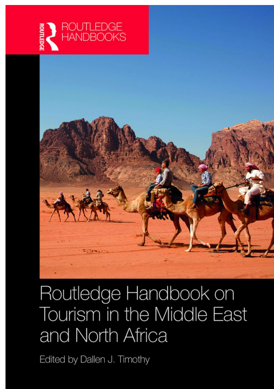
This article was downloaded by: *10.3.97.143*
On: 24 Mar 2023
Access details: *subscription number*
Publisher: *Routledge*
Informa Ltd Registered in England and Wales Registered Number: 1072954 Registered office: 5 Howick Place, London SW1P 1WG, UK



Routledge Handbook on Tourism in the Middle East and North Africa

Dallen J. Timothy

Medical tourism

Publication details
https://www.routledgehandbooks.com/doi/10.4324/9781315624525-27
John Connell
Published online on: 07 Dec 2018

How to cite :- John Connell. 07 Dec 2018, *Medical tourism from:* Routledge Handbook on Tourism in the Middle East and North Africa Routledge
Accessed on: 24 Mar 2023
https://www.routledgehandbooks.com/doi/10.4324/9781315624525-27

PLEASE SCROLL DOWN FOR DOCUMENT

Full terms and conditions of use: https://www.routledgehandbooks.com/legal-notices/terms

This Document PDF may be used for research, teaching and private study purposes. Any substantial or systematic reproductions, re-distribution, re-selling, loan or sub-licensing, systematic supply or distribution in any form to anyone is expressly forbidden.

The publisher does not give any warranty express or implied or make any representation that the contents will be complete or accurate or up to date. The publisher shall not be liable for an loss, actions, claims, proceedings, demand or costs or damages whatsoever or howsoever caused arising directly or indirectly in connection with or arising out of the use of this material.

27
MEDICAL TOURISM
In search of an economic niche

John Connell

Downloaded By: 10.3.97.143 At: 05:45 24 Mar 2023; For: 9781315624525, chapter27, 10.4324/9781315624525-27

PROOF

Introduction

It is sometimes said that the Mesopotamians originally established medical tourism when, as far back as the fifth millennium BP, they travelled to the temple of healing gods or goddesses at Tell Brak in Syria, perhaps in search of a cure for eye disorders. Thousands of years later, Greeks and Romans travelled to spas and Mediterranean coasts in search of respite and cures from the stresses of daily life. The very earliest global ventures into tourism were thus to gain access to some basic therapies associated with the curative properties of particular places, usually associated with water. Over the centuries, coasts and spas became health tourism destinations. Rather later a distinctive, less passive medical tourism developed.

While any definition of medical tourism is inconclusive, it has typically been associated with long-distance, international travel for some kinds of invasive procedures, notably cosmetic surgery. In practice, much of medical tourism is relatively short distance, over adjacent borders and involves procedures as basic as check-ups (Connell 2013, 2015). Definitions of medical tourism are linked to duration, volition, who pays and what is involved. Stem cell therapies have sometimes been excluded, whereas mobility for fertility treatment has been included. While reproduction appears a private and intimate affair, it is bound up in national policies (for example, towards abortion, adoption, provision of contraception, family sizes and one-child families), in what has been described as a 'global market of commercial fertility' or 'cross-border reproductive care' (Inhorn 2011, 2015). Here and elsewhere medical tourism is inextricably related to national policies.

Long-distance travel for medical care has existed for centuries in the Middle East and elsewhere, but it developed in a more modern form in the nineteenth century with the movement of patients to such cities as London, Berlin and New York. Relatively well-off individuals travelled from the countries of the south, including the Middle East, to those of the north. Rather later, Lebanon and Cairo also became attractive destinations for Middle Eastern travellers, but the less well-off travelled to India.

What is now generally regarded as medical tourism is an inversion of this structure, with patients moving from the wealthier countries of the north to those of the south. Its recent growth is largely associated with the rise of travel to South and Southeast Asia, notably to Thailand, Malaysia, Singapore and India (Connell 2011a). The established pattern of movement

9781138651920_pi-386.indd 352 24-Sep-18 7:02:25 PM

of wealthy individuals, travelling northwards from regions such as the Middle East, has fundamentally remained in place because of the status attached to European medicine, while multiple movements also exist across European Union borders, and between the countries of the south; however, most conventional usage of 'medical tourism' relates to movement from richer countries towards poorer countries. Indeed, quintessential medical tourism was often that of mobility from relatively rich Gulf states, notably UAE and Saudi Arabia, to the emerging Asian destinations.

Relationships with tourism and leisure, as sources of pleasure and relaxation, may be tenuous or simply absent for sick, anxious and stressed patients, yet frequent repetition and industry support, for obvious marketing reasons, ensure that international medical travel remains 'medical tourism'. Nonetheless, since mobile patients (and accompanying kin and carers) must travel and stay somewhere, and take advantage of the facilities designed for tourists—principally hotels, restaurants and transport services—and perhaps avail themselves of a range of activities, often during periods of convalescence, such as shopping, medical travel is intricately linked to the tourism industry (Connell 2011a), and is widely marketed and advertised as a pleasurable experience. In a sense, medical tourism constitutes a particular example of niche tourism, though more normative tourism is only exceptionally an intentional part of medical tourism.

Medical travel represents a dynamic transnationalisation of healthcare, once assumed to be highly localised, but now transformed through new knowledge, communications, aspirations, affluence, transport and biotechnology (Ormond 2013). This is part of a wider globalisation of healthcare—involving the mobility of skilled health workers, technology transfer, pharmaceuticals (and diseases and lifestyles), hospital chains, public–private partnerships, and global governance—and of travel. Medical tourism is uneven because of intense competition, political instability and, like the related tourism industry, is subject to shifts in economics, fashion, flight paths and technology, the fluctuations of personal and national economies, and the stability of destinations. It has added one more component to the commodification and globalisation of 'intimate industries' such as adoption, retirement, marriage, sex tourism, and sex work (e.g. Constable 2009; Yeates 2009). Medical tourism is particularly complex in the Middle East as many countries and corporations aspire to be involved and flows of medical tourists are into, out of and within the region.

