrastructural services at the destination are to be improved for achieving a higher degree of patient satisfaction. Formulating and implementing medical tourism laws and policies with particular emphasis on accidents and risks and medical insurance should be a priority. There should be a conscious effort from policy makers and stakeholders of each destination to market and promote the unique and appropriate tourism products to each medical tourist so that they have a convenient and comfortable rest and relaxation after their initial treatment. Like tourist visa, medical visa formalities should be simplified and the government should consider E-visa or on arrival policies considering the very nature of the patient and should ensure fast track system in all the formalities concerned with medical tourists. There should be a proper mechanism to check the reliability of the websites. There should be a protocol for standards, quality and cost which will eventually lead to some sustainable development.

References

Ben-Natan, M., Ben-Sefer, E., and Ehrenfeld, M. (2009). "Medical tourism: a new role for nursing?" *The Online Journal of Issues in Nursing (OJIN)* 14(3): 1-9.

Bennet, M., King, B., and Milner, M. (2004). "The health resort sector in Australia: a positioning study." *Journal of Vacation Marketing* 10(2): 122-137.

Bennett, T. (2009). 'Perspectives. ' *Medical Travel Today*. Accessed on 12 August 2012 from http://www. medicaltraveltoday.com/MTTE08/MTTEv3-16-TrudeBennett-Full.html.

Bies, W. and Zacharia, L. (2007). "Medical tourism: outsourcing surgery." *Mathematical and Computer Modeling* 46(7-8): 1144–1159.

Birch, J., Caulfield, R., and Ramakrishnan, V. (2007). "The complications of 'cosmetic tourism' -an avoidable burden on the NHS". *Journal of Plastic, Reconstructive and Aesthetic Surgery* 60(9): 1075-1077.

Bookman, M. Z., and Bookman, K. R. (2007). *Medical Tourism in Developing Countries*. New York, NY: Palgrave Macmillan.

Carrera, P. and Bridges, J. (2006). "Globalization and healthcare: understanding health and medical tourism." *Expert Review of Pharmacoeconomics and Outcomes Research* 6(4): 447-453.

Crooks, V. A., Kingsbury, P., Snyder, J., and Johnston, R. (2010). "What is known about the patient's experience of medical tourism? a scoping review." *BMC Health Services Research* 10(1): 266-276.

Gahlinger, P. (2008). *The Medical Tourism Travel Guide: Your Complete Reference to Top-quality, Low-cost Dental, Cosmetic, Medical Care & Surgery Overseas*. Minnesota, US: Sunrise River Press.

Henderson, J. C. (2004). "Healthcare tourism in Southeast Asia." *Pac Tourism Rev* 7:111–121.

Horowitz, M. D., and Rosensweig, J. A. (2007). "Medical tourism-health care in the global economy." *The Physician Executive* 33(6): 24-30.

Hurwitz, B., and Sheikh. A. (2009). *Health Care Errors and Patient Safety*. Edinburgh, UK: Blackwell Publishing Ltd.

Jeevan, R., and Armstrong, A. (2008). "Cosmetic Tourism and the Burden on the NHS." *Journal of Plastic, Reconstructive and Aesthetic Surgery* 61(12): 1423-1424.

Krishnan. N., Cockwell, P., Devulapally, P., Gerber, B., Hanvesakul, R., Higgins, R., Ready, A., Carmichael, P., Tomlinson, K., Kumar, S., Baharani, J., and Dasgupta,I. (2010). "Organ trafficking for live donor kidney transplantation in Indo-Asians resident in the West Midlands: high activity and poor outcomes." *Transplantation* 89(12): 1455–1461.

Legido-Quigley, H., McKee, M., Nolte, E., and Glinos, I. (2008). 'Assuring the quality of health care in the European Union: a case for action, European Observatory on health systems and policies.' Report No 12, Copenhagen: World Health Organization on behalf of the European Observatory on Health Systems and Policies.

Lunt, N. T., Mannion, R., and Exworthy, M. (2012). "A framework for exploring the policy implications of UK medical tourism and international patient flows." *Social Policy and Administration*. Accessed on 21 August 2013 from http://www.birmingham.ac.uk/Documents/college-social-sciences/social-policy/HSMC/publications/2012/medical-tourism-spa-article.pdf.

Lunt, N., Smith R. D., Mannion, R., Green, S. T., Exworthy, M., Hanefeld, J., Horsfall, D., Machin L., and King, H. (2014). "Implications for the NHS of inward and outward medical tourism: a policy and economic analysis using literature review and mixed-methods approaches." *Health Services and Delivery Research* 2 (2). Accessed on 21 August 2013 from file:///F:/mixed%20methos%20article%20mt.pdf

MacReady, N. (2007). "Developing countries court medical tourists." *Lancet* 369(9576): 1849-1850.

