Medical Tourism in India: Healing the World but Hurting a Nation?

James Egan

Medical tourism is a booming industry in India, and experts predict that by 2012 medical tourists will pump $2.2 billion into the Indian economy (MacReady, 2007, 1,850). But what does this mean for Indians? This paper addresses the following questions: Is the industry’s tremendous growth a positive development for the masses of Indians that do not directly benefit from it? When thousands of Indians die every year from illnesses that modern medicine has made easily preventable, should the Indian government create policies and use public funds to assist private hospitals that respond predominantly to the demands of the rich and foreign? Is medical tourism healing the world but hurting a nation? After briefly describing the present situation of medical tourism in India and establishing the ethical dilemmas resulting from it, I will argue that a concept of cosmopolitan nationalism must guide solutions to these dilemmas. Medical tourism in India will become an ethical success only by becoming a national success—a success that unites Indians by representing not only what they have to offer the world, but also what they have to offer each other.

Establishing the Problem

In 1916 the renowned Indian philosopher Rabindranath Tagore remarked, “The whole world is becoming one country through scientific facility” (2008, 119). Now, almost a century later, our globalized world has become more inextricably linked than Tagore could have imagined, and not only by computer and information technology. Advances in the medical sciences and the growth of sophisticated medical facilities in the developing world have caused the sick of all nations to board planes and cross borders for treatment. This phenomenon—commonly called “medical tourism”—is yet another way in which scientific facility is bringing people of all nations together. Although the current number of these medical tourists is modest, many studies estimate that it will increase exponentially in the next decade. In a recent study, McKinsey and Company estimate that the current world market is merely 60,000 to 85,000 inpatients a year. They added, however, that the number of American outbound-patients alone would probably range from 500,000 to 700,000 if payers covered medical travel (Ehrbeck, 2). In another recent study, the Deloitte firm projects that “outbound medical tourism [patients living in the US] could reach upwards of 1.6 million patients by 2012, with sustainable annual growth of 35 percent” (Deloitte, 3).

There are many reasons for this fascinating development in modern health care.

The majority of people in this growing number of medical tourists seek “the world’s most advanced technology, better quality, or quicker access to medical care,” not lower prices, and most travel to the United States (Ehrbeck, 2). Nevertheless, entrepreneurs in the developing world are confident that the trend is changing, and they are preparing for big profits. Narsinha Reddy, manager of marketing for Bombay Hospital, has predicted that “medical tourism will do for India’s economic growth in the 2000s ten to twenty times what information technology did for it in the 1990s” (Bookman, 2007, 3). And though his prediction has not proved entirely accurate, Reddy’s excitement at the potential for growth is not completely misguided. Some experts predict that by 2012 medical tourists will pump $2.2 billion into the Indian economy (MacReady, 2007, 1,850).

What is more, it is not only India’s businessmen that are excited about medical tourism. The Indian government is planning for profits as well. In its National Health Policy issued in 2002, the Indian government encouraged the growth of the industry:

To capitalise on the comparative cost advantage enjoyed by domestic health facilities in the secondary and tertiary sector, the policy will encourage the supply of services to patients of foreign origin on payment. The rendering of such services on payment in foreign exchange will be treated as ‘deemed exports’ and will be made eligible for all fiscal incentives extended to export earnings (Vijay, 2007, 1).

The government has many reasons to encourage the growth of the industry. India’s whole economy will benefit from an increase in the number of medical tourists that visit Indian hospitals. Medical tourists bring foreign currencies and create...
good jobs at hospitals. The existence of sophisticated hospitals, moreover, improves the overall health-care infrastructure of the country. These hospitals (and the wealthier patients that visit them) also keep first-rate Indian doctors from leaving India to practice oversees and encourage those that have already left to return to India and practice at home (Knox, 2007).

Despite all of these apparent benefits, not everyone in India is happy with their government’s encouragement of the industry. These critics argue that the Indian government should think twice about capitalizing on the medical tourism boom at a time when the medical system is failing its own people. Dr. Samiran Nundy, a gastrointestinal surgeon in New Delhi, and Amit Sengupta, from the India’s People’s Health Movement, expressed their criticisms in a recent article in The British Medical Journal. “It is time,” they argue, “for the government to pay more attention to improving the health of Indians rather than to enticing foreigners from affluent countries with offers of low-cost operations and convalescent visits to the ‘Taj Mahal’” (Gentleman, 2005). One particularly vehement critic of medical tourism asks, “How could a country like India dare to promote medical tourism when even the basic health care needs of the majority of its citizens have not been met?” (Vijay, 2007, p. 2). To be sure, his question is more of a rhetorical moral indictment than a genuine inquiry.