Because of the competitive nature of the industry, boosterism, the range of procedures, institutions and places involved, the privacy of medical records and the need for success, accurate data are rare and numerical data are rarely anything more than generous guesstimates (Connell 2015a). Even much-quoted and repeated 'data' often prove to be merely derived from newspaper articles or press conferences. That is complicated further since, even more than other facets of tourism, medical tourism is particularly susceptible to political unrest, since sick patients are especially unwilling to travel to dangerous places. Unrest, violence and volatile politics in the Middle East have slowed the growth of medical tourism, discouraging diasporic medical tourism (so significant elsewhere) and even restricted mobility from the region to distant sources of medical care.

This chapter seeks to review recent trends in medical tourism in the Middle East, so covering the rationale for and pattern of travel outside the region, and attempts by Middle Eastern locales (notably Dubai) to reverse the outflow of medical tourists by developing more cost-effective local facilities and the impact of medical tourism in various states. It emphasises the high costs of medical care within much of the region, and especially the Gulf, the ethical concerns attached to giving priority to overseas patients and the constraints to developing an effective industry.

Downloaded By: 10.3.97.143 At: 05:45 24 Mar 2023; For: 9781315624525, chapter27, 10.4324/9781315624525-27

PROOF

9781138651920_pi-386.indd 353 24-Sep-18 7:02:25 PM

Patients and procedures

People engage in medical tourism for a range of reasons. Patients seek out treatments unavailable, inadequate, too delayed or unaffordable at home, especially by moving to places where health care is relatively cheap. Where insurance does not cover such procedures as dentistry and cosmetic surgery, medical tourism offers an option. Demand for relatively rare or complex procedures may involve more distant travel than for straightforward procedures.

A significant component of medical travel is of diaspora patients returning to familiar, usually cheaper circumstances. Such travellers have been poorly documented, being perceived of as having limited economic significance (although that is rarely true) and difficult to distinguish from local patients. The return migration of Indians effectively instigated medical tourism in India. Cultural and linguistic familiarity, proximity, speed, effectiveness and cost are all advantages. In Turkey and Jordan, returning overseas nationals are a significant proportion, perhaps a majority, of medical travellers, which may be true elsewhere (Connell 2011a), and it has accounted for a part of medical tourism elsewhere in the Middle East.

Costs are important and many procedures in the Middle East are routinely stated to cost about a tenth of those in the United States, but they are similar to those in South and Southeast Asia, providing no real global comparative advantage for developing medical tourism. The Middle East must therefore compete on quality (and accessibility) in an amenable cultural context. Turkey, like other countries, thus promotes high quality and low price services, internationally accredited hospitals, educated and experienced human resources and short waiting times, while stressing its general popularity as a tourist destination, where health (wellness) tourism is also possible and popular (Kaya, Karsavuran, & Yildiz 2015). Turkey has also signed agreements with a number of countries, including Sudan, Afghanistan, Yemen, Albania and Kosovo, for the planned treatment of their patients, provided financial support for promotion and marketing and given tax exemptions on half the income earned from medical tourism (Kaya et al. 2015). Few other Middle Eastern states have directly supported the medical tourism sector or developed effective strategies to support it.

Medical tourism involves a range of procedures. The very limited data from Turkey suggest that international patients came primarily because of eye diseases, followed by orthopaedics, internal diseases and ear-nose-throat problems (Kaya et al. 2015). Despite cultural conservatism, demand for cosmetic surgery, especially rhinoplasty and breast augmentation, has substantially increased in the region. Here medical tourism is a want rather than a need, an exercise in empowerment and the discovery of self, distinct from physical notions of 'cure'. Relatively poor regional patients are more likely to travel shorter distances across adjacent borders for quite straightforward procedures and economic reasons (Connell 2016), coming from large parts of the world where basic treatments are expensive or simply absent, because of national policy failures and practices, sometimes because of civil unrest, and often because of the emigration of skilled health workers. Thus, Afghanistan provides a regular flow of medical tourists to Iran, as does Yemen to Lebanon.

Despite the images and aspirations promoted by the industry, much mobility is across nearby borders, with social networks facilitating choice of procedure and destination, and is also often of the diaspora, drawn by cheaper prices, cultural and linguistic familiarity and familial support. Libyan and Afghan medical travellers go mainly to Tunisia and Iran respectively. Azerbaijanis and Iraqis from Kurdish areas travel to Iran (Jabbari, Kavosi, & Gholami 2014; Noubar, Heidarzadeh, & Bahador 2014) while other Iraqis go to Jordan. More than 80 per cent of medical tourists in Shiraz, the main Iranian destination, come from Oman, Bahrain, UAE, Kuwait and Iraq, with a few from Canada and France, significant centres of the Iranian diaspora (Safaeepour,

Downloaded By: 10.3.97.143 At: 05:45 24 Mar 2023; For: 9781315624525, chapter27, 10.4324/9781315624525-27

PROOF

9781138651920_pi-386.indd 354 24-Sep-18 7:02:25 PM

Goodarzi, & Rostami Kondari 2015). By contrast, Turkey claims that most of its medical tourists come from European countries like Germany, the Netherlands and Belgium (Medical Tourism Magazine 2013); if that is so, it is likely that most were of Turkish ancestry. In 2012, most medical tourists in Turkey came from Libya, Germany, Iraq, Azerbaijan and Russia (Kaya et al. 2015): a mix of neighbours and the diaspora. For the more specialised case of reproductive travellers in Dubai, the largest group came from India, followed by Lebanese and from a grand total of 50 countries (Inhorn 2012).