Marsek, S., and Sharpe, F. (2009). *The Complete Idiot's guide to Medical Tourism*. Penguin Group: New York.

McKelvey, A., David, A., Shenfield, F., and Jauniaux, E. (2009). "The impact of cross-border reproductive care or 'fertility tourism' on NHS maternity services." *International Journal of Obstetrics and Gynecology* 116(11): 1520–1523.

Medical Tourism Survey (2013). International Medical Travel Journal (March 2013). Accessed on 15 October 2014 from http://www.imtj.com/resources/research-and-statistics/medical-tourism-climate-survey-2013/

Ministry of Tourism Report. (2011). A Study of Problems and Challenges Faced by Medical Tourists Visiting India. Study Report. Accessed on 14 May 2012 from http://tourism.gov in/writereaddata/CMSPagePicture/file/marketresearch/studyreports/Med. pdf

Miyagi, K., Auberson, D., Patel, A. J. and Malata, C. M. (2011). "The Unwritten Price of Cosmetic Tourism: An Observational Study and Cost Analysis." *Journal of Plastic, Reconstructive and Aesthetic Surgery.* Accessed on 21 November 2013 from http://www.ncbi.nlm.nih.gov/pubmed/21865103

Mudur, G. (2014). "Hospitals in India woo patients." *British Medical Journal* 328(7452): 1-2.

Ormond, M. (2011). "Shifting subjects of health-care: placing 'medical tourism' in the context of Malaysian domestic health-care reform." *Asia Pacific Viewpoint* 52(3): 247–259.

Penney, K., Snyder, J., Crooks, V. A., and Johnston, R. (2011). "Risk communication and informed consent in the medical tourism industry: a thematic content analysis of Canadian broker websites." *BMC Medical Ethics* 12:17. Accessed on 30 February 2013 from http://www.biomedcentral.com/1472-6939/12/17

Porter, M. E., De Vera, M., Huang, M., Khan, O., Qin, Z., and Tan, A. (2008). Medical tourism in the Philippines: microeconomics of competitiveness: firms, clusters and economic development. Accessed on 12 Feb 2012 from http://www.isc.hbs.edu/resources/courses/moc-course-at-harvard/Documents/pdf/student-projects/Philippine_Medical_Tourism_2008. pdf

Priya, S. (2010). "Medical tourism booms in India, but at what cost?" *The Lancet* 376 (9742): 671-672.

Reddy, S. G., York, V. K., and Brannon, L . A. (2010). "Travel for treatment: students' perspective on medical tourism." *International Journal of Tourism Research* 12(5): 510-522.

Reed, C. M. (2008). "Medical tourism." *The Medical Clinics of North America* 92(6): 1433-1446.

Riezman, D. (2010). *Health Tourism: Social Welfare through International Trade*. Cheltenham: Edward Elgar.

Sengupta, A. (2011). "Medical tourism: reverse subsidy for the elite." *Signs* 36(2): 312–319.

Solomon, H. (2011). "Affective journeys: the emotional structuring of medical tourism in India." *Anthropology & Medicine* 18(1): 105-118.

Steven, L. M. (2010). "Ethical Issues Threaten the Future of the Medical Tourism Sector?" *Medical Tourism Magazine.* Accessed on 6 January 2013 from http://www.medicaltourismmag.com/ethical-issues-threaten-the-future-of-the-medical-tourism-sector/

Turner, L. (2008). Cross-border dental care: "dental tourism and patient mobility." *British Dental Journal* 204: 553-554.

Turner, L. (2011). "Canadian medical tourism companies that have exited the marketplace: content analysis of websites used to market transnational medical travel". *Globalization and Health,* 7:40. Accessed on 14 August 2014 from http://www.globalizationandhealth.com/content/7/1/40

Turner, L. (2012). "News media reports of patient death following 'medical tourism' for cosmetic surgery and bariatric surgery." *Developing World Bioethics* 12(1): 21-34.

Voigt, C., Laing, J., Wray, M., Brown, G., Howat, G., Weiler , B., and Trembath, R. (2010). "Health tourism in Australia: supply, demand and opportunities," CRC for Sustainable Tourism Pvt Ltd, Australia. Accessed on 4 February 2014 from http://www.crctourism.com. au/wms/upload/resources/WellnessTourism_Ind%20Summary%20WEB%20(2). pdf

Weisz, G. (2011). "Historical reflections on medical travel." *Anthropology & Medicine* 18(1): 137-144.

Whittaker. A. (2008). "Pleasure and pain: medical travel in Asia." *Global Public Health* 3(3): 271-290.