These concerns are certainly hard to dismiss, and the Indian government is not ignorant of them. Last year, to point out one instance, an Indian Tourism Ministry official reported that the Health Ministry was reluctant to publicize its findings concerning inequality of access to health care at a recent conference in New Delhi on medical tourism (Gentleman, 2005). Of course, the health care inequalities in India can be seen in statistics other than those of the Health Ministry’s recent findings. The World Health Organization reports that thousands of Indians die every year from illnesses that modern medicine has made easily preventable. Tuberculosis kills half a million Indians every year, and readily treatable diarrheal diseases kill 600,000 (www.who.com). Additionally, India’s public health funds are few. In 2008 India spent 5.2% of its GDP on healthcare, but only 0.9% of this came from public funds (Nagaraj, 2009). The Economist reports that “nearly four-fifths of all health services are supplied by private firms and charities—a higher share than in any other big country” (2009). India ranks among the top 10 countries for communicable disease and leads the world in chronic diseases like diabetes hypertension and coronary artery disease (Nagaraj, 2009, 1). The United Nations Children’s Fund reports: “One in every three malnourished children in the world lives in India [and] about 50 percent of all childhood deaths are attributed to malnutrition” (www.unicef.com). In the face of these massive public health problems, should the Indian government create policies and use public funds to assist private hospitals that respond predominantly to the demands of the rich and foreign? It should, but not without an important guiding principle—cosmopolitan nationalism.

**Local Obligations Versus Global Concerns**

What do I mean by cosmopolitan nationalism? India’s history is rich with ideas about both nationalism and cosmopolitanism. The ideas of Jawaharlal Nehru, India’s first president, and Rabindranath Tagore, the famous Indian philosopher with whom I began, are particularly relevant to the ethical dilemmas of medical tourism in India. By exploring their ideas about the relationship between the individual and the nation, we will be able to more fully comprehend the ethical dilemmas of medical tourism.

In his book on nationalism Imagined Communities, Benedict Anderson (2006) reminds us that nations have no native characteristics—no native habits, no native habitats, nor “preordained immutable frontiers” (123). National communities are, therefore, always imagined. Their unity is a matter of work. It is not simply or, even more precisely, naturally given to them. India’s first prime minister, Jawaharlal Nehru understood this. His administration recognized the need for an idea to unify the nation. “Unity in diversity” was the motto it pressed upon the newly born nation. The struggle to establish this unity was certainly a part of Nehru’s nascent India. The trouble, as Sriropa Roy explains in Beyond Belief: India and the Politics of Postcolonial Nationalism (2007), was “preserving a center while accommodating diversity.” India continually faced (and still faces) the “threat of ‘excess’ subnational identity” (4). To deal with this dilemma, Nehru’s administration, in various ways but most notably through hundreds of state-created short-films, broadcast the idea that India’s “real culture” was always and “inevitably located elsewhere” (44). This meant that the nation of India was to be sought after and built. Work was to be done, and individuals were instructed that they had obligations to their fellow nationals, even to those who spoke, ate, and lived differently. Being completely Indian within this paradigm was virtually impossible because no one Indian had complete comprehension of or claim to all of Indian culture. Being Indian, then, was becoming Indian. “True” Indians adopted an intra-national outlook and depended on others for their identity. Moreover, individuals developed a belief that they obligations to the imagined community.

Popular allegiance to this idea was crucial to the development of a unified India, but, taken too far, the idea could be dangerous. No one was more outspoken about this than Rabindranath Tagore. He warned of dangerous styles of nationalism that tempted the early Indian nationalists. The most dangerous idea of all, for Tagore, was the doctrine that all things are to be sacrificed for the glory of one’s nation. In one of his many lectures on nationalism, Tagore declared:

Even though from childhood I had been taught that the idolatry of the Nation is almost better than reverence for God and humanity, I believe I have outgrown that teaching, and it is my conviction that my countrymen will gain truly their India by fighting against that education which teaches them that a country is greater than the ideals of humanity. (2008, 127)
In place of a narrow-minded, selfish nationalism, Tagore argued for the adoption of a global outlook, a concern for people of other nations—in short, a compassionate cosmopolitanism. We have obligations to our nation, Tagore maintains, but none of them, he is careful and adamant to add, remove our basic obligations to humanity.

