ISSN : 2249-7862 (Print) : 2455-877X (Online)
www.aureoleonline.in

Medical Tourism: An Exemplar of Price Discrimination

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Abstract: The medical tourism and healthcare industry is currently growing in leaps and bounds in terms of revenue generation and employment. Medical travel in Asia is relatively new when compared to its Western counterparts. Albeit, within the last decade medical tourism has experienced substantial growth in developing countries around the world. Asia, a current leader in medical tourism growth, is host to Thailand, Singapore, Malaysia and India which has cultivated the market for medical tourists with the emergence of corporate hospitals that provide international patients with an experience that is both medically advanced and a vacation. So, most corporate hospitals have divided their patients into segments that exhibit different demographic profiles. Once identified based on the elasticity of demand and the willingness to pay, corporate hospitals utilise price discrimination to gather additional consumer surplus from high-paying patients, ultimately allowing those who would not traditionally be able to afford treatment to have access to medical care, thus leading to a situation of price discrimination. This paper attempts to provide a comprehensive look at how the healthcare sector engages in price discrimination to extract maximum consumer surplus from medical tourists and its further implications.

Keywords: Medical tourism, healthcare, pricing, Asia

INTRODUCTION

In the last few years, the medical tourism industry has grown rapidly. This type of popular mass culture especially favours countries in Asia wherein there is significant movement between high-earning and lower-earning countries in pursuit of healthcare purposes. The key motivation for such travel has been the excruciatingly expensive, inadequate, or unavailable services in their high-income home countries. In response to the proliferation of demand for healthcare services at affordable costs, governments and private-sector actors in Asian and Latin American countries have begun to capitalise on such opportunities and promoting in their countries, cities, and medical facilities as medical tourism destinations to boost and diversify their tourism and healthcare offerings.

Policy interventions via fiscal measures were a primary tool utilised by various governments to promote their country as a medical tourism destination. The corporate hospital also pursues its slew of measures to promote the same by providing a wide range of affordable healthcare services and implementing differential pricing policies that result in price discrimination between countries and within the host country itself. This makes medical tourism a mushrooming phenomenon with policy implications for health systems, particularly in destination countries.

Despite the hailing of the obvious economic benefits of medical tourism for the host countries, the potential impact on health systems, particularly in terms of equity in access and availability for local consumers, is somewhat murky.

This paper presents a conceptual framework that outlines the policy implications of medical tourism's growth for health systems, how corporate hospitals have erected in place pricing policies that discriminate in terms of prices to make their services more alluring and balance this act on the flip side by providing the same services to the low income earning locals. It draws on the cases of Thailand, Singapore, Malaysia and India for examining price discrimination between countries with special emphasis on factors that are favourable exclusively in the Indian context for differential pricing, via an extensive review of academic and journal publications.

Methodology

The study proposes to use a variety of secondary data sources including journal publications, research papers, etc dealing with pricing policies of the healthcare sector in lieu of medical tourism.

Comparative Study of Price Discrimination in Thailand, Singapore and Malaysia

At the core of medical tourism, is the ability to attract international patients through marked differences in prices, quality of services, delivery of services, human resources etc. As the competition within the industry gains traction, the final destination of the money of those seeking healthcare facilities will be determined by the countries' ability to attract foreign medical travellers.

At the pinnacle of such determining factors is price, which makes medical tourism viable and, therefore, is the most important product attribute. Medical tourism cannot be a viable alternative unless there is significant price difference between the healthcare in the destination country and the country of origin.

The healthcare sector is witnessing rapid growth in Southeast Asia, credited to the burgeoning growth of the private sector to supplement medical tourism. Countries exploit the lucrative opportunity of their popularity as tourist destinations by combining high-quality medical services at competitive prices with tourist packages.

Among the top destinations for medical tourism are Thailand, Malaysia and Singapore and others which combine quite skillfully the affordability of healthcare with numerous picturesque sights to provide a relaxing environment during the recovery period.

Prominent Strategies in the Medical Tourism Industry

The three countries have adopted a combination of different strategies to gain a competitive advantage and promote MT growth. These strategies are overviewed in the table below and compared against each other.

Table 1: MT strategies pursued by Thailand, Singapore and Malaysia

Medical tourism strategies		
Thailand	**Singapore**	**Malaysia**
Cost leadership strategy A product bundling strategy (Special packages of medical travel services)	Differentiation strategy (High-end complex quality & superior technology) Branding strategy (as a regional hub of "medical excellence")	Cost leadership strategy Diversification strategy

SOURCE: https://core.ac.uk/download/pdf/223045584.pdf

India and Thailand have reaped the benefits of gaining market share by offering competitively priced medical packages. They have both employed a similar strategic approach the essence of which is cost leadership. This has posed as a viable alternative for many uninsured and underinsured individuals in the West, particularly the USA which has more than 42 million people without health insurance.

