



Medical Tourism: Between Entrepreneurship Opportunities and Bioethics Boundaries: Narrative Review Article

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Abstract

Nowadays, medical tourism reports impressive growth in terms of number of persons, income and number of countries involved in cross-border flows. So this study was undertaken to clarify entrepreneurship opportunities and bioethics boundaries in medical tourism. For tourism entrepreneurs, these outgoing flows related to medical procedures and tourism become an opportunity that cannot be ignored, so a wide range of tourist services related to health care are provided on a private, entrepreneurial basis. However, social and economic boundaries are omnipresent (impaired health services in receiving (incoming) countries, the crisis of the health care systems in emitting (outgoing) countries, over-consumption of medical and tourism services), and, not least, ethical considerations. Transforming medical care in a market tool, reducing human attributes to the status of commodity that can be bought, sold or negotiated, seriously challenges contemporary bioethics principles. It is a significant entering in the area (which is essentially un-ethical) of market transactions, where libertarianism and consumer-oriented attitudes dominates the spectrum of rational choice. So tourism comes to provide an organized and comfortable framework for all these choices, but many issues still remain controversial and may worsen if national health systems and national and international regulations would not identify their problems and would continue to leave medical tourism to market mechanisms. Market will efficiently allocate the resources, but not always in an ethical manner.

Keywords: Medical tourism, Entrepreneurship, Market, Ethics

Introduction

Medical tourism: a brief historical overview and contemporary issues

Overwhelmed by the wave of information regarding the impressive development of medical tourism, we would think that it is a phenomenon, if not new, at least recent. However, the concept of medical tourism is almost as old as medicine itself. Universal culture tells us through fables, stories and legends about the adventures of mythical heroes to obtain potions and cures for themselves and others in need, or looking for magical fountains of youth, immortality and eternal beauty. Although the use of mineral springs in the treat-

ment of various diseases seems to have been experienced in many ancient cultures, archaeological evidences and records allow us to state that the first clear arguments about medical tourism dates thousands of years ago, when the ancient Greeks had crossed the Mediterranean Sea to reach the land called Epidaurus, near the Salonic Gulf, at the sanctuary of the healing god Asklepios. Historical information and oral tradition also mention "the island of Kos - in the south Sporades group of Dodecanese - where Hippocrates, the legendary doctor, may have begun his career" (1). Later, the Romans discovered and appreciated the value of

natural curative springs and thermal baths, building and exploiting numerous establishments throughout the empire; among them, the most famous ones seem to be Bath (now UK) - a temple and place of healing, Aix and Vichy (France), Aachen and Wiesbaden (Germany), Baden (Austria), Aquincum (now part of Óbuda district of Budapest, Hungary) or Herculaneum (Romania). Persia has got also historical roots and tradition as destination for medical tourism. The Indian subcontinent has been visited by a constant stream of travelers in search of medical alternatives, early Indian medicine dating somewhere over 5,000 years ago. *Ayurveda* has been preserved by the people of India as a true "science of life" and the authentic way to benefit from this ancient medical method was to travel to the lands of *Ayurveda*'s origins. Chinese medicine is also a very large subject and its influence and reputation have surpassed for long ago the borders of the Far East, acting as a real magnet for many pilgrims, people in pain or simply curious.

Closer to our days, towards the end of the medieval period, it has been an extended movement to re-discover ancient Roman treatment centers. Seeking for famous physicians or specific treatments begin to be a widespread concern. Even if the travel conditions, the costs and dangers made the travels extremely difficult, history preserves the names of some great personalities who have become, by will or by necessity, real "brands" of medical tourists. Thus, Michel Eyguem de Montaigne, the great French philosopher of the Renaissance, "traversed the continent for nine years in search for a cure for a troublesome gall bladder problem he is said to be the most noteworthy medical tourist" (1). Historical records of these medical tourists *avant la lettre* allow us to understand that long travel for medical purposes were essentially limited to wealthy or truly desperate people.