This sentiment is not foreign to the modern world. Thanks to people like Tagore, this idea has increased its force throughout the world. The improvement of Indian public health in recent years, for example, has come by way of the cosmopolitan spirit. In July of 2009, Bill Gates was awarded the Indira Gandhi Prize for Peace by India’s President, Pratibha Patil, for the millions of dollars his foundation donates to India every year for health-related projects. His remarks on the occasion were cosmopolitan. He told the audience: “A poorest child in the poorest country is just as precious as your children or ours” (The Economic Times, 2009). Were it not for wealthy cosmopolitans like Gates, millions of people in India would lack desperately needed aid.

As with nationalism, however, a helpful concept of cosmopolitanism must be clearly defined. If we speak of our moral obligations only in relation to the massive abstraction called humanity, we run the risk of forgetting those that we are often in the best position to help—our neighbors. Thus, an important question for cosmopolitans becomes: Can one have special concern for one’s own nation, even value it more than others, and still be a cosmopolitan? If, along with Bill Gates, one is to believe that a child in one’s own country is “just as precious as” any other child anywhere in the world, then how is one’s commitment to his nation to remain? In Cosmopolitanism: Ethics in a World of Strangers (2007), Anthony Appiah argues quite eloquently that local commitments can and should remain. In response to those who presuppose that “cosmopolitan moral judgment requires us to feel about everyone in the world what we feel about our literal neighbors,” he writes, “To say that we have obligations to strangers is not to demand that they have the same grip on our sympathies as our nearest and dearest. We’d better start with the recognition that they don’t” (158).

A healthy cosmopolitanism, then, does not require us to try in vain to think about and feel for every person what we feel for our nearest and dearest. What it requires, instead, is that we resist the thought that “our neighbor is not our neighbor but our neighbor’s neighbor” (Nietzsche, 2003, 104). The cosmopolitan sees the recognition of one’s duty to one’s local neighbor as a necessary step towards the recognition of one’s obligation to foreign strangers. Edmund Burke, the great champion of the local, wrote, “To love the little platoon we belong to in society, is the first principle (the germ as it were) of public affections. It is the first link in the series by which we proceed towards a love to our country and to mankind” (Appiah, 2007, 152). Cosmopolitans must value the practical power that local associations can generate. For their position to be effectual, they must recognize the importance of the unique and particular, even the patriotic.

How is all of this relevant to the ethical dilemmas of medical tourism? A cosmopolitanism void of respect for national obligations combined with a nationalism that ignores the universal worth of individuals is leaving many without medical help that they could be receiving. Sophisticated Indian hospitals are healing wealthy foreigners. There is certainly a bit of the cosmopolitan spirit in this work. But there is also a lack of concern for the local. In addition, the Indian government is intent on improving the health of the national economy by maximizing the profits of the medical tourism industry. In this, it exhibits concern for the condition of the nation. And yet this concern for country appears to be crowding out a concern for the individual in a way that would disappoint Tagore.

Although the pressures of globalization encourage leaders to focus on the national economy (so as not to fall behind), they do not mandate ignoring the needy. Policies that focus only on markets are unwise. “Putting the market before the society,” Donald Blinken, a former U.S. ambassador to Hungary, remarked, “is an invitation to trouble and disappointment” (Friedman, 2000, 162). In one of his lectures on nationalism that I mentioned earlier, Tagore speaks of the same issue as if he were speaking today to those among medical tourism’s supporters who focus strictly on profit margins:

> But when, instead of being numerous separate machines, [the people of a nation] become riveted into one organized gregariousness of gluttony, commercial and political, what remotest chance of hope will remain for those others, who have lived and suffered, have loved and worshipped, have thought deeply and worked with meekness, but whose only crime has been that they have not organized. But, you say, ‘That does not matter, the unfit must go to the wall—they shall die, and this is science. . . . I assert that man’s world is a moral world, not because we blindly agree to believe it, but because it is so in truth which would be dangerous for us to ignore.’ (2008, 45)

A concern for the “moral world,” as he calls it, is essential to Tagore’s cosmopolitan nationalism. Using a physiological metaphor that is appropriate for this discussion of health care, Tagore adds, “Our nerves are more delicate than our muscles” (2008, 152). Indeed, a people’s well-being does not result from muscular (economic) strength alone. The nerves (morals) of a people are equally important.

