Comments on
Myths and Medical Tourism

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Review of presentation

(based on slides and background paper)

- Medical tourism vs Health tourism/definition
- Demand side view – lack of hard data, predictions of flows of patients seem "vaporware"; different types of demand
- Supply side view – need to understand better the demand side

Review of presentation

- Matchmakers: how do demand and supply meet? – role of networks, information, travel and hospitality, quality of care, aftercare, legal issues
- Impacts on origin country and on destination country

Myth	Rated as
Myth 1 – Exponential growth	**Busted** – not realized; take a reality check
Myth 2 – Global market	**Plausible** for same types of care; but bilateral flows are more relevant than initially thought; not a level playing field
Myth 3 – Government action can help	**Busted** – go back to myth 1 and myth 2

Comments

- The Demand side:
- Definition of consumers – narrow definition – out-of-pocket & sick & willing to travel
- But for important procedures people want to have insurance. This changes a lot:
  - New player – the third payer
  - Changes the trade-off of staying at home for treatment and travelling for treatment
  - Who's really the key decision maker?

- In the OECD report, more types of medical tourists:
  - Temporary visitors abroad – unlucky to get sick – not medical tourism, not likely to be
  - Long term residents – not medical tourists – but create a pressure for local health systems (ex: patients treated in Portugal with type of care denied in the UK)
  - Common borders – share of facilities, not really medical tourism, “it is just the border”
  - Outsourced patients – “collective” medical tourists – the more promising in my view.

Demand side

- Key features (OECD report): “low cost treatments”, “helped by cheap flights”, “internet sources of information”
- Is this diverted demand or new demand? Crucial to understand the dynamics and implications of policies and business decisions
- Diverted demand likely to create over-investment with no patients flow corresponding

- Medical tourism vs. cross-border care in Europe
- Basic element – people choose but payment is limited at cost/payment at home by the third party payer (public or private)
- Economic properties similar to that of reference price system in pharmaceuticals, but here product differentiation / certification / reputation can soften competition - but we need more analysis on market interactions and competitive process

Demand side

- Some attempts look at demand from Diaspora populations – how much of it can be done for Portugal? Portuguese in US & Canada (price), in Africa (lack of services), in other European countries (back-to-origins?)

Supply side

- Suppose that medical tourists are solely patients willing to pay out-of-pocket - are they in sufficient numbers and steady flow to justify investments?
- First years of global activity may reflect a stock effect and not a permanent flow a patients
- Which investments can be justified by the flow?

Supply side

- Are we talking about *de novo* investments or just additional patients to use idle capacity in the supply side?
- Target outsourced patients? Institutions can do repeated purchases, establish a valuable relationship that can be nurtured
- Minimum efficient scale to operate?
- What opportunities?

Prices in Portugal - SIGIC

	US	India	Thailand	Singapore	Malaysia	Mexico	Poland	UK	Portugal
CABG	113,000	10,000	13,000	20,000	9,000	**3,250**	7,140	13,921	**9,527**
Heart Valve Rep	150,000	9,500	11,000	13,000	**9,000**	18,000	9,520		**15,227**
Angioplasty	47,000	11,000	10,000	13,000	11,000	15,000	**7,300**	8,000	**14,830**
Hip repl	47,000	9,000	12,000	11,000	10,000	17,300	**6,120**	12,000	**6,624**
Mastectomy	17,000	7,500	9,000	12,400		7,500			**2,774**
Rinoplasty	4,500	2,000	2,500	4,375	2,083	3,200	1,700	3,500	**1,217**

Units: USD; Portugal prices based in DRG paid under the SIGIC (Sept 2012)

Market factors

- Errors, medical liability and judicial system
- How information is given?
- What information?
- What if?
  - NHS providers attempting to deal with institutions
  - NHS – to – NHS – reciprocity?

Matchmakers

- Internet: information (reliable?); patients experience and satisfaction
- Certification / accreditation – from distinctive factor to minimum threshold?
- Who are the critical decision makers?
- Economics? Can we talk about two-sided markets features?

Origin and destination

- Bear in mind that outbound from some countries need to be inbound to others
- Net income is not as important as consultants want to make believe (conflict of interest?)
- Look for general equilibrium effects – moving patients North – South – pressure on South medical labour markets, increasing wages and cost of care there, while having the reverse effect on North; but alternative is factor mobility, brain drain?

Government intervention

- Not clear where is the externality / public good / market failure requiring intervention
- Not clear where is the data to define intervention type and intensity
- Governments can be on both sides – as a payer (demand) and as a supplier / support to suppliers (supply)

Government intervention

- What if all countries try to do the same?
- No demand creation just demand diverted from other places
- No net gain but too much investment

- Different issue: what if Government institutions try to do it? No business risk (failure) for public hospitals? (Government failure in business decisions)