

Original Paper

Medical Tourism in a Socialized Health Care System—The Need for Strict Systemic Supervision

Zvi H. Perry^{1*}, Liat Apel-Sarid², Liat Salzer³ & Asaf Toker⁴

¹ Ben-Gurion University of the Negev, Department of Epidemiology and Surgery Ward A, SUMC, Beer-Sheva, Israel

² Western Galilee Hospital, Nahariya, Israel

³ The Helen Schneider Hospital for Women, Rabin Medical Center, Petach Tikva, Israel

⁴ Ben-Gurion University of the Negev, Department of Health Systems Management, Beer-Sheva, Israel

* Zvi H. Perry, Ben-Gurion University of the Negev, Department of Epidemiology and Surgery Ward A, SUMC, Beer-Sheva, Israel

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Abstract

Medical tourism is defined by the active act of traveling from a patient's country of origin to a different country, specifically to receive medical treatment. Globalization has made a tremendous change in the field of medical tourism. Medical tourism statistics revealed an anticipated growth of the industry from about \$40 billion in 2004 to \$100 billion by 2012, as estimated by the McKinsey Company (Shetty, 2010). The size of the global medical tourism market increased about 2.5 times from 2004 to 2012 by approximately USD 10 billion, and it is expected to reach approximately USD 33 billion by 2019 (Seo & Park, 2018). Israel has emerged as a medical tourism destination due to the advantages it can offer. Israel's facilities are recognized throughout the world, and provide high quality of care at reasonable prices. But, Israel has a socialized health care system. This means that the national health insurance program is financed mainly by the government from public sources, such as health insurance tax that is collected by the general payroll and other general tax revenues, but also directly from the public through out-of-pocket money and private complementary health insurances. In comparison to OECD countries, Israel's hospitals are characterized by a very low bed to population ratio, an extremely low average length of stay, a high rate of admissions per 1000 population, and a high occupancy rate, which means this is already a very "lean" and effective system, that is on the verge of collapse due to a lack of funding. In relation to this medical tourism raises a lot of ethical, moral and economic issues for the Israeli health system. In the current article we try to shed some light upon these problems and

suggest feasible solutions for them.

We suggest that countries should adopt an ethical code and health policy, which will be used by local hospitals to maintain the delicate balance between medical services to the local population and medical tourism.

Keywords

socialized health care system, medical tourism, globalization

1. Background

1.1 Medical Tourism as a Phenomena

Medical tourism is defined by the active act of traveling from a patient's country of origin to a different country, specifically to receive medical treatment. International patients are usually seeking services such as major surgery or chemotherapy treatment, but are also looking for elective surgeries, as well as advanced diagnostic procedures.

Seemingly this is mainly an act of people who are sponsoring from their own money a medical procedure, diagnosis or other service in a country not their own.

The main motivations for the engaging in medical tourism include (Metz et al., 2016):

1. Insufficient health care systems in the patients' country of origin.
2. Insufficient medical expertise or experience in the specific field needed.
3. Lack of advanced technologies.
4. Lower cost and more affordable healthcare.
5. Long waiting lists in their country of origin.
6. Regulations in the patient's country of origin (e.g., for abortions, transplantations, FDA medical approval).
7. Quality of care that is perceived better.

Globalization made a tremendous change in the field of medical tourism. Where medical tourism used to be from less-developed to more-developed countries, traveling to less-developed countries in order to lower costs and bypass waiting lists, or governmental regulations has become an attractive option (Eltorai & Garimella, 2018). In recent years, citizens of Asia and Africa have spent billions of dollars for medical treatment in other countries (Shetty, 2010; Seo & Park, 2018).

The Confederation of Indian Industry predicted that India would see revenues in excess of 2 billion dollars from medical tourism by 2012 (Shetty, 2010). Statistics published on hospitals across Thailand, estimated a revenue of about \$850 million (33 billion Thai baht) during 2005, generated from 1.28 million foreigners seeking medical aid (Crozier & Baylis, 2010). The Czech Republic's medical travel industry was reportedly worth over \$182 million per year in revenue in 2008 (Speier, 2011). Costa Rican healthcare professionals treated roughly 150,000 medical travelers in 2007, mostly for cosmetic and dental procedures. Medical tourism statistics revealed an anticipated growth of the industry from about \$40 billion in 2004 to \$100 billion by 2012 (Shetty, 2010), as estimated by the Confederation of

India and the McKinsey Company (LLC). Similar results have been seen in a study that has surveyed the time trends in health tourism in Canada (Loh, 2015), and recent studies have shown that the size of the global medical tourism market increased about 2.5 times from 2004 to 2012 by approximately USD 10 billion, and it is expected to reach approximately USD 33 billion by 2019 (Seo & Park, 2018).

