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Medical Tourism: The View from Ten Thousand Feet

I. Glenn Cohen

Introduction

Medical tourism—the travel of patients from their home country to another for the primary purpose of seeking medical treatment—is already big business. In 2005, Bumrungrad International Hospital in Bangkok, Thailand, saw 400,000 foreign patients, 55,000 of whom were Americans, and centers in India, Malaysia, Singapore, Mexico, and elsewhere also attract significant foreign patient populations.[1] Some of these patients are seeking care that is unavailable at home, such as surrogacy services or stem cell treatments. Others are uninsured or underinsured Americans looking for price savings (in some cases upwards of 80 percent) compared to what they would pay out of pocket in the United States.[2]

Governments, too, have taken interest. The U.S. Senate held a hearing, "The Globalization of Health Care: Can Medical Tourism Reduce Health Care Costs?" West Virginia considered (but ultimately rejected) a bill that would have given its public employees financial incentives to get treatment abroad (something many self-insured U.S. firms already do). Texas has taken steps to ban insurers from making their covered populations use health care services abroad.[3]

Medical tourism raises a panoply of legal and ethical questions. In this short space I offer only the view from ten thousand feet, setting out the different types of medical tourism and the kinds of concerns they can pose. Consider this as a statement of a kind of research agenda, one that I hope readers will join me and other scholars in developing.[4]

One can usefully distinguish three kinds of medical tourism.

Medical tourism for services that are illegal in both the patient's home and destination countries. Organ sale, which is illegal in all countries except Iran, is a good example. While in such cases both the patient's home and destination countries have decided to ban the practice, medical tourism raises a set of questions about extraterritoriality and the coordination of domestic and foreign regimes of criminal law. If a foreign country criminalizes organ sales but has a lax enforcement regime that essentially tolerates a gray market, should the United States use also its own criminal law against its citizens that purchase organs abroad? One model here would be the Protect Act of 2003, which levies either a fine or thirty

years in prison or both in the United States for any U.S. citizen or permanent resident "who travels in foreign commerce, and engages in any illicit sexual conduct" including "any commercial sex act … with a person under 18 years of age."[5] Another possible approach (that is potentially even more draconian) currently in place to curb organ tourism is sketched in Medicare regulations requiring that physicians inform patients seeking organ transplantation that transplantation by an unapproved center "could affect the transplant recipient's ability to have his or her immunosuppressive drugs"—required to avoid tissue rejection—"paid for under Medicare Part B."[6]

One set of ethical questions is whether these approaches go too far in their penalties; perhaps we should defer to the level of enforcement and penalties in the destination country. A corresponding set of pragmatic questions asks how we can do a better job of detecting this kind of medical tourism if we decide to penalize it through domestic criminal sanction.

Another set of questions focuses on the duties of U.S. doctors. If a patient is waiting for an organ and appears unlikely to get it, does his doctor have a duty if asked to inform the patient of better versus worse transplant centers dealing with such purchased organs abroad, or at least to refer the patient to a colleague who will? May a physician faced with a patient she determines has purchased an organ abroad and who now requires follow-up care decline to provide that care? Can she decline only if she finds another physician willing to provide care?

Medical tourism for services that are illegal in the patient's home country but legal in the destination country. Let me give three quite different examples of what might fall within this second category: (1) A same-sex married couple has difficulty in securing a traditional surrogate in their home state of Massachusetts (where surrogacy agreements involving compensation to traditional surrogates are unenforceable) and turns to a clinic in the village of Anand, India, where many women serve as surrogates and a clinic offers surrogacy services at one-third of the cost in the United States. (2) A patient with squamous cell carcinoma has run out of treatment options approved by the Food and Drug Administration and is also barred from joining a clinical trial of the experimental drug Erbitux because she does not meet the inclusion criteria, but travels to France, where the drug is available for purchase. (3) A patient travels abroad for physician-assisted suicide, which is illegal in her home country.[7]

These cases raise many interesting questions: for the surrogacy case, should we respect a country's sovereignty in deciding that this form of "exploitation" is not worthy of legal condemnation, and does the answer depend on our views about whether the exploited group was sufficiently enfranchised and able to participate in the democratic process? Should we view the development of fertility tourism markets as a welcome "safety valve" to our domestic prohibition, or should we instead view ourselves as responsible for creating the market through our domestic prohibition and thus complicit in whatever exploitation occurs?

For the assisted suicide or surrogacy case, if the fear is "corruption"—if we fear that the practice will change moral attitudes and lead to disrespect of the female body or those at the end of life[8]—then is the corruption likely to be contagious across cultures? For the drug case, will medical tourism make it more difficult to recruit people for randomized, double-blind clinical trials of experimental drugs in the United States? Does medical tourism produce problematic socioeconomic status inequalities in access to experimental drugs, in that the wealthy can travel abroad, while the poor cannot?

If, based on any of these concerns, we decide we want to try to reign in our citizens' activities abroad, then we face difficult challenges in designing regulation. Detection can be difficult if the activity is sanctioned—and, therefore, not policed—in the destination country (although our control of immigration may allow us to detect cases of fertility tourism).

Medical tourism for services legal in both the home and destination countries. Traveling to India for cardiac bypass or to Thailand for hip replacement is paradigmatic of this kind of medical tourism, which may result from purchasing care either out of pocket (sometimes via an intermediary) or through an insurer that gives incentive to seek treatment abroad. For example, the West Virginia bill discussed above would not only have covered travel, lodging, and sick leave for the employee using medical tourism but would also have waived all deductibles and copayments, as well as offering the employee a "rebate" of up to 20 percent of the cost savings realized by undergoing treatment in a foreign facility. We can usefully divide the issues raised by this kind of medical tourism into three categories.

The first category, patient-protective concerns, focuses on the welfare of the tourist-patient. The concerns are both about the quality of care and, should medical error occur, about medical malpractice recovery. Here we face both theoretical and practical difficulties in trying to provide patients with the kind of information needed to make informed choices. We also face questions about the limits of justified paternalism, and whether a laissez-faire approach to medical tourism can be squared with our domestic practice of prohibiting the contractual waiver of medical malpractice or the protections of state licensure statutes. The answers to these questions (and our policy options for intervention) differ depending on whether medical services abroad are purchased out of pocket or are prompted by an insurer.

A second category, concerns about others in the home country, looks at the possible effect of medical tourism on the cost and availability of health care in the home country. If patients frequently seek care abroad, will that fact dampen or promote efforts to secure universal access to health care? Will increased competition from global providers have salutary or destructive effects on the U.S. health care industry? Would regulatory competition give

legislators incentives to weaken or strengthen parts of health care law, and would those changes be beneficial? Would it further fragment insurance markets, or would the volume of medical tourism expected be too small?

A final category consists of concerns about patients in the destination country. These require both an examination of how medical tourism affects access to health care for patients who live in the destination country and a normative analysis of our obligations to people in those countries. If medical tourism improves access to health care for people in the United States while limiting access in the destination country (a big "if," to be sure), is that a reason to curb the practice? This in turn depends on how we resolve practical questions about how to curb medical tourism and theoretical debates about different conceptions of global justice.

The globalization of health care is an increasing fact of life. Medical tourism is but one piece of that puzzle. Beyond posing ethical and regulatory challenges in its own right, medical tourism offers us a welcome opportunity to reexamine some fixed stars in the constellation of domestic health care regulation.