Unfortunately, the “moral world” is being ignored by parts of the medical tourism industry in India. The situation at Indraprastha Apollo Hospital in New Delhi is a striking example of this. The hospital was built in 1996 on 15 acres donated by the Delhi government. This land was worth an estimated $2.5 million. The government invested $3.4 million in the construction of the hospital and contributed $5.22 million as equity capital. It also provided tax and duty waivers on import of equipment. All of this assistance was offered with the agreement that the hospital would reserve one-third of its beds for the treatment of poor patients at no cost. Sadly, “only 2% of indoor cases in 1999-2000 in Apollo Hospital...
were treated free and most of these were relatives of staff, bureaucrats and politicians” (Vijay, 2007, p. 1).

The problem, moreover, is not just empty beds. The focus of funds and doctors is a concern as well. In *Medical Tourism in Developing Countries*, Milica and Karla Bookman (2007) point out the contrast between the money and excitement associated with treating the rich and the “dismal picture of public health.” According to the Bookmans, “regular deworming in remote villages is considerably less flashy” than more lucrative, sophisticated procedures (2007, 175). Global health statistics affirm that the health needs of the rich attract much more attention than those of the poor. Less than 10% of global health expenditure every year is “directed towards diseases that affect 90% of the population” (169). Most of India’s poor need help with diarrhea, childbirth, and nutrition. They do not need CAT scans and laser-guided surgeries.

**Health Care: The Problem and the Solution**

Luckily, experts like the Bookmans still have hope. They claim, paradoxically, that “health care is at once both the problem and the solution” for countries in the developing world (7). They argue that medical tourism has the potential to produce general economic gains that will improve the health of a nation and to provide revenues for struggling public health systems through macroeconomic redistribution of tax revenues. Medical tourism can begin a “self-reinforcing cycle” that catalyzes both economic growth and improved public health, two outcomes that mutually improve each other (175).

The Bookmans claim that “macroeconomic redistribution policy” is “by far the most important way in which medical tourism can enhance public health” (179). In India, tax revenue from medical tourism should be increased and redirected to programs that focus on the most common public health problems. Tax revenues could be used to encourage doctors to work in less-desirable rural areas through augmented salaries. They could also be used to provide much-needed equipment such as dialysis-machines, a lack of which prevents fewer than 5% of Indians with kidney failure from receiving life-saving dialysis (Knox, 2007, 1). Funds could also be used to more properly finance already existing programs such as the Public Health Foundation of India in New Delhi. The foundation was created by the Health Ministry in 2006 to “build training capacity through five new public health schools, establish standards in public health education, and serve as a think tank for the government and the private sector” (BMJ 2006). But public funding was not enough to get the foundation started. Public funds are expected to make up a small part of the $110 million the foundation will need over the next five years. Private donors, including the Bill & Melinda Gates Foundation, will provide the rest (BMJ, 2006). This paradigm of “private funding for a public mandate” has been the model for many of India’s public health initiatives (BMJ, 2006). Tax revenues from medical tourism could be an important part of reforming this model.

But redistribution of tax revenues cannot be the only way in which the benefits of India’s growing medical industry can be used to solve its many public health problems. Private entrepreneurs can play a major role as well, and some already are. A number of private-health providers are expanding to meet the needs (and money) of India’s growing middle class and even its poor. Vishal Bali, CEO of Wockhardt Hospitals, “plans to take advantage of tax breaks to build hospitals in small and medium-sized cities,” which can be home to as many as 3 million people in India. Prathap Reddy, Apollo’s founder, plans to do the same (The Economist, 2009). Rick Evans, owner of a hospital chain called Columbia Asia, “says his investors left America to escape over-regulation and the political power of the medical lobby.” The Columbia Asia business model involves building simple hospitals (as opposed to the Sheraton-Hilton style) and offering “modestly priced services to those earning $10,000-20,000 a year within wealthy cities.” It appears that health care in general, not just medical tourism, in India is predicted to become much more lucrative in the near future. The Economist reports that “Technopak Healthcare, a consulting firm, expects spending on health care in India to grow from $40 billion in 2008 to $323 billion in 2023” (The Economist, 2009). Hospitals like these are part of the reason for the recent boom in health insurance in India. This development is good news for these hospitals, of course; more insured Indians means more revenue for hospitals.