At every scale and in every region, word of mouth concerning quality of care is of crucial importance (e.g. Kangas 2007; Yeoh, Othman, & Ahmad 2013). Despite the rise of the Internet, in Oman more than 70 per cent of medical travellers got their information from friends and a further 19 per cent from family (Al-Hinai, Al-Busaidi, & Al-Busaidi 2011). Word of mouth and precedent are more valuable than international recognition. The most significant global accreditation is by JCI (Joint Commission International) but, while well understood within the industry, it is of little significance to most potential travellers contemplating destinations. Nonetheless, in 2014 Turkey had 43 JCI-accredited hospitals, Jordan had ten, Egypt seven and Lebanon four. The UAE had even more than Turkey—a crude and limited measure of the strength of health services in the region.

In quest of niches

Medical tourism emerged in Asia after the Asian financial crisis of 1997 and in this century has become particularly competitive as new countries and transnational corporations have sought to enter the market. International mobility has become more probable and feasible as privatisation of medical care continues, discontent with public care increases, cosmetic procedures are marketed and disposable capital is available. Medical tourism is consumer-oriented and competitive, centred on price and quality, since some procedures do not need to be undertaken, and most are possible in many countries, usually including home countries.

Medical tourism is a source of foreign exchange and employment; earnings from incoming patients are potentially greater than from domestic patients, especially where the public sector dominates healthcare, while the expenditure of medical tourists can be greater than that of standard tourists (partly because of the duration of stay). It therefore appears an attractive option for many countries despite ethical questions centred over its relationship to national health care provision. In 2003 in Tunisia, the only country where reasonable income estimates exist, medical tourists spent rather less than average tourists, but medical tourism created more than 10,000 jobs, over half of which were in the tourism sector (Lautier 2008). Patients rarely travel alone, preferring family groups for friendship and reassurance (Connell 2011a), thereby making a larger contribution to destination incomes.

National and institutional interest in economic development and diversification have instigated both 'strategic' investment to encourage inward flows of medical travellers and 'defensive' investment to discourage outbound travel and capital flight. Both situations exist in the Middle East. Many countries and hospitals have sought to develop medical tourism, despite the challenges of breaking into a crowded market, where experience is invaluable and word of mouth vital. Several Asian states, such as Malaysia and Korea, have been vigorous national proponents of the industry, as a modern, strategic growth strategy, with hospitals subsidised through advertising, tax reduction or infrastructure support (Connell 2011a). Outside Turkey, such support and promotion has been rare in the Middle East. However, various improbable claimants have emerged. Some countries have geographical and cultural advantages, are adjacent to a large market, have a reasonable tourist reputation, political stability, and a significant

Downloaded By: 10.3.97.143 At: 05:45 24 Mar 2023; For: 9781315624525, chapter27, 10.4324/9781315624525-27

PROOF

9781138651920_pi-386.indd 355 24-Sep-18 7:02:25 PM

diasporic population. Others lack the necessary skilled human resources, sometimes as outmigration has created shortages. Success requires an existing health industry, investment, a positive image, identity and political stability, somewhat difficult to create in a volatile competitive context where some countries are barely known, even in what they perceive as future markets, or are known as places of turbulence rather than tranquillity.

Despite widespread assumptions that medical tourist numbers are increasing, there is no particular reason to assume that this is so, nor that new countries might easily establish an industry. Indeed, success in following the leaders has been rare. Korea, having oriented itself to a growing Russian and Chinese market, is a rare example of belated success, but otherwise no great diversification from the established players has occurred.

For much of recent history, the countries of the Middle East have been suppliers of medical tourists to other parts of the world, especially as oil wealth made this feasible for greater numbers of people. Much of this has been associated with the movements of patients to Europe and, more recently, to Southeast Asia and India, an established destination for less well-off patients from Oman and the UAE particularly. At the same time there have been some significant flows within the Middle East from relatively poor countries such as Yemen. After 11 September 2001, when Middle East residents became, and perceived themselves to be, more unwelcome in the United States, medical tourists became rather more likely to travel to Asia. Falling oil prices and thus revenues from the mid-2010s have slowed medical tourism from the region, and encouraged more 'defensive' investments.

The outwards flow of medical tourists from the Middle East has been a function of the affluence of many patients from states such as Saudi Arabia and the UAE, but also of the willingness of the state, in countries like the UAE, Kuwait, Qatar, Bahrain and, formerly, Libya, to foot the bills of overseas patients and, in many cases, of their close kin. Many formal, documented medical travellers in major Thailand metropolitan hospitals are thus from the UAE and other Gulf states. They are reputed to come with more family members, and spend more both on healthcare and beyond; hence, hospitals in South and Southeast Asia have sought to emphasise their being Arab and Moslem-friendly, with halal food, Arabic-speaking staff, and distinct wings and floors of hospitals (Ormond 2013). Symbolically, images of Gulf patients typify popular coverage of medical tourism in Thailand.

Violence in the Middle East has also had implications for medical tourism from the region. Indian hospitals lost patients from Iraq and Syria in mid-2014 when increased insurgency resulted in medical travellers' inability to secure plane tickets, the Iraqi government being unable to fund them, while visa restrictions and security concerns prevented Indian doctors travelling to the region to engage in preliminary consultations (Anon. 2014).