Diagnostic and surgical service in Western countries is more costly than what an Asian medical tourism destination could offer. The cost affordability considerably rationalises the attraction of medical tourists towards low-cost MT destinations.

Cost Comparisons

Woodman (2007) made a direct comparison of the costs of seven major medical treatments between the US and major medical tourism destinations in Asia: Thailand, Singapore, Malaysia and India. Medical treatment in Asia costs six to 33 percent less compared to what it would have cost in the United States. For example, a heart bypass procedure costs US$ 130,000 in the United States and only costs less than one-tenth in Malaysia at US$ 9,000. Similarly, a heart valve replacement in the United States would cost about 15 times higher than in Singapore, Thailand, and Malaysia, at US$ 160,000.

For the majority of medical procedures that are most sought after, Thailand and Malaysia appear to be the cheapest destinations, while Singapore is the most expensive. Nevertheless, medical treatment in Singapore is still much cheaper than it would be in the United States.

Table 2 : Medical tourism prices (in selected countries)

Procedure	USA	Malaysia	Singapore	Thailand
Heart bypass	130,000	9,000	18,500	11,000
Heart valve replacement	160,000	9,000	12,500	10,000
Hip replacement	43,000	10,000	12,000	12,000
Knee replacement	40,000	8,000	13,000	10,000
Spinal fusion	62,000	6,000	9,000	7,000

Source: Woodman (2007) in Malaysia Healthcare Travel Council 2012, as cited in Penang Monthly: Statistics-February 2013

Source: Authors, March 2011, compiled from medical tourism providers and brokers online.

Traveling costs are not included in the above cost comparison, yet its importance in decision-making cannot be overlooked. The current relatively affordable cost of air travel has become one of the motivators for Western medical tourists to travel to another part of the world to seek medical treatments. For example, the introduction of Malaysian AirAsia with low airfares has been instrumental in boosting the promotion of medical tourism among the 3 countries.

Policies Related to Medical Tourism in Malaysia, Singapore and Thailand

Since the establishment of the National Committee for Promotion of Medical and Health Tourism (NCPMHT), the Malaysian government has reinforced the activities in the medical tourism industry with a special focus on tax incentives, fee packaging, accreditation, promotion, etc. Medical tourism spans several sectors and comprises representatives from the Ministry of Health, Ministry of Culture, Arts and Tourism, etc. The promotion of medical tourism in Malaysia has been the focal point of the 8th Malaysia Plan (2001-2005) and the 9th Malaysia Plan (2006-2010).

Under the 1998 Private Healthcare Facilities and Services Act (Laws of Malaysia 1998), the 13th fee schedule is in force (Malaysian Medical Association n.d.) implying that prices are regulated as a maximum chargeable fee is set. As Malaysia is moving towards universal health care coverage, a social health insurance system with access to both public and private facilities across all levels of care in addition to cost-sharing options has been considered in response to the demands of the growing middle class.

In Singapore, the medical tourism industry is backed by extremely strong and integrated government support. Singapore Medicine, led by the Ministry of Health is a government-industry partnership was established in 2003. It involves the Economic Development Board, International Enterprise Singapore and Singapore Tourism Board.

In Singapore, for subsidised citizens and permanent residents, hospital bills are dependent primarily on the condition and type of procedure. In the public sector, the doctor fees are set by the Ministry of Health. The government offers multiple schemes that serve the locals exclusively such as the MediSave, the compulsory national medical savings scheme, which can be used for hospitalisation expenses. Patients also have the added option of MediShield, an opt-out, voluntary low-cost catastrophic

illness insurance scheme with deductibles and co-insurance. MediFund, an endowment fund caters to the needs of low-income Singaporeans. Private and foreign patients in public or private hospitals, on the other hand, are not subsidised and prices have been market determined since 2006 and may differ.

In 2004, Thailand promoted its vision to be a world-class “Medical Hub” which was its explicitly announced tourism policy. But the Thai government has stepped back from this policy and left the rumination and action in the area of medical tourism to be largely driven by the private sector. This was a scenario quite different from that of Singapore and Malaysia where the government worked in tandem with the private sector for the most part.

In Thailand, patients visiting private hospitals that are not contracted by the NHSO or SSO mostly pay out of pocket as very few have private health insurance coverage. This can be attributed to the fact that there is a dimming potential for the private health insurance market in Thailand at present due to the prevalence of risk-pooling within the family. An observation made by a representative of a tier 1 hospital was that 75% of their claims were settled in cash. What this means in the medical tourism industry is that the cost of private hospital treatment is largely determined by negotiations between patients and providers directly, and not through negotiations between a third party and providers since, in Thailand, the industry is characterised by a large degree of service differentiation.