2. Discussion

2.1 Ethical Dilemmas in Medical Tourism

The fact that Israel has a socialized health care system with a chronic shortage of manpower, hospital beds, and other resources, leads to several dilemmas that we would like to address in the current article. To date, to our knowledge, there are no official laws or regulations regarding medical tourism in Israel. The main ethical dilemmas in medical tourism in Israel focus on the delicate distinction between improving the health of Israel's population or compromising it. The question is seemingly simple—are we trying more efficiently to use the Israeli infra-structure while bringing medical tourists here, or are we stressing it to an even worse situation that it already is? Since the option of medical tourism is not obligatory, questions must be asked and be addressed. These questions are even more pressing now, that the Germann committee for the revision of the Israeli health system has reviewed these issues but did not yet decide upon the proper way to address them. This has become even more relevant after the conclusions of the Germann committee have been rejected due to the change of government.

2.2 Medical Tourism in Israel

Israel has emerged as a medical tourism destination due to the advantages it can offer. Israel's facilities are recognized throughout the world, and provide high quality of care at reasonable prices (Rotem et al., 2009). The Israeli physicians are known to be well-trained and multi-lingual; many of the specialists were trained in North America and Europe. Israel also offers an advanced communication registrar and transportation accessibility which makes it ideal for medical tourism.

One of Israel's main advantages is an untapped potential of medical infrastructure, mainly in the evening and at night, as Israeli hospitals and clinics mainly work during the morning due to work related regulations.

Patients come to Israel for procedures such as bone marrow transplants, oncological and neurological treatments, *in vitro* fertilization, heart surgery and catheterization, rehabilitation, and many other medical and surgical fields. Unfortunately, no one has real time data upon the number of tourists or procedures done in Israel for medical tourists and thus we rely on estimations (Rotem et al., 2009).

Israel has a socialized health care system. The entire population is covered by the national health insurance program. According to state law, the health system provides a wide range of medical services also known as the "basic health basket of services" to all citizens of Israel (which means a universal coverage for them). Services not included in the "basic health basket" are financed by complementary private health insurance paid for by the citizens, which now are held by close to 80% of the population in Israel.

The national health insurance program is financed mainly by the government from public sources, such as health insurance tax that is collected by the general payroll and other general tax revenues, but also directly from the public through out-of-pocket money and private complementary health insurances. Health care accounts for approximately 8% of Israel's gross domestic product (Bruce, 2009), which is lower rate than that found in other OECD countries.

In recent years, there has been a change in hospital funding in Israel. First, the share of public financing out of total health system financing has declined (Zwanziger & Brammli-Greenberg, 2011), while the share of private financing, especially voluntary health insurance and co-payments, has increased (Sax, 2005). According to the information in the Israeli Ministry of Health (<http://www.health.gov.il/PublicationsFiles/doch Hashvaatui2015.pdf>) the deficit in these 4 HMO as more than a billion shekels (280 million\$), almost 2.5 times more than in 2014. One must mention that hospital revenue derives primarily from the sale of services, mainly to the four Israeli health plans. This means that hospital income from the HMO is capped and that if a hospital has increased activity it loses money in many procedures. Therefore, public hospitals are limited by financial constraints in providing service to Israeli residents. This leaves many hospital facilities such as surgical suits imaging equipment, radiotherapy equipment, etc. free beyond the regular working hours.

Moreover, the distribution of health expenditure between hospitals and the community has changed. Now, the community stands in the front of medicine. For example, in 2009, spending for hospitals and the community was approximately 34% and 45%, respectively. Empowering of the community is considered a global phenomenon, and is due to progress in community professionalism, improvement of the diagnostic measures, and investment in infrastructure. In addition, according to the National Health Insurance Law, the basket of services is updated and the Israeli health plans are being paid. The health maintenance organizations (HMOs) choose to invest in community services and to duplicate activities previously provided in the hospitals. In addition, the state has not further invested in developing hospital systems or adding beds in the past decade.