Developing medical tourism

Most regions have one or more countries that have sought to position themselves as medical tourism hubs. Some such regional hubs have succeeded; in the Middle East there has been only partial success, because of the inadequacies of some national health care systems and nearby violence, rather than the attractions and benefits of cross-border mobility. Beneficiaries of violence in parts of the region have been those neighbours that have remained largely stable and peaceful. Iran has drawn medical travellers from nearby troubled countries (after initially entering the industry for 'defensive' reasons), as has Tunisia for the Maghreb, while Jordan has targeted both the Arab diaspora and nearby Iraq and Syria. Symptomatic of the challenges that face medical tourism in the Middle East are those that beset Turkey in 2016, seen as 'the falling star of medical tourism' as 'it faces a battle to combat the impact of terrorism, Syria, human rights issues,

Downloaded By: 10.3.97.143 At: 05:45 24 Mar 2023; For: 9781315624525, chapter27, 10.4324/9781315624525-27

PROOF

9781138651920_pi-386.indd 356 24-Sep-18 7:02:25 PM

embargoes, refugees and civil war' (Youngman 2016: n.p.), even before a decline in Russian tourism (because of political differences between Ankara and Moscow), bombings in Ankara and Istanbul, and an attempted military coup.

Medical tourism has grown slowly in MENA, often assisted by diaspora patients. Jordan, Tunisia and Turkey have been relatively successful. Jordan serves patients from some parts of the Middle East, and at least in 2005 its low costs made it a regional hub, especially for patients from nearby Iraq, Palestine and Syria, without the resources to travel to more distant locations (Alsharif, Labonté, & Zuxun 2010). Unlike several states which, largely unsuccessfully, targeted better-off patients, from as early as the 1990s Jordan sought to become a popular destination for less well-off patients from Yemen, Libya, Algeria, Sudan, Iraq and Syria. It has also specialised in, and become recognised for, reproductive medicine.

It was said that in 2007, including some health and wellness visitors, over 250,000 patients from around 84 Arab and other foreign countries were treated in Jordan (Vequist, Bolatkale, & Valdez 2009). No data corroborated that and exactly the same number was given for 2012 with patients said to be accompanied by more than 500,000 companions with a total revenue exceeding US$1 billion. A year later it was claimed that 210,000 patients came from some 48 countries, and US$1 billion—some 4 per cent of GDP—was again suggested (Kronfol 2015; Stephano 2014). Political stability and an existing tourism infrastructure have been beneficial. Though, as elsewhere, neither numbers nor revenue are likely to have been so substantial. Indeed, Jordan's ability to provide health care for foreigners has been challenged by the influx of refugees from Iraq and Syria, and the need to provide for them, and a shortage of health workers, especially nurses.

In North Africa, Tunisia claims dominance with as many as 250,000 foreigners said to have visited the country for medical treatment in 2009. If true, that would represent a massive increase from 2003 when 42,000 foreigners, more than three-quarters from Libya, were said to have arrived for medical treatment, generating a revenue of US$55 million and providing an estimated 10,500 jobs (Connell 2011a; Lautier 2008). By 2013, an estimated 155,000 foreign patients visited Tunisia, again mainly from Libya. Most medical tourists in 2009 came from adjoining Libya (perhaps up to 70 per cent) and Algeria, but also from Sub-Saharan Africa (about 12 per cent), notably from Francophone and Moslem states. Some medical tourists are said to be Westerners (from France, Germany and elsewhere in Europe). Thus, Tunisia has drawn patients from nearby, either from the more affluent parts of Western Europe, some of whom are migrant Tunisians, from adjoining Libya and from other Francophone sources—a range of countries greater than for most other MENA destinations. Recently, Tunisia has faced terrorist actions that have devastated its tourism industry, and Morocco has provided growing competition as a somewhat similar destination, close to Western Europe, with an extensive tourism infrastructure, and such specialisms as cosmetic surgery, laser eye surgery and dental tourism. It has attracted older patients from Francophone European countries, but especially Moroccan migrants in Europe.

Turkey, like Tunisia, until recently relatively peaceful and with a modern health care system, has had some success with cosmetic surgery, and has sought to promote both health and medical tourism (Sugorakova 2014). Turkey grandly claimed to have received 300,000 medical tourists in 2013 (although this included health tourism) and was seeking to double that total by 2023. That was an advance on the equally dubious figure of 270,000 in 2012 who were said to have produced a net revenue of US$1 billion (Kaya et al. 2015; Medical Tourism Magazine 2013). Once again, diaspora medical tourism was common (Nielsen, Yazici, Petersen, Blaakilde, & Krasnik 2012). Turkish medical tourism has had relatively strong government support and promotion, links with the national airline and public–private

Downloaded By: 10.3.97.143 At: 05:45 24 Mar 2023; For: 9781315624525, chapter27, 10.4324/9781315624525-27

PROOF

9781138651920_pi-386.indd 357 24-Sep-18 7:02:25 PM

partnerships, and a strong tourist industry. It has had some success with hair transplants and, somewhat improbably, a niche within a niche: moustache transplants. Unlike most Middle Eastern countries, Turkey has actively sought a Sub-Saharan market, directed at the many travellers leaving Kenya and Nigeria, with the Medical Park Hospital Group, a consortium of 19 hospitals in Turkey, orienting to Kenya (quoted in Medical Tourism Magazine 2014: 22). Little African success has yet been reported.

Even such limited successes have largely eluded other states. Israel caters to Jewish patients and others from nearby countries, through specialising in female infertility, IVF and high-risk pregnancies. It has also sought to market medical tourism in combination with the perceived therapeutic and restorative qualities of the Dead Sea, one of the rare examples in the Middle East where medical tourism had been combined with a broader restorative health tourism. In 2010, Israel is said to have received 30,000 medical tourists, many of whom were from Russia, and Russia remains a key source.

