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Medical tourism in Oman

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Abstract

Health tourism and medical tourism are known yet unfamiliar phenomenon and is on increase in recent decades. The exact numbers and economic burden is rather speculative, as exact data is difficult to assess. The phenomenon is observed from both developing and developed countries, the reasons being different. There is not much international published literature on the subject.

The situation, with respect to health tourism, in Oman is not much different as seen in other Middle Eastern countries.There are distinct perceptions based on social, economic, preferential reasons of travel. There are perceptions about health care systems locally abroad, and there are diverse reasons of selection of destination. The travel has unique economic impact and issues arising from multiple opinions and management scenario.

We in this review discuss the types of medical travel, reasons for travelling abroad for health care, the impact of medical tourism, and issues arising from this medical travel.

Introduction

Traveling to a foreign country for healthcare services is referred as health tourism [1]. Health tourism, which includes medical tourism, can be defined as organised travel outside local environment or home country for the maintenance, enhancement, or restoration of an individual's physical or mental health. Medical tourism is regarded as more organised travel outside one's natural health care jurisdiction. Medical tourism is part of health tourism and it has a long-standing past history. Many centuries ago, patients used to go to the healing god Asklepios in Epidauria – Greece [2,3], and in other regions people used to travel to therapeutic spas and collect holy waters from shrines for cure. More recently, in the 18th century, health spas were a common feature of medical tourism.

Medical tourism was rather unfamiliar and rare until a few decades back but has abruptly hastened in recent times [2]. Globalisation has prompted countries to evaluate their position on trade in health services [4] Contemporary medical tourism is the phenomenon of middle-class from industrialized countries and the affluent class from developing countries who avail first-class or desired medical services at distant terminuses [5]. Though extensive, exact figures related to magnitude and revenue involved remains unavailable as data is sparse, yet a guarded annual estimate is over 100 billion USD globally [6]. Only Thailand and India receive over 200,000 patients from other countries annually [7]. Malaysia is reported to have treated 360,000 foreign patients in the year 2007. Eastern Mediterranean regional office (EMRO) of WHO reported that Jordan treats more than 120,000 non-Jordanian patients annually, an annual US$ 1 billion in revenue [3]. It is not restricted to developing countries only, as an estimated number of American medical tourists traveling abroad will reach 2.3 million in 2017 [6]. A very few scripts and data is available describing the phenomenon and related factors [6]. Some empirical studies attempted to establish the relationship between various factors, such as motivations, service quality, service satisfaction, and visit intention [8].

Type of medical tourism

There are several categories of medical tourism:

1) A majority are temporary medical tourists, who travel for either check-up or treatment for a brief time

2) A very few are Long-term residents like people who move to a better location for their health care (Few Americans moving to Florida or the Caribbean)

3) Medical tourist from two neighbouring countries who share common borders and have agreed upon to share health care system

4) Outsourced patients are patients who are sent abroad by their respective government, as the essential required management and care is not available locally. This category matches many of the Omani patients.

Why patients travel outside

There are several reasons as to why patients choose to become medical tourists. The motivation, decision making, behaviour, and destination selection of medical tourists is a complex phenomenon [9]. Medical tourists travel to destination countries for various reasons like significant cost saving, unaffordability in home country, access to procedures banned in home country, cultural reasons, family pressures and reasons, combination of minor medical procedure and traveling for leisure, and a long waiting list for procedures in home countries with public funded healthcare system [10]. For the Americans and

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Europeans, the attraction is monetary value or affordability. For example the price of a coronary artery bypass graft (CABG) is $200,000 in the USA, but only $25,000 in India; heart valve replacements cost $180,000 in USA, but $15,000 in India, and knee replacements cost $80,000 in the States, but only $1, 5000 in India [11] Most prices of surgery in India, Thailand and Singapore as only 10% of the prices in the USA [12]. A forecast by Deloitte Consulting published in August 2008 projected that medical tourism originating in the US could jump 10-times over the next decade [11,12]. Travelers from Southeast Asia travel abroad mainly because of mistrust and perception of low-quality local medical services, unavailability of latest procedures and diagnostic services, mistrust toward local service providers, and poor state of public healthcare system [13]. Some also travel because of the unaffordability of medical fees at their home country [14].

There are five major factors involved in decision making: affordability, accessibility, availability, acceptability and additional factors [13]. Affordable is the major reason and is particularly true for patients from the well-off developed countries like America and UK, where private health care is expensive, and some surgeries are not covered by their health insurance. Non-Availability of medical treatment they need in their local areas or not trusted by the patients, as often is the case with Omani patients. Accessibility applies more particularly to patients from countries where there is long waiting list, NHS in UK and in Canada. The private health care may be available locally, but is expensive and unaffordable [15]. Acceptability applies to services which are affordable, available, and accessible, but they are not acceptable in the patient's own country for religious, political or social reasons [16]. Additional reasons are availability of perceived better care, better technology, or a more qualified and experienced health care professionals, or simply better service and personalised care abroad compared to care in the home country [17,18].