What is more, these health care business innovations are attracting attention and encouraging the kind of cosmopolitan cooperation that will undoubtedly benefit India in the long run. Apollo now sells its expertise to American hospitals. Aravind, the world’s largest eye-hospital chain, has developed ideas that will be helpful elsewhere. Instead of looking to the government for handouts, Aravind’s founders “use a tiered pricing structure that charges wealthier patients more (for example, for fancy meals or air-conditioned rooms), letting the firm cross-subsidise free care for the poorest.” This helps them treat hundreds of the 12 million blind in India whose cases mostly arise from preventable causes like cataracts. What is more, the hospital staff rotates so that they treat both paying and non-paying patients,” a practice that tries to ensure that there is no difference in treatment quality (The Economist, 2009). Wockhardt hospitals, to add another example of the valuable, marketable knowledge being developed in Indian health centers, pioneered a special type of heart surgery that “causes little pain and does not require general anaesthesia or blood thinners” and that puts patients “back on their feet much faster than usual” (The Economist, 2009). Not only do some of these ideas bring medical tourists to Indian soil, but they bring entrepreneurs and scientists as well. They come to learn and to witness startling new innovations.
HEALING AT HOME
These developments are also attracting the attention of expatriate Indians who have left their mother country for a chance to earn a better living for their families. Many are returning to India to practice in a rapidly developing and increasingly sophisticated health sector in an environment they love. This is perhaps the best example of how national affections are combining with the cosmopolitan spirit in India in ways that will benefit the country’s public health situation. What has in the past been a “brain drain” problem may turn out to be a great boon for Indian public health.

Indian doctors are not hard to find in the elite circles of medicine around the world. No other country has exported as many physicians as India. More than 40,000 Indian physicians practice in the United States, making up one of every 20 U.S. doctors (Knox, 2007), and “one out of five doctors in the world is Indian” (Bookman, 2007, 6). For most of the recent past, thousands of Indians have been trained in medical schools outside of India and less than half of them have returned (Bookman, 2007, 6). Furthermore, many of those who have been trained in India, particularly in its most prestigious medical schools (public schools included), have emigrated to practice abroad. One study in particular conducted by Manas Kaushik of the Harvard School of Public Health reveals the unfortunate “brain drain” India has experienced in recent decades. In 2007 the National Public Radio reported:

[Dr. Kaushik] tracked hundreds of graduates from the All-India Institute of Medical Sciences, India’s equivalent of Harvard Medical School. He looked at alumni dating back to the 1950s. ‘Over this period, we roughly had 450 physicians who graduated from the All-India Institute of Medical Sciences,’ Kaushik says. ‘And almost 50 percent of them emigrated to the U.S.’ In 50 years, Kaushik says, only one of those doctor-emigrants went back to India — and he returned to America a year later. (Knox, 2007)

Fortunately, this trend is slowly reversing. Although the “brain drain” has certainly not ceased, the opportunity to practice Western-style medicine in their native India is becoming ever more attractive for Indian doctors in the West. The pay is not comparable (moving home involves a considerable—as much as 50%—pay cut), but well-trained doctors make a very good living in India. The opportunity to work in their native country provides them with non-monetary, valuable benefits; they return because of national affection (Lagace, 2008). Indeed, nations can, as Benedict Anderson writes, “inspire love, and often profoundly self-sacrificing love” (2006, 141).

CONCLUSION
To finish, I return to the Tagore quote with which I began: “The whole world is becoming one country through scientific facility.” He was certainly right then, but maybe even more so now. Yet it should be said that Tagore did not write his essays on nationalism simply to make prescient observations like this one. He wished to enlighten his neighbors, both at home and abroad. He aimed to remind them that “goodness is the end and purpose of man” (2008, 23). Therefore, in addition to his observation concerning the interconnectedness of the modern world, he added the much more important idea: “And the moment is arriving when you also must find a basis of unity which is not political” (2008, 119). Such a basis might be impossible, it may be a naïvely conceived ideal, but Tagore did not fear an idealism that brought people together. While it is impossible to completely escape the pressures and realities of political association, the adoption of a cosmopolitan nationalism will prove to heal more than physical bodies in India. It will make medical tourism both a national and an ethical success—a success that unites Indians by representing not only what they have to offer the world, but also what they have to offer each other.

REFERENCES