Egypt and Lebanon, once the major tourism destinations of the Middle East, have sought to break into medical tourism. Making Lebanon the 'hospital of the East' has been the ambition of its Tourism Council for over a decade, and a relatively modern health care system otherwise offers opportunities, especially for cosmetic surgery, but Lebanon has been hampered by the lack of a durable peace in Beirut. As elsewhere, Iraq has been a source of many medical travellers, whether in need of basic care or seeking cosmetic surgery, with continued warfare in places and the breakdown of the national health care system (after the departure of military health care services and the migration of skilled professionals). A significant proportion has gone to Lebanon for cancer treatment. While the growth of medical tourism was predicted to average an annual 30 per cent between 2009 and 2011 (Connell 2011a), there was a steady decline in numbers as political tensions increased, so that only Jordanians and Iraqis go to Lebanon. Lebanon is one of the very few countries that has ever admitted to an actual decline in medical tourism numbers.

Egypt claimed in the first decade of this century to receive 50,000 medical tourists a year from other Arab countries, including perhaps 40,000 from Libya, and was seeking to build medical tourism around rehabilitation and recuperation alongside its existing tourism industry (Helmy & Travers 2009; Johnson 2010). But that was before the 'Arab spring' became a bleak autumn, and tourism numbers plummeted.

In Iran, the health minister claimed in 2004 that 'No Middle East country can compete with Iran in terms of medical expertise and costs', comparing the cost of open heart surgery at US$18,000 in Turkey, US$40,000 in UK and US$10,000 in Iran so that patients 'can afford the rest on touring the country' (quoted in Connell 2011a: 55). However, such arguments have not enabled steady development of a medical tourism industry in a country where diasporic tourism is minimal, and political tensions and religious differences with neighbours discourage regional travel. It is claimed that some 30,000 people went to Iran in 2012 for medical treatment but the figures are impossible to verify. Most medical tourists are from relatively poor neighbouring countries including Azerbaijan, Turkmenistan, Iraq and Turkey, or they are less affluent residents of Kuwait and Oman.

Even high-cost Saudi Arabia has sought to link medical tourism, and especially cosmetic surgery and dentistry, with pilgrimage (*hajj*) visits to the country, with most patients being from other Gulf countries (Connell 2011a). That was never likely to lead to an industry. Bahrain, too, has considered medical tourism as a means of diversifying away from the oil industry (Ebrahim and Ganguli 2017) but is unlikely to be competitive in the near future.

By 2016, relatively low-cost Jordan remained the main medical tourism destination in the Middle East, with Israel an emerging but limited success story, and Tunisia and Turkey fading in the face of violence. Compared with other regions of the world, medical tourism in the Middle

Downloaded By: 10.3.97.143 At: 05:45 24 Mar 2023; For: 9781315624525, chapter27, 10.4324/9781315624525-27

PROOF

9781138651920_pi-386.indd 358 24-Sep-18 7:02:25 PM

East has been limited, and is characterised by patients leaving the region, or crossing regional borders, rather than visiting from more distant countries, despite a small flow from the diaspora.

Reversing the flow?

While such countries as Tunisia, Lebanon and Iran were actively promoting medical tourism as a national revenue-generating exercise, a second phase became more evident towards the end of the 2000s when some Middle Eastern states, notably the UAE, centred on Dubai, began to discourage medical tourism, because of the significant loss of income, and instead to develop more adequate and accessible local facilities, that might also play a role in attracting medical tourists from elsewhere in the region, who might have otherwise gone elsewhere. While Lebanon and Jordan have drawn patients from the Gulf States, most medical tourists from there have gone to Asian or high-cost European destinations. The huge loss of medical tourists overseas has prompted Gulf States to develop better national services with the intention of redirecting flows of medical tourists. Enormous variations exist in the extent to which countries have given financial support to health services, and contributed to a regional medical tourism industry by easing the entry of foreign capital and corporations, removing visa restrictions or establishing public–private partnerships.

After 2002, Dubai began to build Dubai Healthcare City (DHCC) in order to capture the Gulf and Middle Eastern market and discourage Gulf medical tourists from going to Asia. DHCC was intended to be small city, centred on a 'medical mall' offering a range of services. Unable to compete on price, the Gulf now largely seeks to compete on quality, with Dubai bringing in German doctors to guarantee high skill standards, and hired many foreign specialists to build expertise in the medical field and become a regional hub. It has also extended the visas of medical tourists and their carers from one to three months.

In 2014, the Dubai medical tourism strategy was aiming at building expertise in orthopaedics, sports medicine and a range of other specialisms and had a target of bringing half a million medical tourists a year to the city's hospitals by 2020. In 2015, the city reported 135,000 foreign visitors using its hospitals, and this was expected to increase to 150,000 in 2016. However, a majority were expatriate residents in the UAE, rather than travelling there for medical care. A minority, however, were infertile men from various parts of the Middle East, notably Lebanon and other parts of the UAE, and elsewhere, especially India, travelling for Dubai's particular specialisation (Inhorn 2012, 2017). Since prices for cosmetic surgery are similar to those in London, and thus much more than in Asia, Dubai must otherwise compete on quality, and by 2015 there was very little evidence that it had been able to do that (Kronfol 2015). Moreover, Dubai continued to struggle to provide the basic healthcare needs of its own rapidly growing population.

As medical tourism has grown in the Gulf, rich world countries have become more involved. Thus, the Bavaria Medical Group (BMG) has developed links with Oman and Qatar Airways, with some patients being taken from Oman to Germany, and specialist BMG doctors visiting Oman, the latter of which may have contributed to better national health, and reduced some flows, but has not reversed them. Such developments are yet to attract medical tourists to high-cost destinations. The Gulf states have not stemmed the tide.