Destinations of medical travel are further categorized according to the type of services tendered. Some destinations are famous for cheap and quality services as India, while others are famous for combining medical practices with leisure like Thailand and the Caribbean. Few destinations are famous to offer costly but highly sophisticated services, such as Singapore [19-21]. Generally medical tourism websites are packed with images emphasising sophistication, advanced technology, hygiene, proficiency, price, accreditation of hospital, affiliation of doctors, qualified and smart staff, lavishly furnished accommodations, and language support services [22]. Though Medical tourists appreciate quality of care beyond any other factors [23], excellent medical and support services are important attraction factors in destination selection.

In ME spending a large amount of money on the health of dear ones is the duty and responsibility of each family member [24]. Some patients are highly motivated to travel to a particular destination because of their emotional attachment with doctors, hospitals, or the destination [25]. Many Omani patients visit Shiraz in Iran for treatment because of its religious and cultural familiarity [26].

Impact of medical tourism

Medical tourism is a burden on local economies on one hand while it has benefited economies of several countries like India, Thailand, Germany, Singapore, United Kingdom, USA, Canada, Cuba, Mexico, Malaysia, and South Africa [3]. Besides the financial benefit, there are other advantages for a patient to have treatment abroad in a centre of excellence for certain conditions. Many of the countries seeking to develop medical tourism invite qualified and experienced professionals from well-known reputed health care centres to offer excellent medical care. Many of them are encouraged and supported by their host governments, e.g. India has specifically introduced a special M-Visa category for medical tourists [27]. Malaysia's Ministry of Health has formed a special national committee for the promotion of health tourism. This has contributed to the reversal of the geographical trend of medical tourism. In the past, patients from the East were travelling to the West to get the best medical treatment. Now, patients from Western developed countries, travel East ward to developing countries for the best medical and technologically advanced health care. Eastern Europe has now joined the bandwagon including Hungary and Poland which are popular for dental work.

Medical tourism is guided by clients' and their family beliefs, attitudes, intentions, and behaviour [28]. It is based on motivations, intentions, risks, constraints, and perceived image of travel destination [29,30]. The motivations of medical tourists will positively influence their visit intentions. There is a strong negative relationship between perceived risks and visit and revisit intentions to same destinations. The perceived risks strongly influence tourists to avoid a particular destination [31], and higher travel constraints reduce the plans of travel. Attributes and benefits form the overall destination image; while disability, lack of knowledge, poor medical information, and perceived image of destination are limitations to travel.

Issues arising from growing medical tourism

Medical tourism carry many risks (health related, quality related, destination related), some perceived by traveller as well. These are security, safety, quality of services, risks to patients' health, risks of travel, pre- and post-operative risks, and compensation in case of complications [15]. Undergoing a procedure that is illegal in the home country can also expose to unknown risks [16]. Patients can develop psychological and emotional distress being away from home [17,18].

There are several problems with medical tourism as discussed by several authors [32,33] these include poor or no follow-up of care. After being in hospital for a short period, the patient comes home often with complications of surgery or toxic side effects of the drugs. As a principle every surgeon must look after his own complications and obviously that does not apply for most patients who have been treated abroad. Many destined countries have very weak malpractice legislations and patients have restricted capacity to complain about any poor medical care. Medical tourism also influences host countries with the setback of internal brain drain; whereby all high-quality doctors abandon serving the public sector to go into the lucrative private health care centres serving the medical tourists. Thailand's Brumungrad Hospital, which treats about more than half a million international patients a year, is a major source of internal brain drain leading to a political discussion within Thailand and shortage of Thai doctors in Bangkok because of the higher pay offered by Brumungrad [34]. Globalisation thus impacts world health care, both in the host and the donor countries [35]. There are other risks which medical tourism poses to patients. For example, patients may not tolerate travel very well, or may not have inherent resistance to some of the diseases in the host countries [12]. The article in this issue of this journal reported a 15% complication rate [36]. A survey by the British Association of Plastic, Reconstructive and Aesthetic Surgery showed 37% complication rate arising from overseas cosmetic surgery, much higher than NHS locally. In another survey in the UK, 60% of complications were of emergency nature requiring inpatient admission [37].