In modern times, most of the physical, economic or cultural barriers have been removed, and international travel has become more accessible. Expanding communications and the implacable progress of global capitalism have stimulated large and various categories of people to travel, seeking

for medical cure, for wellbeing or simply to discover healthy lifestyles. So this study was undertaken to clarify entrepreneurship opportunities and bioethics boundaries in medical tourism.

Economic dimensions of medical tourism: trade, service, price and quality

According to World Trade Organization and World Health Organization (2), there are four models concerning the commerce and trade with medical services, namely the following:

- *Cross-border supply of health services*: New technologies and innovations in communications enable remote delivery of medical services beyond national borders, and these opportunities augment, to some extent, the health counseling services provided by a large number of hospitals. However, due to novelty, insufficient testing or objective limitations, we cannot speak about a large extent of such services: remote surgery remains an element of the exceptional rather than a common practice, even in large hospitals from developed countries;
- *Consumption of health services abroad*: The export of health services to foreign patients is considered by some authorities as an opportunity for economic development (2). This is the case of many developing countries that have chosen to develop traditional and alternative medicine services, to exploit the lower levels of costs of labor, insurance and also the local traditions;
- *Commercial presence*. Increasing tourist flows due to medical reasons, and involving the private sector and institutions responsible for health insurance (public or private) have resulted in an increased presence of foreign investment in recipient countries - from medical establishments to accommodation facilities, counseling etc. A large majority of these investments are the result of bilateral arrangements, rather than effects of market liberalization;

- *Movement of medical staff as natural persons:* Basically, this mode is based on the free movement of medical staff in different countries of the world, for treating local patients. The variety of these movements is considerable, both in terms of complexity and contractual nature: voluntary, bilateral/mutual exchange or on a paid basis.

The above list, tributary to the vision of the world trade with services, seems to be more schematic and wider than what we currently name "medical tourism". According to Christine Lee (2006), there is no universally accepted definition of medical tourism, the approaches in literature preferring rather to explain the content, the activities, purpose or motivation: "the term 'healthcare' tourism has been used to cover travel and tourism that are related to medical procedures, health and wellbeing purposes" (3), thus including medical tourism, cosmetic surgery and spa and alternate therapies (4).

Some studies consider that the term "medical tourism" should cover activities such as cosmetic surgery, beauty and rejuvenation procedures only, while non-cosmetic procedures – from relatively simple operations to heart bypasses or spinal surgery are considered as "medical outsourcing" (5, 6). According to TRAM (7), medical tourism and health care are included in the following activities or segments: illness (medical tourism), enhancement (cosmetic surgery), wellness (spa/alternate therapies) and finally, reproduction (fertility treatment). Obviously, the first category (i.e. illness/medical tourism) includes a wide range of procedures, such as medical check-ups, health screening, dental treatment, joint replacements, heart surgery, cancer treatment, neurosurgery, transplants and other procedures requiring qualified medical intervention. The next two categories (i.e. enhancement and wellness), although in some cases do require medical staff (e.g. plastic surgery), they are not essential, sharing rather aesthetic and lifestyle purposes. Finally, reproduction (fertility treatment) tourism segment includes both fertility treatments *in vitro* and *in vivo*, and similarly, the situations when a pregnant mother travels in another country to give birth. Sometimes, this category

does not have a real medical reason, but it is more related to the possibility of obtaining a desired citizenship for the children born in certain country; the reason for this travel goes beyond the objectives of this article.

Phua (2010) used a different typology of cross-border medical tourism, as follows:

- *Price-sensitive medical tourism:* The purchasers (patients) are less affluent people (considering the standards of developed countries), mostly traveling abroad to seek treatment at affordable prices. Compared with US price, the prices of medical procedures are only between 40-60% in Brazil, Mexico, Costa Rica and Turkey, 30% in Thailand or even 20% in India;
- *Quality sensitive medical tourism:* Patients are affluent people searching high quality and sophisticated medical services, often not available in their home countries. In this case we refer to relatively small groups of wealthy individuals, both from developed and developing countries (8).