Ethics and equity

The language of contemporary international, corporate healthcare involves public relations prose, aggressive marketing, profitability, business models and trade fairs. In Asia especially

Downloaded By: 10.3.97.143 At: 05:45 24 Mar 2023; For: 9781315624525, chapter27, 10.4324/9781315624525-27

PROOF

9781138651920_pi-386.indd 359 24-Sep-18 7:02:25 PM

regional and global networks of hotel chains have extended, with packages linking tourism, airlines and healthcare (Toyota, Chee, & Xiang 2013) and 'hospitels'—hospitals that resemble hotels—but that phase with its elaborate linkages has yet to occur in the Middle East. That has not displaced some concern over the impacts of medical tourism.

Healthcare is labour intensive yet many countries where medical travel has emerged, or is proposed, have existing skilled health labour shortages, uneven access to healthcare, and an internal brain drain of skilled health workers, hence the emergence of two-tier systems—a private sector serving better-off local and international patients, where medical tourism is established, and a public sector that may be underfunded and short of skilled workers, especially in regional areas. Concern exists in several Asian destinations (Chen & Flood 2013; Connell 2011b), and in Israel and Jordan, skilled health workers (doctors, nurses and technical staff) may be drawn into the medical tourism sector (where wages are higher) at some cost to the national system, without real national benefits from taxation. By contrast, in Tunisia entry in the medical tourism industry was stimulated by the overcapacity of private clinics (Lautier 2008). Although this does not necessarily mean an effective public sector, there was no evidence that medical tourism had disadvantaged the Tunisian health system, either through an internal brain drain or the diminished availability of healthcare for the poor. The costliest medical tourism is a metropolitan phenomenon, rarely evident outside capital cities (because of preferences for direct flights and JCI-accredited hospitals), hence concerns exist over urban bias and the marginalisation of remote regions. In Lebanon at least, medical tourism has been perceived as attractive enough to draw in fake providers, often of 'alternative' medicine, and of counterfeit drugs and medicines (Anon. 2015). That too has failed to boost the image of the industry in the region.

In Israel, particular attention has been given to notions of national need and equity: an indication that medical tourism has been significant enough to attract wider health policy interest. Some Israeli hospitals give preferential treatment to medical tourists at the expense of locals, and medical tourism revenue goes directly to doctors rather than being reinvested in equipment or hiring staff. A two-tier system has emerged where hospitals provide the best facilities to affluent patients from Russia and elsewhere, resulting in a general shortage of beds and nurses (Anon. 2016a; Connell 2015b). That prompted Israel, in 2016, to pass a Medical Tourism Bill, supported by the Minister of Health, at the core of which were three principles: quality of and access to treatment for Israeli citizens must not be lowered and should be improved (perhaps anticipating some trickledown benefits); income received from the medical tourism sector must be directed to improving the public health system (a rare recognition of national health care provision in association with medical tourism); and the need to ensure that medical tourists must be 'protected', by receiving ethical, professional and fair treatment. To enable these three principles to be achieved, it was intended, first, that restrictions be put on the total number of medical tourists in a particular hospital, to ensure that the quality of care for Israeli citizens would not be compromised. Second, hospitals interested in attracting medical tourists must develop infrastructure to send adequate data to the Ministry of Health so that procedures could be properly monitored. Third, income from medical tourists must be utilised to improve the public healthcare system, and fourth, hospitals must show economic flows in a transparent manner in order to properly track the revenues gained from medical tourism (Anon. 2016b).

More than any other Middle Eastern state, Israel has consciously considered how medical tourism might fit into the national health care system and, more importantly, not compromise (but rather improve) overall health care. More frequently, medical tourism has not been conceptualised within the national system. Concern for any negative consequences of medical tourism has been largely absent elsewhere. That may be a partial reflection of the relative insignificance of the industry, but there is reason for concern over the extent of tax

Downloaded By: 10.3.97.143 At: 05:45 24 Mar 2023; For: 9781315624525, chapter27, 10.4324/9781315624525-27

9781138651920_pi-386.indd 360 24-Sep-18 7:02:25 PM

exemptions offered to the Turkish industry, and the promotion of a private sector that is unusually advantaged relative to the public sector. Moreover, Israel's national health care system, where medical tourism exists within the public sector, enables a greater degree of regulation and the possibility of generating more useful data on its economic significance, than is occurring elsewhere. Beyond Israel and, to a limited extent, Tunisia, no analyses have been made of the wider impact of medical tourism, although, other than in Turkey and Jordan, it is unlikely to have had a significant impact.

Nonetheless, even Israel has experienced a situation where

> attempts over several years by the government and politicians to find out if medical tourism affects the health services offered to locals have been stymied by hospitals flatly refusing to cooperate and argue that information on numbers, spend or profit are all commercial information that no state organisation or politician can have access to.
> *(Anon. 2016a: n.p.)*

This is even more indicative of the situation elsewhere and emphasises the scepticism that must be attached to all data.

Little solid research has been undertaken on the industry in the Middle East, hence conclusions over its economic and social impact, and the extent to which it has influenced the national health system or the tourist industry are conspicuous by their absence. Attempts to develop medical tourism plans have often been frustrated by the lack of data and the unwillingness of hospitals and other organisations to release relevant data, as in Egypt (Helmy & Travers 2009). There is some risk that should medical tourism in the Middle East grow, its ethical and equitable impacts will be ignored in the pursuit of economic growth, as is presently occurring in Jordan and Dubai.

Conclusion

Political instability, weak and fragile states, inability to deliver services adequately, and wealthy individuals, ensure there will always be sources of medical tourists, but impecunious travellers attract little interest in the industry, where ability to pay and stay is welcomed. With many countries unable to meet the basic health needs of all their people, medical travel is relatively common, but often for simple procedures across regional borders. By contrast, medical tourism in the Middle East is symbolised by relatively well-off patients and their families travelling in some degree of style to Europe and Southeast Asia. That better-off patients choose to travel overseas, and lack trust and confidence in national systems, has been a significant brake both on developing health care systems in the Middle East and making the region a destination for medical tourism. Consequently, despite attempts to reduce flows from the region and build more effective local and national health care systems, catering for both national and overseas needs has yet to occur. Even relatively successful nations, such as Jordan and Turkey, have been held back by considerations of regional violence and distrust, while developments such as DHCC are out of economic reach for most of the population of the region.