This change means that the hospitals have even more resources that are used less and less and can be employed to treat medical tourists and yield more revenue to the hospitals which are getting less and less funding, and that rely more than ever upon donations.

Compared to OECD countries, Israel's hospital are characterized by a very low bed to population ratio, an extremely low average length of stay, a high rate of admissions per 1000 population, and a high occupancy rate (Rotem et al., 2009; Afek et al., 2011). For example, the average bed-population ratio in Germany is 5.33/1000, while the OECD average is 3.43 and the Israeli average is 1.91 (these are official Israeli ministry of health statistics for 2011, as seen in https://www.health.gov.il/PublicationsFiles/OECD_2011.pdf).

According to the data above, it is obvious that the activities of hospitals are limited by budget. In addition, the hospitals are also limited in the manner and scope of activity. Standards for hospital personnel are limited and hospitals cannot add personnel according to the activity and needs. Moreover,

unlike the business model, the surplus revenues of the hospitals will be transferred to the Treasury and will not increase profits of the hospital. Some of the activities at the hospital also cause financial losses. Earning potential is limited and does not necessarily allow addressing the requirements. Competition with the private sector is difficult, and in most cases the reward is significantly lower. National agreements with the Israeli HMOs may also cause an increase in losses over a certain threshold.

During recent years, Israeli hospitals were involved in several financial initiatives to increase their revenues, including revenue from hospital parking lots, building in-hospital shopping malls, promoting services that are not included in the “basic basket”, commercialization of the intellectual property and Research & Development capabilities of their employees through technology transfer companies, and the development of medical tourism. Due to these reasons, the field of medical tourism in Israel started to grow during recent years. The leading medical institutes started to promote their services, looking for additional sources of income based on the existing foundations. Thus, from 15,000 medical tourists in 2009 (Rotem et al., 2009), the number rose to close to an estimated of 30,000 in 2017. The price list for tourists is higher than for Israeli residents.

Discounts for tourists are minimal compared to the discounts given to HMOs, insurance companies, or even to the private Israeli consumer, and the payment is usually prepaid, unlike the local market that can pay with credit and in payments.

According to reports of the Ministry of Tourism, between January and June 2009, 23,000 medical travelers visited Israel, 1% of the total tourists to Israel. Moreover, 4% of the tourists coming to Israel from Russia are medical travelers (M, 2010). No formal authority, including the Ministry of Health, collects the data regarding medical tourism, so the only available data are from the medical institutes that accumulate it themselves. Information gathered and published by Rotem et al. showed that during 2006, 16,000 medical tourists were treated in Israeli hospitals for an income of US\$160 million (Rotem et al., 2009). This lack of regulations (i.e., even the fact that no ministry is solely responsible for medical tourism in Israel) has echoed in the Germann committee for the revision of the Israeli health system. The committee was founded by the prior secretary of health—Yael Germann. This committee had her conclusions laid in 2014, and one its main conclusion was the dire need in regulation of the issue of medical tourism, as this field was considered to be chaotic and unjust. Except for a lot of publicity, these conclusions had no real impact upon medical tourism in Israel. Sadly enough, the Israeli Medical association had a few meetings after the conclusions were laid down, but took no real action about it.

2.3 How to Approach Medical Tourism?—Different Points of View

One of the proposed approaches is to refer to medical tourism as an export product. If so—Israel, for example, should only export after fulfilling its in-house needs. Looking at medical tourism as an export—A country exports a variety of commodities, including food, equipment, drugs, education, tourism, ammunition, art, literature. Just as we have never limited hotels for Locals before we make them accessible to tourists, we can not say that Health care is not a product for sale all over the world.

Why is selling medicine ethically different than selling education or selling high tech medical devices to the world? To date this is one of the strongest arguments of hospitals CEO's.

On the other hand—in Israel, regulations also prevent the option of increasing volumes of medical activities to the local population, so this might be an opportunity to import money that will ultimately bring better health to the citizens.

The question of whether it is “ethically” appropriate to consider medicine and health as a product “for sale” within the normal market rules, should also be considered.