Understanding the determinants of health tourism is complemented by a broader range of motivational factors, such as reducing waiting times (the most suggestive example concerns organ transplants for those patients who want to avoid long waiting lists in their home countries), seeking treatment or medical procedures that are unavailable, illegal or not approved in their home country (abortion, euthanasia, or experimental, miraculous treatments for desperate patients), tolerance, discretion and convenience (gender change, plastic surgery) or even a combination of medical procedure and treatments with luxury travel packages for patient or the accompanying persons. In other cases, the patients are motivated by a mixture between the confidence in the highly qualified medical services and cultural closeness, religious beliefs and family relationships that can be found in the destination countries (9).

However, we can state that the main motivator and driver for medical tourism is the cost differential of health care (combined with touristic attrac-

tions), as in the famous slogan: "First World Treatment at Third World Prices" (10).

Developments and business opportunities in medical tourism

Recent data on medical tourism phenomenon reveal the importance of this segment, both of medical and tourist nature equally, suggesting in the same time the huge growth potential for the next decades. Explain the abbreviation completely first and then abbreviation (OECD) statistics consider medical tourism as the most important component of trade with health services (i.e. physical movement of patients across borders to receive treatment), but also they mention the booming category of trade with goods and services remote-

ly delivered, such as pharmaceuticals ordered from another country or diagnostic services provided from a doctor in one country to a patient in another country (11).

Thus, between 2005 and 2007, the global medical tourism industry has generated annual revenues of approximately 60 billion US Dollars, with an annual growth of about 20%, although more prudent estimations indicate medical tourism revenues about 40 billion US Dollars for 2010 (11). The figures reported for OECD countries reveal a total revenue from medical services (exports and imports) of around 6 billion US Dollars in 2009 (12), (Table 1) but it is likely to be an underestimated figure.

Table 1: Share of imports and exports of medical services in total medical expenditures in selected OECD countries (2009)

Country	Share in total expenditure for health care (%)		Country	Share in total expenditure for health care (%)	
	Import	Export		Import	Export
Luxembourg	9.49	1.15	Czech Republic	0.21	3.58
Island	1.11	0.02	Korea	0.18	0.15
Portugal	1.02	NA	France	0.14	0.15
Germany	0.47	NA	Poland	0.06	1.62
Hungary	0.3	2.08	United Kingdom	0.05	0.06
Canada	0.24	0.08	USA	0.04	0.11

Source: OECD (2011). Health at a Glance 2011. *OECD Indicators*, pp. 158-59. NA: Not available

The figures from OECD reports show that the size of medical tourism expenditure is marginal for most OECD countries, but still growing (more important values are reported by Germany for the imports of medical goods and services, and Portugal in terms of cross-border flows of patients). For example, if the case of the prosperous state Luxembourg seems exceptional, with its people substantially consuming medical services abroad, OECD statistics note that, more recently, many Central and Eastern European countries have become popular destinations for patients from other European countries, especially for dental care and surgery. The annual revenue growth registered in the last five years is quite significant for countries

such as Czech Republic (28%) and Poland (42%) (12).

The most important global medical tourism destinations include Turkey, Brazil, Thailand, Taiwan, India, Singapore, Pakistan, Korea, Mexico, Malaysia, while in the Central and Eastern Europe could be mentioned Czech Republic, Hungary, Poland, Romania, Russia and Latvia.

Undoubtedly, medical tourism is a booming segment (in terms of activities, actors and revenues) which makes it highly permeable to entrepreneurship. Entrepreneurship can occur in various areas but should not ignore the special nature of medical activities (see the discussion below, about the "commodification" of health care) and the

particular standards imposed by a complete medical tourism: material, financial and organizational resources.

However, entrepreneurship has opened a wide field of action both within tourism itself and within complementary medical services such as (13):