Many medical tourists are often satisfied with their endeavour. Satisfaction, however, does not always corresponds with quality of care, standard of care or desired outcome. Often satisfaction can merely be a result of courteous service [37]. An institution has to be accredited for good medical care with a quality assurance programme rather than just good service. Now more and more of the provider institutions try for accreditation by either the Joint Commission International (JCI) or for Canadian accreditation ACI.

Patients going abroad should get good prior advice. According to the World Tourism Organization's Global Code of Ethics for Tourism, tourists even medical should have the same rights as citizens of destination countries [38]. Unfortunately, this is not always true and that is another potential source of problems like in areas of confidentiality and an informed consent.

An additional probable substantial snag with medical tourism is that often it impacts the source country's health care system. A source country may befall complacent by sending its citizens abroad and thus fail to improve its health care services appropriately. The late acquisition of positron emission tomography (PET) in Oman is an example. Sending patients abroad is expensive, and dilutes the political will and commitment to develop several essential national services. This situation creates a two-tier system in the destination country where the local population receives second-class treatment while medical tourist gets much better treatment in the more sophisticated, well-equipped, state-of-the-art hospitals.

Another disadvantage of medical tourism is related to health insurance companies, who refuse to provide cover for a patient going abroad for legitimate reasons, or conversely may actually encourage patients to go abroad if the treatment is cheaper, but then not cover the travel and logistic expenses. If the insurance companies are asked to cover the cost of overseas treatment this may imply rising premiums, another undesirable effect on medical tourism for some patients.

Medical tourism commonly raises the expense of health care in the host country, by declining services and internal brain drain of hospital administrators and of doctors as described previously.

A foremost concern associated with medical tourism is the ethical aspects of treatment [32]. It should be examined and the risks discussed with the patient. On the other hand, patients must have their own autonomy in decision making. Beneficence and non-maleficence are the basis of medical ethics and it is our obligation to promote patients' well-being, treat them with justice and improve their health while avoiding harm to them. These ethical principles are not easily upheld in the delicate balance of commercial interests versus medical ethics. Another attribute of medical ethics is the ownership of responsibility for treating the complications of the treatment given abroad. Each country may have a distinct standard and code of medical ethics. For example, an experimental therapy in one country like stem cell transplant is routinely used in the private institutions providing care for medical tourists in other countries. Similarly, the medical ethics related to organ transplant vary from country to country. Most countries do not allow the involvement of money in organ donation, yet it is a common practice in some countries and donors can be a living non-relative. The Declaration of Istanbul on Organ Trafficking and Transplantation Tourism, 2008, has condemned organ transplant tourism [39] and it is the responsibility of medical profession to stop the trend of treating medicine and health care like goods, trade, or business [40,41].

Medical tourist from Oman showed a 95% satisfaction rate with lowest from India as 83.3%. Nearly 55% patient came back from abroad with improved clinical condition, and a reported complication rate was 15-33% [3].

Burney has pointed out in SQUMJ that medical tourism may receive "uncalled for treatment" [42]. The quality assurance trend in health care has introduced the term "consumer" to describe patients in an effort to improve the quality of care in hospitals. Unfortunately, the term "health consumer" is now misused in the business of delivery of health care. The quality and safety of medical treatment abroad has to be studied and questioned and it should be under the scrutiny of the medical profession and the Ministry of Health in Oman. Unless we have good grip on the quality of the care that our patients are receiving abroad, their safety may be at risk. We need more statistics, better studies and better reporting systems. The question of who will look after these patients when they return, has not been answered, but must be tackled. Thus, there is a major lack of systematic data about health services provided abroad, not only for Omanis, but, also for citizens of many other countries. More organised studies are needed and specifically outcome studies. Research into the delivery of health care has not yet adequately evaluated medical tourism. The issue of lack of data must be taken very seriously. Medical tourism has some benefits, but there are more problems with it and, as physicians, we have to keep in mind our basic principles of beneficence and non-maleficence.

Discussion and conclusions

A very small report published from Oman of 45 patients in 2011 disclosed that Orthopaedic ailments were the most frequent settings leading Omani patients to pursue treatment abroad. Thailand was the most preferred destination (50%) followed by India (30%). Approximately 85% of patients went abroad for only treatment purpose, 10% for treatment plus tourism; while 2.5% were healthy and went overseas for a routine health check-up. Intriguingly, 15% of the subjects went abroad without first seeking any medical care in Oman. From those who were initially evaluated and managed in Oman 38.2% had no precise diagnosis locally, and over 1/3 obtained treatment locally which was ineffective. About ¾ acquired information on management abroad from a friend, whereas Internet and medical tourism offices were the least used sources. More than 15% of the patients suffered from complications after their treatment abroad [3].