Medical tourism is particularly susceptible to political unrest, and global images of a region seemingly constantly fraught with internecine warfare and unending instability have discouraged all forms of medical tourism. That has been well summed up for Lebanon: 'The problem is how to change the image of the country and get more medical tourists from a wider range of countries. As yet the government has no solution' (Anon. 2016c: n.p.). That has consequently stimulated more interest from countries such as Germany to attract

Downloaded By: 10.3.97.143 At: 05:45 24 Mar 2023; For: 9781315624525, chapter27, 10.4324/9781315624525-27
PROOF
9781138651920_pi-386.indd 361 24-Sep-18 7:02:25 PM

medical tourists from the region (Stephano 2015). Diaspora medical tourism has helped keep Lebanon and Turkey afloat. Bombing, an attempted coup and subsequent repression have almost destroyed contemporary Turkish aspirations. Medical tourism is fragile and fluid. Intra-regional competition is strong. Violence has deterred corporate interest and limited successful linkages with the travel industry. Inadequate health services in several countries and the loss of skilled health workers have done much to stimulate the regional medical travel of both the poor and the wealthy. Much travel is of the most needy, themselves often affected either directly by violence or by its outcome. Only rarely can it be seen as tourism; for such travellers, despite their expenditure on travel, food and accommodation, tourism has no relevance.

Much dubious data is centred around grandiose expectations of growth that are barely based in reality. Only Kangas (2002, 2007, 2011) and Inhorn (2012) have studied medical tourism from the perspective of the travellers themselves and their welfare. With the partial exception of Tunisia, no published source examines the economic impact of medical tourism anywhere in the region. Ethics have been avoided. Effective forward planning will require more accurate data.

Quite different national strategies, alongside those of hospital chains, are indicative of the increasingly complex globalisation of healthcare, the multi-directional flows of patients and investment, the extent of corporatisation, the centralisation of profits, and orientation towards those who can pay (rather than those in need). Some Middle Eastern governments have strongly promoted medical tourism, occasionally in association with health tourism. Others, such as Iraq and Syria, have more immediate objectives. Border crossers and basic needs are absent from all such strategies. Here, even more than elsewhere, mobility for healthcare has little to do with tourism, and is centred on needs rather than wants, and far from dominant images of global trajectories in search of expensive and indulgent cosmetic surgery. However, without a lasting peace in the region, medical tourism may well remain that of the relatively poor from nearby, and the distant departure of the better off—a distinctive regional two-tier system, rather than an industry that fills a niche and comes close to rivalling that in other parts of the world.

References

Al-Hinai, S., Al-Busaidi, A., & Al-Busaidi, I. (2011) 'Medical tourism abroad: A new challenge to Oman's health system—Al Dakhilya region experience', *Sultan Qabus University Medical Journal*, 11: 477–484.

Alsharif, M., Labonté, R and Zuxun, L. (2010) 'Patients beyond borders: A study of medical tourists in four countries', *Global Social Policy*, 10: 315–335.

Anon. (2014) 'Iraq crisis hits Indian medical tourism'. *International Medical Travel Journal*, 14 July. Available online: www.imtj.com/news/iraq-crisis-hits-indian-medical-tourism/ (Accessed 12 September 2018).

Anon. (2015) 'Lebanon seeks to clean up health care provision'. *International Medical Travel Journal*, 25 August. Available online: www.imtj.com/news/lebanon-seeks-clean-healthcare-provision-0/ (Accessed 12 September 2018).

Anon. (2016a) 'Israeli hospitals must record medical tourism statistics'. *International Medical Travel Journal*, 6 October. Available online: www.imtj.com/news/israeli-hospitals-must-record-medical-tourism-statistics/ (Accessed 12 September 2018).

Anon. (2016b) 'Israel makes headway in medical tourism legislation'. *Medical Tourism Magazine*, November. Available online: www.medicaltourismmag.com/israel-medical-tourism-legislation/ (Accessed 12 September 2018).

Anon. (2016c) 'Medical tourism a priority for Lebanon'. *International Medical Travel Journal*, 30 October. Available online: www.imtj.com/news/medical-tourism-priority-lebanon/ (Accessed 12 September 2018).

Chen, Y., & Flood, C. (2013) 'Medical tourism's impact on health care equity and access in low- and middle-income countries: Making the case for regulation', *Journal of Law, Medicine and Ethics*, 41(1): 286–300.

Connell, J. (2011a) *Medical Tourism*. Wallingford: CAB International.

Downloaded By: 10.3.97.143 At: 05:45 24 Mar 2023; For: 9781315624525, chapter27, 10.4324/9781315624525-27