A nation's economic standing is a key factor in medical centres in underdeveloped nations being able to offer healthcare services at low costs. Indeed, there is potential to enhance the accessibility and quality of treatment accessible to the population of these nations given that the costs of medical care in a destination country often correlate with that nation's per-patient costs. The government of destination countries must implement and enforce appropriate macroeconomic policies to ensure that the residents of these nations realise the potential benefits of the medical tourism industry.

Study of Price Discrimination in India

In 2003, Finance Minister, Jaswant Singh in his annual budget speech announced the government escalating interest in combining expenditure and tourism when he envisioned “India becoming a global health destination”.

Medical tourism finds its ultimate destination in India as the country offers quality care, cheaper services compared to the West, package deals and affordable packages from the tourism and hospitality sectors and diversification in the options offered by holistic medicine.

The economic advantage of being in the medical tourism industry is acquired by price discrimination in terms of various procedures offered when compared to Western countries. The main element in advancing MT is this. Even though patients receive the greatest medical care, they also can see India through dependable travel services for tourism and pilgrimage.

The literature available on medical tourism often discusses the implications of a slowly-by-surely emerging existence of a two-tiered healthcare system, with the majority of low-purchasing power domestic patients relying on basic, inadequately equipped public facilities, while medical tourists are treated in state-of-the-art private facilities. Additionally, it is frequently claimed that urbanisation of healthcare

delivery will compound the issues brought on by a two-tiered health system (Smith, Álvarez and Chanda 2011). A few studies claim that medical tourism may lead to the transfer of best practices and technology, although this beneficial spillover impact could only apply to fields that are pertinent to medical tourism, like cosmetic surgery. However, only anecdotal evidence is the dominant source of such assertions since the segregation of the impact of well-off domestic patients versus medical tourists is taxing considering the dearth of literature addressing the same.

Why Treatment in India Costs Less

Fees for treatments in India range from 50% to as little as one-fifth of the price in the United States. For example: Apollo Hospital in New Delhi, India, charges $4,000 for cardiac surgery, whereas the same procedure costs $30,000 in the United States. A rhinoplasty procedure that costs only $850 in India would cost $4,500 in the United States.

India is also an economically favourable destination for non-surgical procedures. Another example: a six-hour comprehensive fitness exam — including an echocardiogram, stress test, lung-function test and ultrasound of internal organs — costs only $125 at India's Rajan Dhall Hospital; a similar battery of tests in the United States could easily top $4,000.

Table 3: Comparison of costs of medical procedures between US and India

TABLE I

The Cost of Medical Procedures in Selected Countries
(in U.S. dollars)

Procedure	U.S. Retail Price*	U.S. Insurers' Cost*	India**	Thailand**	Singapore**
Angioplasty	$98,618	$44,268	$11,000	$13,000	$13,000
Heart bypass	$210,842	$94,277	$10,000	$12,000	$20,000
Heart-valve replacement (single)	$274,395	$122,969	$9,500	$10,500	$13,000
Hip replacement	$75,399	$31,485	$9,000	$12,000	$12,000
Knee replacement	$69,991	$30,358	$8,500	$10,000	$13,000
Gastric bypass	$82,646	$47,735	$11,000	$15,000	$15,000
Spinal fusion	$108,127	$43,576	$5,500	$7,000	$9,000
Mastectomy	$40,832	$16,833	$7,500	$9,000	$12,400

* Retail price and insurers' costs represent the mid-point between low and high ranges.

** U.S. rates include at least one day of hospitalization; international rates include airfare, hospital and hotel.

Sources: Subimo (U.S. rates); PlanetHospital (international rates), cited in Unmesh Kher, "Outsourcing Your Heart," *Time*, May 21, 2006.

Source Subimo(US rates),cited in 'Outsourcing your heart',Time,May21,2006.

Reasons that Enable India to Charge Low Prices :

Labor costs

Labour costs and wage rates are significantly lower in India when compared to the US. This is evidenced by an example at Fortis hospitals in India where doctors earn about 40 percent less than physicians of equal standing in the United States. Nurses salaries also show similar characteristics; only 20% of those in US. These lower labor costs make it much less expensive to build and operate hospitals in other countries.

Package Pricing

In India, where package pricing is quintessential, patients can compare rates with the aid of medical travel agents. In contrast, prices are challenging to obtain in American hospitals and often, when disclosed don't appeal to the patients. But in India, even non-fixed pricing companies will give pretty accurate price quotations. As a result, hospitals and clinics that serve a lot of medical tourists frequently provide price quotes in advance and seek out cost-saving measures for their patients.

Less to No Third-Party Payment

In Western countries, when the government or insurance covers the majority of medical expenses, markets can become constrictive. Insurers and the government collectively account for around 79 percent of the cost of healthcare in the US. For this reason, the companies that service them rarely compete based on pricing.