In her book, *Medical tourism in developing countries*, Bookman addresses an ethical dilemma that developing countries are facing when approaching questions regarding medical tourism (Bookman, 2007). Whereas the local population suffers from a low health care levels, long waiting lists for medical treatment, lagging public health infrastructure, and services that are simply too expensive to consider, tourists are getting advanced medical care and excellent hospitalization conditions considerably less expensively than in their home countries. On the other hand, the same revenues that can be used to finance the local medical system enable more advanced medical equipment and improve the health care system infrastructure. So, considering all these, it is important that the Israeli population will truly receive the same standard of treatment as the tourists, and more importantly that the Israeli population by no means be negatively affected by medical tourism.

The Israel Medical Association (IMA) published a position statement stating that no preference should be given to medical tourists and no delay in treatment or diagnosis of a local patient should occur (<https://www.ima.org.il/MainSiteNew/ViewCategory.aspx?CategoryId=5959>) (Rotem et al., 2009). But, statements stay just that with no real government legislation to enforce it.

Considering all this, the ethical dilemma in the case of medical tourism can be confusing and challenging—One can say that we are compromising the well-being of the Israeli patient, but on the other hand we might just be finding a way to utilize the system in a more efficient way.

It is a combination of a good deed by itself, aiming to collect money that will allow others to receive better health care than they could otherwise get.

The ambition of an individual or a hospital to earn money and to use resources for a “good deed” might get to the point of not reflecting the needs of the individual patient in the home country. Moreover, there might be involvement of private marketing companies that will not always obey the “ethics” of the special “market” of medicine. This is even truer due to the fact that we are talking about big (and confidential) money—according to a Israeli parliament - Kneset report (<https://www.knesset.gov.il/mmm/data/pdf/m03330.pdf>) the revenue of all large hospitals in Israel from medical tourism has risen from 191 million shekels in 2010 to almost 300 million in 2013. More recent data is lacking, even though the impression of those affiliated with these hospitals is that in 2014-5 there was a decline in revenues from medical tourism.

Another issue that should be addressed is “Patient Autonomy”. It seems that our look is a bit paternalistic—we have to remember that the patient who is seeking medical help has the autonomy to

decide where, when, and how to receive medical treatment. We can refer to the individual patient and try to ask what will bring him to his best health. The decision must be made considering the patient's medical problem, the urgency of the treatment and its implications, and the patient's resources. By medical tourism we allow this autonomy to exist and even further promote international health. In a world of increasing globalization—this might even be a common international goal. Thus, International patients choose the country, the hospital and the doctor on the free market.

If they want to choose the physician in Israel, they need to go to a private hospital. But, in the same time—this autonomy is not kept for Israeli patients, which are not allowed to decide these same decisions.

This has just deteriorated in the last year since the ability to use personal health insurance plans in choosing the surgeon or physician taking care of the Israeli patient has been reduced due to new regulations (Filc & Davidovitch, 2016).

There is certainly a conflict between the Israeli patient and the medical tourist, but it does not mean that we should refrain from medical tourism. This is not only an Israeli problem—The Johns Hopkins medical center is one of the finest medical institutions in the world. A new rule in Maryland caps the income for Maryland citizens which creates lines and disincentive in increasing the numbers of patient treated. At the same time citizens from outside Maryland and out of the USA who pay good money, not regulated and not capped are more than welcome. Thus, these rules coerce Johns Hopkins to avoid the admission of rich payers because of the new regulation in a Maryland aimed to cut health costs. Not surprising then, is the fact that in 2008, The American Medical Association (AMA) issued guidelines on medical tourism (2008 AMA Annual Meeting, 2008). The Council on Medical Service recommended that certain guidelines should be maintained by employers, insurance companies, and other entities that facilitate or incentivize medical care outside the United States.

In 2011, the commission for medical tourism in public hospitals reported to the Israel Ministry of Health. The main arguments reported against medical tourism were: medical tourism is done at the expense of Israelis who are waiting longer for treatment, lack of supervision by the Ministry of Health, lack of clear rules limiting the activity by the state, contracts between hospitals and private marketing agents who present themselves as hospital workers.

