

Medical Tourism in India – Private profit, public pain.

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Medical tourism, the movement of people from developed countries to less developed countries, like India, to access medical care which is available in their own countries, for reasons of cost or to avoid waiting, is not benign. It has deleterious effects on the countries which seek to provide such services like India. The reason for this is that these countries are not providing from a situation of overabundance. Nor are they providing something which everyone can share without any one's share being affected, as for example looking at Banff Bay. When people from Canada come to India seeking treatment they are reducing the chances of a person from India getting the treatment. According to the government of India: (1)

India excels in providing quality and cheap health care services to overseas tourists. The field has such lucrative potential that it can become a \$2.3 billion business by 2012, states a study by Confederation of Indian Industry (CII). In 2004, some 150,000 foreigners visited India for treatment, and the numbers have been rising by 15 per cent each year.

India is in the process of becoming the "Global Health Destination" owing to the following advantages:

- The cost of medical services in India is almost 30% lower to that in Western countries and the cheapest in South-east Asia.
- Language is a major comfort factor that invites so many foreign tourists to visit India for medical and health tourism. India has a large populace of good English speaking doctors, guides and medical staff. This makes it easier for foreigners to relate well to Indian doctors.
- Indian hospitals excel in cardiology and cardiothoracic surgery, joint replacements, transplants, cosmetic treatments, dental care, Orthopaedic surgery and more.
- The medical services in India include full body pathology, comprehensive physical and gynecological examinations, audiometry, spirometry, Chest X-ray, 12 lead ECG, 2D echo Colour Doppler, gold standard DXA bone densitometry, body fat analysis, coronary risk markers, cancer risk markers, high strength MRI etc.
- All medical treatments and investigations are done using the latest, technologically advanced diagnostic equipments.
- Indian doctors have got an expertise in performing successful cardiac surgeries, bone marrow transplants, liver transplants, orthopaedic surgeries and other medical treatments.
- The cost of Infertility treatments in India is almost 1/4th of that in developed nations. The availability of modern assisted reproductive techniques, such as IVF, and a full range of Assisted Reproductive Technology (ART) services have made India the first choice for infertility treatments.

Endemic poor health, rich people, rich hospitals

The people of India are very poorly off in terms of health. According to the national commission on

macroeconomics and health(2), more than 40% of the people of India are infected with Mycobacterium tuberculosis, 8.5 million people have the disease at any one time, and it is the leading cause of death. 66 of every 1000 children born will die before the age of one year, and 95 will die before the age of five. 440 of every 100,000 women will die during childbirth. Malaria, dengue and other vector borne diseases are still common in India. No reliable estimates are available for these diseases – which have become uncommon in the developed world due to improvements in the standard of living and health care - due to poor epidemiological data. The government does not want to know! A country which can put a satellite into space would be expected to tackle these conditions, once common all over the world, but now restricted to the least developed countries, countries with high rates of inequity. India, is not a poor country. It is a country with poor distributive justice.

In the Forbes list of the top ten richest people in the world there are two from India at four and five! (Canada comes it at number 20.)

This has not come about by accident, but by deliberate policy of successive governments of India, which have allowed the resources of the country to become the private property of a few. Policies which enable a select few to become very rich, while allocating just enough tax money to public goods like transport, education, food, housing and health have become the hallmark of Indian government policy. To give but one example: mining iron ore is in the hands of a few individuals to whom the government leases out the mines. The approximate cost of extracting the ore is Rs.150 (Canadian dollar 3.4), the minimum rate at which it is sold is around Rs. 1500 per tonne (\$ 34) and it is often sold at Rs.6000 per tonne (\$ 136). The government charges a royalty of Rs.27 (\$ 62)per tonne!(3)