- Specialized services for tourist transportation: Tourists driven by medical reasons represent a niche market with a unique profile and therefore adequate for provision of a wide range of customized services;
- Tourism agencies and tour-operators; based on careful market research on incoming and outgoing countries: These companies can conceive, design, develop and sell products and services that best contribute to the needs of medical tourists. For example, we can mention charters for special use, pre-consultation services, connections with certain medical doctors, registration in clinics or hospitals, visas, hospital guide services, translators, booking rooms at hotels in the proximity of hospitals and treatment centers for persons accompanying, short trips and visits in surrounding areas, adapted to the prescribed effort, insurance, wheel chairs, recommended diet etc.;
- Tourist offices located in hospitals: Hospitals intending to sell medical services for foreign tourist are interested in a dedicated tourist office, even on site, which should act as a marketing division of the hospital, by managing both specific internal services and services provided by other partners (e.g. local tour-operators) and providing extra-services such as ticketing, obtaining or extending visas, foreign exchange etc.;
- Professional services: They include reservations software, support, remote medical consultations, etc.;
- Wellness centers, centers for rejuvenation, alternative therapies etc.: They can be developed within or near existing tourist accommodation facilities, capitalizing certain traditions or local natural resources;
- Staff training companies: Given the special nature of purchasers and their expectations regarding the hospitality they expect to enjoy from hospital staff, it becomes necessary to identify the factors which generate patients' satisfaction, and how can be delivered employee's training as to provide appropriate behavior;
- Brokers in medical tourism: All over the world, the demand for health care has contributed to emerging "smart" enterprising people with connections in the medical and health insurance sectors, ready to "help" patients to avoid waiting lists, to negotiate prices on their behalf, and so on, obviously on a fee basis. To what extent these activities, situated somewhere between formal and informal business, could become registered and respectable business, depends on several factors, e.g.: organizational and legal factors, personal motivations and expectations etc.;
- Public relations companies: Specialized in the promotion of medical tourism among public, looking for support from local and central authorities, which are organizing lobby and honest campaigns in order to prevent negative opinions regarding the effects of health care globalization etc.

The limits of medical tourism expansion: From economic to social, and back to bioethical perspective

Globalization of healthcare services through medical tourism could raise serious problems to health systems both in destination countries and in home countries, and also to the patients involved in these international flows. Even the nature and the exercise of these consequences are different; many segments of civil society raise serious doubts on the benefits stated in medical tourism promotion.

- (i) *For receiving countries:* Promoting medical tourism could be a real invitation to the global spread of contagious diseases in countries in which they never appeared before (13), and to which

they may be completely unprepared. The probability for a fast spread of these diseases is given not only by the flexibility of air transportation, but also by the situation that many of these patients share with residents and other travelers the touristic and public facilities, and often they enter into a destination country without specifically declaring the real purpose and by omitting (voluntary or not) to declare their state of health.

Many organizations act against the widespread promoting of medical tourism in third world countries, claiming that the medical infrastructure available in these countries is far to meet even the domestic demand. They state that medical tourism supporters' argument – i.e. the fact that part of the revenues earned by hospitals in the third world countries from wealthy patients from developed countries will return to the local health system, contributing to improving infrastructure, providing medicines and medical services to local people – is not only mercantile, but also false. Actually, most of these entries will suffer from the effect of leakage – already reported in other tourism segments, such as luxury tourism in exotic destinations, and by consequence actually insignificant revenue will contribute to the development of recipient countries. Most of that money will return in the rich countries (through external excessive expenses made by hospital administrations in management contract, promotion, travel) or they will simply go to "small islands" of local prosperity (huge salaries to managers, to some physicians etc.).

The argument that affluent people (mainly from abroad but even wealthy locals) would obviously prefer some exclusive medical facilities and thus will free of pressure most medical facilities does not stand. In fact, the government and local authorities in poor countries– encouraged by the apparent financial revenues obtained from medical tourism– will redistribute the insufficient health budgets funds to luxurious hospitals and will disadvantage "popular" hospitals, crowded and underfunded. Focusing national resources on treat-

ing foreign patients will harm the chances of their own citizens to proper adequate treatment; the "logics" of the advantages of luxury tourism promotion (mainly the "export" of services) cannot be applied to the "export" of health care services, as they could divert human and material resources (insufficient anyway) from own citizens to medical tourists (14).

The "crowding out" phenomenon (as an insidious inflation) is another issue associated with medical tourism. In cases of recurrent and consistent medical tourists' entries, the cost of health care for local patients in the receiving country will rise, due to increasing incomes and expectations of medical staff and suppliers; thus, medical services and goods become less affordable to local patients. Of course, this problem would disappear if the benefits from medical tourism revenues would be (relatively) balanced distributed within the society (directly or indirectly), and thus they would stimulate growth. However, as the benefits are actually captured only by socio-economic elites, the benefits do not reach the poorest members of the society and their access to essential medical services could be even more problematic than before medical tourists' arrival (10).