In nations with developing, competitive medical markets, a substantially larger proportion of private health spending is out-of-pocket. For example – patients pay 75 % of health care spending out of pocket. Patients are more inclined to compete with providers based on pricing when they have greater control over their healthcare spending. As a result, the private healthcare markets in these nations are more severely competitive.

Scarce opportunities for Cross-Subsidisation

Revenues from treatments for certain patients are used to defray the expenses of treating other patients in non-profit general hospitals in the US. Because certain medical procedures generate more income than they cost to give, cross-subsidisation is conceivable. This means that although a hospital's fees for heart surgery more than cover its expenses, those for emergency department care do not. The hospital can cross-subsidise without suffering a revenue loss if there is no competition for the business of cardiac patients in the hospital's service area. However, a provider that does not cross-subsidise may charge the same fee for the cardiac treatment and still turn a profit.

Modernised Services

There are hospitals and specialty clinics where duties and processes have been simplified for maximum effectiveness. This is a characteristic feature of most hospitals in India heavily engaged in the medical tourism industry whereby the hospitals run as productive "targeted factories." For instance, Fortis Healthcare's Rajan Dhall Hospital in New Delhi adopts a business strategy that blends the individualised service of the hospitality sector with the production methods of an

automotive. Vice President of Operations at Rajan Dhall, Jasbir Grewal, spent years working for the Hilton hotel network. He describes their hospital as “a hotel providing clinical medical excellence.” Harpal Singh, the chairman of Fortis and a former executive in the car sector emphasises the necessity of streamlining processes for the prompt completion of tasks.

Limited Malpractice Liability

Malpractice litigation costs are also lower in other countries than in the United States. While American physicians in some specialties pay more than $100,000 annually for a liability insurance policy, a physician in India spends less than $3,000 per year. In addition, malpractice awards are far lower than in the United States.

Less Legislation

American hospitals are unable to form the kinds of cooperative agreements that many hospitals abroad do because of the country's excessive health care laws. The rationale is that physician pay plans cannot infringe on Stark legislation in American hospitals. In contrast to American hospitals, overseas hospitals can design remuneration for the doctor in such a manner as guarantee financial incentives to deliver effective treatment.

Policy Implication

The rise in medical tourism has implications for health financing and outreach of its services, including the possibility that local customers would eventually face higher treatment prices as a result of differential pricing for international patients. These gains could be countered by financing schemes that distribute wealth. The public health system might be funded by taxing medical tourism earnings, increasing social insurance coverage, or requiring private doctors to take part in programmes that cover local customers. These financing methods do not depend on a person's capacity to pay. Depending on a centre’s area of clinical competence, private hospitals may offer services to a specific proportion of international patients and local clients registered in government programmes. They may also offer specific specialised treatments for locals. The implementation of such policies is the need of the hour when high out-of-pocket expenditure on health is posing a crushing burden on some 55 million Indians annually, with over 17 percent of households incurring excruciating levels of health expenditures every year according to the World Health Organisation (WHO) report.

CONCLUSION

Based on a review of pertinent literature, a solid comparative overview shows that these destinations have successfully developed a variety of medical tourism strategic capabilities. This success has been driven by a distinct market orientation that has been supported by sound and well-integrated strategies. Singapore has worked to provide better value by utilising a sophisticated healthcare system, greater services, and cutting-edge technology. Thailand and Malaysia, in contrast, have developed a hybrid strategy that focuses on best-value offerings and relies on an alluring combination of price, quality, modernity, and much more through attractive vacation packages.

India has established itself as the industry's low-cost provider and has subsequently gained a solid market position by satisfying the needs of a substantial portion of medical tourists who are looking for inexpensive treatments.

Concerns about medical tourism's potential impact on health systems, specifically the aggravation of the already existing unequal resource distribution between the public and private sector, have been raised by its rise in Asian countries and the government's endorsement of the trend. There is no region where this is more apparent than in Southeast Asia, where regulation and corrective policy initiatives have lagged behind the region's booming private sector over the previous three decades.

This paper presents a conceptual framework that identifies the elements of price discrimination through differential pricing in medical tourism for health systems and how policies have been implemented by the government in the pursuit of the development of the industry, from a comparative analysis of Thailand, Singapore and Malaysia. This framework also provides the basis and reasons that allow Indian hospitals to quote a significantly lower price and retain their competitive edge in the market.

Countries may profit economically from medical tourism, resulting in more money to spend on healthcare. The financial gains from medical tourism for health systems might, however, come at the price of local consumers' access to and usage of health care if not effectively controlled and regulated on the policy front. Governments and business leaders would be well to keep in mind that both local and international populations value good health.

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