As in other sectors of the economy, so also in health and medical care, successive governments have ignored the needs of the citizens and permitted a small section of the population to make large profits by converting medical care into a business proposition. It is obvious that in order to be profitable, private medical care will focus on those treatments which will yield the highest profits. Obviously this cannot be malaria, dengue and tuberculosis, which mostly affect those with poor capacity to pay. The money spinning interventions are cardiac surgery, total joint replacements, dental treatment and perhaps eye surgery. In pursuit of profit, private entrepreneurs have developed facilities for treatment of these conditions. This has not been done with private capital but by lobbying the government for cheap land to build the hospital, cheap loans to finance expenditure, and tax breaks. In a country, where the poorest are taxed on every item they buy, the concessions handed out to the rich are simply obscene. For example, the Apollo group, foremost among the entities which promote medical tourism, was given 15 acres of land worth Canadian dollars 2.6 million, at a lease of one rupee per year, and Rs 160million (approximately 3.65 million Canadian dollars) for construction of their hospital in Delhi besides Dollars 5.2 million as equity capital. In return the group was mandated to provide one third of the beds in this hospital for the underprivileged, a mandate which has never been honoured. The Public Accounts Committee of the government was constrained to observe ““Ultimately, what was started with a grand idea of benefiting the poor turned out to be a hunting ground for the rich in the garb of public charitable institutions.” (4)

The website of the International Hospital Corporation, Hyderabad, states the following as investor advantages: (5)

- Duty free import of equipment & supplies
- Income Tax holiday for 5 years
- State level tax & duty concessions
- Power & water price concessions
- Various other concessions

Only 3.4% of tax money is spent on the health sector. According to the National Sample Survey over 70% of spending on medical care is met out of the patient's own resources.

Medical needs vs medical supply

Soon after independence in 1947, the government of India expressed its intention to provide universal medical care to all citizens and accepted the recommendations of the Bhore committee, the most important of the recommendations being: (6)

1. Integration of preventive and curative services of all administrative levels.

2. Development of Primary Health Centres in 2 stages :

a. Short-term measure – one primary health centre as suggested for a population of 40,000. Each PHC was to be manned by 2 doctors, one nurse, four public health nurses, four midwives, four trained dais, two sanitary inspectors, two health assistants, one pharmacist and fifteen other class IV employees. Secondary health centre was also envisaged to provide support to PHC, and to coordinate and supervise their functioning.

b. A long-term programme (also called the 3 million plan) of setting up primary health units with 75 – bedded hospitals for each 10,000 to 20,000 population and secondary units with 650 – bedded hospital, again regionalised around district hospitals with 2500 beds.

3. Major changes in medical education which includes 3 - month training in preventive and social medicine to prepare "social physicians".

By the 1960's it became obvious that the goal of universal coverage had not been met. The two primary reasons for this was that various state governments in India's federal set up did not provide enough money, and that many doctor's were not willing to work in remote areas. Subsequently, the government set up many committees to solve the human resources problem, notably the Mudaliar committee 1962, the Kartar Singh committee in 1973, Shrivatsav committee 1975, the Bajaj committee 1986 right up to the National Commission on Macroeconomics and health 2005. It is remarkable how many of these commissions identify the same problems, and how these problems have never been solved till date. The Alma Ata goal of health for all by 2000 AD has been missed by a wide margin.

Not only is there an overall shortage of suitable medical care personnel, there is a gross maldistribution of resources, with over 75% of all medical personnel in cities and towns where less than 30% of the people live.

Every committee of the government has remarked on the need for a human resources policy in health care, to address this skewed distribution, but no effective steps have been taken. All good intentions seem to be set at naught either by sheer callousness or by private interests.

India does not have an overabundance of medical personnel.(7) The number of physicians per 10,000 population in Canada is 19, in India the figure is 6. The number of nurses per 10,000 population in Canada is 101. In India the figure is 13. The number of hospital beds per 10,000 population in Canada is: 34. In India the figure is 7

In the highly privatised system in India, it is not profitable for doctors to work in rural centres. Poor

infrastructure and standards of living are other potent causes for the crowding of doctors in urban centres while most rural areas are poorly served. In a representative survey in Andhra Pradesh, it was found that the private sector has 75% of the specialists and 85% of the technology. 75% of service delivery for orthopaedics, dental health, mental health, vascular diseases and cancer are in the private sector.(1) It is not surprising that these are the very sectors of focus for medical tourism.

