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Globalization and medical tourism: the North American experience

Comment on “Patient mobility in the global marketplace: a multidisciplinary perspective”

Arturo Vargas Bustamante*

Abstract

Neil Lunt and Russel Mannion provide an overview of the current state of the medical tourism literature and propose areas for future research in health policy and management. The authors also identify the main unanswered questions in this field ranging from the real size of the medical tourism market to the particular health profiles of transnational patients. In addition, they highlight unexplored areas of research from health economics, ethics, policy and management perspectives. To this very insightful editorial I would add the international trade perspective. While globalization has permeated labor and capital, services such as healthcare are still highly regulated by governments, constrained to regional or national borders and protected by organized interests. Heterogeneity of healthcare regulations and lack of cross-country reciprocity agreements act as barriers to the development of more widespread and dynamic medical tourism markets. To picture these barriers to transnational health services I use evidence from North America, identifying different “pull and push factors” for medical tourist in this region, discussing how economic integration and healthcare reform might shift the incentives to utilize healthcare abroad.

Keywords: Medical Tourism, Patient Mobility, Cross-Border Care, North America, Healthcare Reform

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Introduction

As Neil Lunt and Russel Mannion point out in their editorial, medical tourism promotion is prone to “provider exaggeration, and industry ‘grand standing’, [making it increasingly] difficult to distinguish rhetoric from reality” (p.156) (1). Scholars who have attempted to investigate the size, characteristics, and prospects of different medical tourism markets often times encounter data limitations and difficulties agreeing on adequate conceptual frameworks and disciplinary boundaries. In spite of it, Lunt and Mannion highlight some of the main contributions to this literature that have made a conscious effort to investigate medical tourism from a scientific perspective, differentiating it from the overboard marketing that characterizes this field. The authors also provide an excellent overview of the main unanswered questions in this field ranging from the real size of the medical tourism market to the specific health profiles of international patients. One of the main contributions of this editorial is the overview of specific areas for future research by health policy and management sub disciplines, such as health economics, health policy ethics, politics of health, health management, and health policy.

Globalization and healthcare

From my perspective, two of the main areas for future research in medical tourism are: i) the characterization of market failures in medical tourism markets; and ii) how specific transnational healthcare markets could evolve within existing economic association agreements. Economic liberalization since the

1970s has eliminated trade barriers in manufacturing and the financial sector, transforming how labor and capital—two key elements of modern capitalist societies—are used in national economies. Today cars, phones, appliances, and several other manufactured products are assembled in production lines that cover different continents and a multiplicity of countries. Capital flows also move with relative ease across national borders speeding up international economic integration. Governments have promoted globalization by opening borders, harmonizing regulations, and overcoming resistance from organized interests who benefited in the past from protectionist measures. By contrast, in most service sectors, such as education or healthcare, economic liberalization and internationalization has been less widespread. Services in most countries remain highly regulated by governments, constrained to regional or national borders and protected by organized interests.

Healthcare is still a local industry in most countries. Regional and national governments remain as the main payers in many countries and in some cases the main provider of health services and employer of the healthcare workforce. Incompatible cross-national healthcare regulations and organized interests have often mobilized to erect protectionist measures to prevent rule homogenization or reciprocity agreements that could facilitate healthcare quality regulations and patient management across countries. Governments have been passive at facing this opposition. Globalization, however, has been slowly permeating the healthcare ‘production line’, from growing healthcare outsourcing to increasing mobility

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of professionals and patients. We are currently witnessing the first stages of healthcare internationalization triggered by cost differentials across countries and increasing patient and provider mobility due to lower transportation costs and better information technologies.

Health systems around the world have different financing, organization, and delivery characteristics. Specific features of these health systems such as cost sharing, rationing, provider choice, can act as incentives for patients to travel abroad in search of better alternatives. For instance, the European and U.S.-Mexico transnational healthcare markets are very different in terms of motivations to travel abroad and patient demographics. In the U.S.-Mexico transnational market the main incentives for medical tourist from the U.S. to travel south of the border are the high healthcare costs, access to care barriers for minority and low-income populations in the U.S., and cultural familiarity with the Mexican health system in the case of the Mexican diaspora in the U.S. (2). By contrast, in the European Union the incentives of patients to seek healthcare abroad are often times explained by rationing of specific treatments and access to more affordable elective procedures abroad (3). These two cases show that in addition to cost differentials, other considerations such as access to care, service availability and type of procedures are key issues to consider in medical tourism conceptual frameworks.