Oman has a national committee for making decision and advice on treatment abroad and decides on the eligibility of candidate patients. The number of people it sent for treatment abroad was only 20 per 100,000 of the population in 2010 (nearly 610 patients), declined from about 59 per 100,000 in 1977. There is further decline in this government outsourced number recently with the availability of PET scan in Oman. The number of patients going privately on their own expenses still remains high. The total expenditure on treatment abroad by the Ministry of Health (MOH) in Oman in 2003 was US$ 2.6 million [3,42].

It is a common observation in Oncology practice that at least 60-70% patients of cancer in Oman travel at least once during their management timeline. Over 85% patient come back to continue the treatment in Oman. The major reasons of travel are failure of early and prompt diagnosis, time delays in investigations and diagnosis, some investigations are not available, bottle necks and waiting lists in hospital, inability of primary and secondary care to envision and narrow down diagnosis, inability to refer timely to appropriate speciality, mistrust in the system and health care professionals, family pressures, social pressures, a symbol of affection to patients, a symbol of affluence and status, etc. Another perplexing issue is that a good number of patients

and their family are not informed about their diagnosis of malignancy. When they are not cured it obviously makes the patient to loose trust on treating physicians.

Multiple different factors clearly have an important influence on remedial tourism. Different motivations of medical tourists lead them to travel, whereas existing various risks also associated with it influence medical tourists to avoid destinations or avoid the travel. Travel constraints hindering the initiation of travel may also influence the decision making of medical tourists in terms of their visit intentions.

The motivations of medical tourists differ and may also vary based on individual needs and based on these perceived risks of medical tourists. Form of travel constraints can also be changed according to their regions of residence, health conditions, and medical needs.

We therefore need to have better scientific studies on the impact of medical tourism on the health care services of the source and destination countries as well as on the patients themselves. We need more statistics on the rate of complications. Americans and Europeans now realise that they need to analyse the impact of medical tourism—beneficent or maleficent—on the patients and the country's health care system.

Many of the patients do not get standard of care abroad, as the practices and management of foreign patients is not absolutely controlled and regulated. This is due to short stay and lack of knowledge on part of patients and their families. The outsourced patients, sent by government, are better off in this respect as the destination can be selected and de-selected periodically as per evaluation. Many patients coming back from abroad after consulting private physicians, brings with them fancy prescriptions which are standard of care not approved by regulatory bodies, nor recommended by international guidelines, after phase III randomized controlled trials. There are obviously issues of regulating practice at host destinations. The patients after being back insist on these, out of nowhere, treatment plans. In oncology it is a catch 22 situation, as an advanced cancer will progress after an interval. If you do not follow and change these out of bound prescription, on progression of disease you gets the blame. It puts clinical practice on defensive. On one hand you have to balance advice from abroad, while on other you have to satisfy those who are your practice regulators locally.

Due to low medical care costs India and Thailand were the most popular destinations for treatment abroad in Oman. Saudi patients travelled more to Pakistan, Philippines, Egypt and the United States. About 10% Omani travelled for tourism as well. A study on reproductive health tourism in the United Arab Emirates (UAE) observed that yet another reason for travel is privacy; an apprehension in a society where both infertility and in vivo fertilisation are yet stigmatised. It is interesting thing that a good number of the patients travel abroad directly without any local consultation or management. The reason for such trend is not clear, though dissatisfaction with local treatment may well be a reason. People still use traditional methods (word of mouth) as their source of information.

One may think that medical care abroad is cheaper, overall costs are still turn out to be high. The complication rate is quite high and late complications may ensue at a later date like graft rejection, CMV and hepatitis B and C.

More studies in the GCC region is needed to obtain a clearer picture of the treatment abroad trend. It is often difficult to obtain information on patients who travel abroad for treatment. There is a need to establish national registries and databases. Facts, figures, costs, implications, issues, and rights regarding medical tourism should be made clear to the community and must be safeguarded by appropriate regulatory and advisory agency. There must be a system to Accredit medical tourism companies and the institutes they represent and then regularly review their accreditation. These promotor companies must be obliged to contribute to funds to protect clients from financial losses and to compensations. The people should be mandated to report to their primary health care institution on their return for recording and follow-up. Patients planning on medical tourism should know that they need to consult their local doctors first, for advice and help even for 2nd opinion abroad.

If the trend of increasing medical tourism continues at an enhancing pace, it will have major global implications for public health systems, profession, practitioners and patients. A growing number of countries are now competing for patients by offering a wide diversity of medical and surgical services. There are growing medical tourism promotor companies with commercial interests which catch patients from hospitals and clinicians, facilitate appointments, and make travel arrangements and book hospital admissions. There is a business sort of situation, with commercial incentives for everyone at every level.

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