9781138651920_pi-386.indd 362 24-Sep-18 7:02:25 PM

Connell, J. (2011b) 'A new inequality? Privatisation, urban bias, migration and medical tourism', *Asia Pacific Viewpoint*, 52: 260–271.
Connell, J. (2013) 'Contemporary medical tourism: Conceptualisation, culture and commodification', *Tourism Management*, 34(1): 1–13.
Connell, J. (2015a) 'Medical tourism: Concepts and definitions', in N. Lunt, D. Horsfall, & J. Hanefeld (eds), *Handbook on Medical Tourism and Patient* Mobility (pp. 16–24). Cheltenham: Edward Elgar.
Connell, J. (2015b) 'From medical tourism to transnational health care? An epilogue for the future', *Social Science and Medicine*, 124: 398–401.
Connell, J. (2016) 'Reducing the scale? From global images to border crossings in medical tourism', *Global Networks*, 16(4): 531–550.
Constable, N. (2009) 'The commodification of intimacy: Marriage, sex, and reproductive labour', *Annual Review of Anthropology*, 38: 49–64.
Ebrahim, A., & Ganguli, S. (2017) 'Strategic priorities for exploiting Bahrain's medical tourism potential', *Journal of Place Management and Development*, 10(1): 45–60.
Helmy, E., & Travers, R. (2009) 'Towards the development of Egyptian medical tourism sector', *Anatolia*, 20(2): 419–439.
Inhorn, M. (2011) 'Globalisation and gametes: Reproductive "tourism", Islamic bioethics and Middle Eastern modernity', *Anthropology and Medicine*, 18(1): 87–103.
Inhorn, M. (2012) 'Reproductive exile in global Dubai: South Asian stories', *Cultural Politics*, 8(2): 283–306.
Inhorn, M. (2015) *Cosmopolitan Conceptions. IVF Sojourns in Global Dubai*. Durham, NC: Duke University Press.
Inhorn, M. (2017) 'Medical cosmopolitanism in global Dubai: A twenty-first-century transnational intracytoplasmic sperm injection (ICSI) depot', *Medical Anthropology Quarterly*, 31(1): 5–22.
Jabbari, A., Kavosi, Z., & Gholami, M. (2014) 'Medical tourists' profile in Shiraz', *International of Health System & Disaster Management*, 2(4): 232–236.
Johnson, J. (2010) 'Egypt: Where it all begins', *Medical Tourism Magazine*, 15: 36–38.
Kangas, B. (2002) 'Therapeutic itineraries in a global world: Yemenis and their search for biomedical treatment abroad', *Medical Anthropology*, 21: 35–78.
Kangas, B. (2007) 'Hope from abroad in the international medical travel of Yemeni patients', *Anthropology and Medicine*, 14: 293–305.
Kangas, B. (2011) 'Complicating common ideas about medical tourism: Gender, class and globality in Yemenis' international medical travel', *Signs*, 36(2): 327–332.
Kaya, S., Karsavuran, S., & Yildiz, A. (2015) 'Medical tourism developments within Turkey', in N. Lunt, D. Horsfall, & J. Hanefeld (eds), *Handbook on Medical Tourism and Patient Mobility* (pp. 332–338). Cheltenham: Edward Elgar.
Kronfol, N. (2015) 'Medical tourism developments within the Middle East', in N. Lunt, D. Horsfall, & J. Hanefeld (eds), *Handbook on Medical Tourism and Patient Mobility* (pp. 307–312). Cheltenham: Edward Elgar.
Lautier, M. (2008) 'Export of health services from developing countries: The case of Tunisia', *Social Science and Medicine*, 67: 101–110.
Medical Tourism Magazine (2013) 'Medical tourism providing needed Band-Aid to Turkish debt', *Medical Tourism Magazine*, 28: 16–17.
Medical Tourism Magazine (2014) 'Out of Africa: Cures for ailing health systems found in foreign lands', *Medical Tourism Magazine*, 30: 21–22.
Nielsen, S., Yazici, S., Petersen, S., Blaakilde, A., & Krasnik, A. (2012) 'Use of cross-border healthcare services among ethnic Danes, Turkish immigrants and Turkish descendants in Denmark: A combined survey and registry study', *BMC Health Services Research*, 12: 390.
Noubar, H., Heidarzadeh, N., & Bahador, B. (2014) 'Evaluating strategies for promoting health tourism', *Journal of Political and Social Sciences*, 1(1): 15–19.
Ormond, M. (2013) *Neoliberal Governance and International Medical Travel in Malaysia*. London: Routledge.
Safaeepour, M., Goodarzi, M., & Rostami Kondari, N. (2015) 'Planning and developing medical tourism in megalopolis Shiraz', *Management Science Letters*, 5: 123–136.
Stephano, R. (2014) 'Just doing it: Jordan making a name for itself in medical tourism', *Medical Tourism Magazine*, 32: 61–63.
Stephano, R. (2015) 'Germany's designs on Arab patients', *Middle East Health*, September: 28–32.
Sugorakova, D. (2014) 'Turkey: Renaissance of thermal therapy', *Medical Tourism Magazine*, 32: 103–105.
Toyota, M., Chee, H., & Xiang, B. (2013) 'Global track, national vehicle: Transnationalism in medical tourism in Asia', *European Journal of Transnational Studies*, 5(1): 27–53.

Downloaded By: 10.3.97.143 At: 05:45 24 Mar 2023; For: 9781315624525, chapter27, 10.4324/9781315624525-27
PROOF
9781138651920_pi-386.indd 363
24-Sep-18 7:02:25 PM

Vequist, D., Bolatkale, E., & Valdez, E. (2009) 'Health tourism economic report—Jordan', *Medical Tourism Magazine*, 2: August.
Yeates N. (2009) *Globalising Care Economies and Migrant Workers: Explorations in Global Care Chains*. Basingstoke: Palgrave.
Yeoh, E., Othman, K., & Ahmad, H. (2013) 'Understanding medical tourists: Word-of-mouth and viral marketing as potent marketing tools', *Tourism Management*, 34: 196–201.
Youngman, I. (2016) 'The falling star of medical tourism'. *International Medical Travel Journal*, 15 April 2016. Available online: www.imtj.com/news/falling-star-medical-tourism/ (Accessed 11 September 2018).

PROOF

Downloaded By: 10.3.97.143 At: 05:45 24 Mar 2023; For: 9781315624525, chapter27, 10.4324/9781315624525-27

9781138651920_pi-386.indd 364 24-Sep-18 7:02:26 PM