One of the main questions that medical tourism scholars would start to face in the upcoming years is how transnational healthcare markets develop and follow similar economic liberalization trajectories as economic integration in other economic sectors, such as manufacturing or finances. Health policy and management scholars could analyze this trajectory from an international trade perspective, investigating how healthcare liberalization evolves within current economic association agreements such as the European Union, the North American Free Trade Agreement (NAFTA), MERCOSUR or ASEAN. As Lunt and Mannion mention in their commentary, a variety of “push and pull factors” explain increasing international patient mobility. Centering this framework in specific economic zones could help identify specific policies and regulations that address existing market failures in medical tourism market and create new institutions and organizations to more effectively manage transnational patient mobility.

The North American experience

In the specific case of NAFTA, Canada, the U.S. and Mexico have substantially increased their economic interactions in the last two decades. Since NAFTA was signed in 1993 international trade between the U.S. and Mexico has increased six-fold and almost 5 million Mexicans have migrated to the U.S. attracted by new economic opportunities. “Push” factors that incentivize medical tourism in the U.S.-Mexico region are access to care barriers for Mexicans in the U.S., an ageing population that each year increases the number of U.S. retirees moving south to Mexico in search of better weather and a more affordable lifestyle, and significant cost differentials for most health services in the two countries (4). Likewise, “pull” factors that promote transnational patient

mobility in this region are geographic proximity, declining transportation costs, cultural familiarity with the Mexican healthcare system among 30 million Mexicans who live in the U.S. and an active policy by private hospitals in Mexico to seek international certification in order to make themselves more attractive to medical tourists. In spite of these factors that incentivize transnational healthcare utilization in the region, heterogeneity of healthcare regulations across Canada, the U.S. and Mexico; and lack of cross-country reciprocity agreements on quality of care supervision and patient management act as barriers to the development of more widespread and dynamic medical tourism markets in North America.

Under NAFTA, Canada, the U.S. and Mexico have established new healthcare collaborations. For instance, Canada provides health coverage for seasonal farmworkers from Mexico. The U.S. state of California has regulations that allow local health insurers to offer health coverage in Mexico for U.S. workers (5). In spite of these timid efforts to increase cross-border collaborations, protectionist measures have prevented further integration of healthcare markets. For instance, the U.S. state of Texas rejected a law proposal that resembled California’s health insurance cross-border legislation due to the lobbying from local healthcare providers who feared increased competition from lower cost providers in Mexico (6). Canada’s Medicare once reimbursed members who used healthcare in the U.S. but stopped doing so as a cost control measure. Similarly, the legal framework that introduced private managed care organizations in Mexico as part of NAFTA was opposed by local unions and healthcare providers (7). The resulting legislation diluted all incentives for the expansion of international private health insurers in Mexico, slowing down the integration of North American healthcare organizations that could have offered better coverage to increasingly mobile populations.

These examples suggest that in spite of trade liberalization in North America, market failures in healthcare delivery for transnational populations are likely to remain in place for some time. Governments’ attention currently focuses on domestic health policy. Both, Mexico and the U.S. have recently implemented ambitious healthcare reforms that will expand health insurance coverage to millions of currently uninsured individuals. It is still unclear whether these reforms would be effective at reducing the demand for healthcare abroad or if they would just shift the type of services that medical tourists would seek abroad. As suggested by Lunt and Mannion, health policy and management scholars would need to identify new “push and pull factors” that will drive medical tourists abroad. In the upcoming years, medical tourism scholars could analyze how health policy changes shifted incentives to utilize healthcare abroad. In addition, they could analyze how increasing economic integration put more pressure on governments to coordinate across national borders to ensure quality of care for medical tourists and a better way of financing transnational health services.

Ethical issues

Not applicable.

Competing interests

Author declares that he has no competing interests.

Author's contribution

AVB is the single author of the manuscript.

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