Thus, the above mentioned committee advised:

- A. Separation of registration and accounting of medical tourism from that of current hospital activities, to create transparency and allow effective monitoring.
- B. Medical tourism incomes will be designated to improve treatment for Israeli citizens.
- C. Medical tourism appointments will be determined on the basis of additional resources and/or on availability and not at the expense of Israeli citizens.
- D. The medical team will be rewarded according to the type of activity and not by the type of patient.

An alternative to this proposal was that the total medical tourism activity will not exceed 10% of total medical activity.

E. There will be no option for choosing a specific doctor for money.

The Israeli state controller has just issued a new report upon the Israeli health system, and in it he had a lot of criticism upon medical tourism to Israel. In this report it was stated that in 2012 (the last year with reliable information upon this phenomenon) 30,000 medical tourists were treated in Israel, and this industry engulfed more than 300 million shekels in revenue. In this report it was stated that medical tourist had been shorter time to diagnosis and treatment in comparison to Israeli residents.

The controller has finalized this report by saying that the ministry of health should make public of the rules and regulations about medical tourists, mainly how these patients will not cause additional stress and aggravation to the Israeli health system.

Until the writing of this article no official regulations, guidelines, or laws had addressed this issue. But the Germann committee for the revision of the Israeli health system tried to give some answers.

The main recommendations of the Germann committee upon the Israeli health system (<https://www.health.gov.il/Services/Committee/German/Pages/default.aspx>) regarding the field of medical tourism are:

1. There is a dire need for regulation of the field of medical tourism, and periphery should have an advantage upon hospitals in the center of Israel in treating medical tourist.
2. It is also needed to have a formal committee that will supervise on a monthly basis upon the implementation of the aforementioned rules.
3. The need for a Medical tourism agent that has a strict and known licensing and ethical code. The responsibility for a medical tourist lies upon the agent, and he/she has no linkage to the medical staff, only to the medical administration of the mentioned hospital.
4. Payment is to the hospital itself and not to the agent who gets his commission from the hospital itself. The hospital can under specific rules act alone with no agent, under the same restriction as that of the aforementioned agent.
5. As mentioned, medical tourism necessitates a specific permit from the ministry of health, which has the ability to revoke that permit from agents or hospitals that violate the stated rules regarding medical tourism.
6. A hospital that gives medical tourism services needs to have a distinct and separate accounting system for medical tourists, and it should always be profitable to the hospital to give these services.
7. On the other hand, the hospital is not allowed to price treatment more than twice their cost for Israeli patients. 15% of the overhead will be taxed by the MOH for shortening queue times for Israeli patients.
8. Full transparency will be demanded from hospitals who engage in medical tourism, especially in pricing and the treatment options open for medical tourists.
9. No treatment will be possible for medical tourists, who is not open for Israeli patients.
10. In public hospitals, there will be a restriction of the extent of medical tourism, which will be no more than 6% of its revenue.

11. Upon the hospital who is interested in giving services to medical tourist to make all its' records (mainly the occupancy at its wards, and the accessibility of these procedures to the general public).

12. Treatment of medical tourist will be after work hours, and the profit from this area will be channeled to the hospital itself. 20% of the revenue will be used to shorten waiting time for common medical procedures, and always Israeli patients will be favored in treatments. On the other hand, a medical tourist will not fair worse than a local patient.

13. The hospital will have a specific physician (Case Manager) who is responsible for the specific medical tourist, and in the case of complications the cost will lie upon the hospital who performed the procedure, and not upon the patient.

14. Physicians who treat medical tourists will be paid by the hospital itself and there will be no financial relationship between the physician and the medical tourist.

As one can read between the lines, the Germann committee was unable to solve this complex issue, and we all still wait for specific rules from it regarding medical tourism.

3. Conclusions

In our opinion, it is reasonable to assume that medical tourism can improve local health care. On the other hand, this opportunity might be abused. Due to the delicate balance between grace and immorality, Israel, like many other developed countries should develop a strict mechanism for the control of medical tourism and put the tensions above to a working equilibrium.

To date, there are no defined regulations or laws regarding medical tourism in Israel and no ethics codes are available.

It is time that the Ministry of Health and the major stakeholders enforce policy and guidelines that will promote medical tourism on one hand, but protect the Israeli population on the other. A good way to start with is the Germann committee which laid some basic regulations.

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