In the early years of independence, medical education in India was in government run colleges and the fees were and are, very low. In the past 30 years, the number of private colleges has outstripped the number of government colleges. Although the fee structure in these colleges is supposed to be fixed by government, like many sectors in India, there is huge corruption and parents of students pay truly huge amounts under the table to get into these colleges. This money cannot be recouped by working in the government hospitals. Medical graduates from India have always been going abroad for a better standard of living. About 54% of graduates trained between 1989 and 2000, from the All India Institute of Medical Sciences, the premier centre for medical education in India, now work abroad.(8) Indian doctors in the United States, now exceed 50,000, the largest group of physicians after native born Americans. Let me emphasise here that this figure refers to doctors born and trained in India who have emigrated to the United States of India. There is one Indian doctor per 1325 Americans, whereas there is only one doctor for every 2400 people in India. Thirty percent of the doctors in the National Health Service of the United Kingdom are from India.(9) In recent years, such migration has become more and more difficult as most countries in the Western hemisphere are now self-sufficient in medical human resources. This has seen a return of many doctors with special training in areas which require large investments.

In the last thirty years, there has also been huge developments in medical technology. With government unwilling to invest in these expensive technologies, the private sector in India, saw an opportunity and set up so-called high-tech centres. The money for these centres has been raised by corporatisation, that is by issuing shares and listing these hospitals on the stock – market. The bulk of the money invested in these hospitals is from the savings of the public, not from promoters. For example, it is estimated that the Apollo group borrowed two rupees for every one of owner funds.(10) Unfortunately, it appears that there are not enough people in India who can afford to pay what it takes to make these hospitals profitable. So we have the terrible dichotomy – millions of poor who cannot afford even the most basic medical care, and hospitals with facilities and medical specialists to spare. And this is the source of the push to get patients from abroad.

Make no mistake – this is an artificial over capacity. It arises out of inability to pay. It is like saying there is too much food available because people are not able to buy it. All of us who oppose medical tourism do so because we want to force the government to make good on its promise to provide comprehensive, equitable medical care to all.

No money to buy

These policies of the government, notably miniscule public investment in medical care resources, subsidies to private entrepreneurs in medical care, has led to significant overcapacity in certain medical treatments, because people with the capacity to pay are not enough to meet the supply available. The Working Group on Health Care Financing of the government of India states that paying for medical care is a cause of indebtedness in 3.3% of the population. It is the number one cause of debt amongst people living in rural areas of the country. (11)The small pool of people with enough money to pay has led to the ugly practice of patients being wooed, coerced and sometimes hoodwinked into having medical procedures. It has become common to pay a kick back to any one, doctor, cab-driver or ambulance personnel, who brings the patient to the facility. All major corporate hospitals have marketing managers whose job it is

to entice patients. They also have so-called counsellors whose job it is to convince the patient to have an expensive procedure. The market in India is now saturated with these practices, so the next step in profit seeking is to entice patients from abroad – so called medical tourism. Make no mistake, this has a bad effect on the socio-economic conditions in India. In the competition for patients it directly promotes unethical practices like fee splitting for patient referral, inappropriate use of diagnostic tests, doing procedures not because the patient needs it but because the machine is available and so on. In short, people with money may get what they do not need, while people without are deprived of the most fundamental care that civilized people all over the world consider as a basic human right.

Development can only realize its stated goal if the policies are followed through to its logical end and the logical end to any developmental activity is the availability of the product to all its citizens. Therefore when the government has invested in and aided the creation of world class competence and medical care, it must go further and ensure both affordability and availability of these facilities to its people. The purpose is defeated if, after the creation of facilities, we stand back and let market forces take over. This is not equitable development.

We want to force our government to stop providing subsidies to the rich businessmen to set up hospitals which our citizens cannot enter. We want our government to be responsive to the basic needs of our people and put people before profit. The medical tourism industry will mean big money for a few businessmen and a few doctors

In summary, costs are low in India because government is using tax payer money to subsidise corporate hospitals. There is no waiting time because local people who need these treatments cannot pay the costs.

Lets share the pain my brother,
you shall have more than your share,
Pain for you, pills for me,
germs for you, jabs for me,
Though you die young, long life for me,
Tranquillisers, deep x-ray, penicillin and nothing to pay for me,
A little clinic, a mobile clinic per 100,000 people, for you,

Lets share our wealth my brother,
lets share all that you have,
Gold for me and beads for you,
Christ for me, the devil take you,
Bingo, bombs, drugs and booze,
money to burn and waste and lose for me,
And a little aid, just a little aid, when we can spare it, for you,

Anonymous.

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