- (ii) *For tourists emitting countries:* Many experts in health insurance systems warn about the future of these systems under a dual pressure: On one hand, the huge cost of financing these systems through taxes collected from the local population, and on the other hand, the pressure from tax payers to allow the insurance settlement for external treatments. Thus, when the national health insurance funds and the large private insurance companies will be substantially involved in this business, encouraging and covering widespread medical procedures abroad, the effect on local medical centers in developed countries could be significant and even devastating.

This pessimism is amplified by the opinion of medical staff from developed countries who consider medical tourism as a bad signal, as a "ghost"

of future national health systems, developing an economically motivated complicity between hotels and luxury beauty care centers (spa) and medical centers internationally connected, providing international luxury concierge services for patients covered by the exaggerated cost of travel tourism (15), but much less honest care. According to Milstein and Smith (16), we are witnessing a new influx of refugees, the “new refugees of modern world”: American patients looking for medical treatments and procedures at affordable prices in India or Thailand, which will aggravate the already compromised U.S. health system.

- (iii) *For medical tourists:* Medical tourism is market driven: The insufficient financial resources and the exaggerated prices of medical procedure and treatments in home country, and also the existing waiting lists fuel the international movement of people. The consequences for medical tourists go from bearing the risks of insufficient verified services, to the improbability of pursuing treatment and supervision after return.

Medical tourism brokers are strongly motivated by substantial margins obtained from selling travel packages. If these brokers are not bound by legal codes and by ethical and professional standards of practice, while significant investments were made in the medical facilities in the effort to increase the international market of patients, the overall effect could be to encourage customers to consume and accept additional treatments, sometimes unnecessary. Of course, this criticism is not specific to medical tourism, as it stands in any context where health care is provided as a commodity.

What distinguishes, however, international medical travel from other market circumstances arising from the provision of health services is, in many recipient countries, the lack of clarity on the legal protection of local (or cross-border) ethical and professional standards, able to limit greed and to ensure that patients make choices with sufficient information and fully aware of the benefits and risks. It is possible that lower prices of international medical services would be accompanied not

only by a lack of information but also by a propensity to minimize risks, by exaggerating benefits and encouragements to continue the pursued treatment (10). Thus, the lack of regulation goes hand in hand with the lack of information and protection of patients.

- (iv) *Ethical boundaries of medical tourism:* Medical tourism can encourage secret unethical practices, e.g. clinics recorded on cruise ships where performing abortion or euthanasia (12) or even organizing trips for assisted-suicide tourism (17). For many analysts, these challenges to morality and ethics should not be considered as isolated cases only: medical tourism practice to the edge of “criminal” indictment, or an exotic touch given to medical tourism malfeasance. Further analysis has to achieve the market practices in healthcare sector, i.e. to approach the “commodification” of medical care.

A significant number of studies and policies have considered medical services and health care as simple “commodity”, insisting on the increasing market rules in the organization of health care services, in economy and society. The effects of this “commodification” of health care are product standardization, market expansion and active marketing of health brokers on “consumers” (i.e. the patients) (18).

The basic foundation of this philosophy is – as in all liberal or neoliberal approaches – Adam Smith's theory exposed in his famous work *The Wealth of Nations* and *Theory of Moral Sentiments*: people act from self-interest, so that the public interest is served; pursuing personal profit will contribute, ultimately, to the social benefit. However, Adam Smith's work does not stop here, it speaks about sufficient income for human subsistence, and even about limits to market intervention in some sectors, which must remain in governmental administration. But these thoughts do not seem to generate scruples: the perspective for exceptional gains deserves to be justified by morality and certified by academics.

This approach, based on the classics of the economic theory but later developed in an aggressive and globalized form in modern economy, affects health services provision in general and medical tourism in particular. It could not avoid criticism from the medical world and from the civil society, who is denouncing— in terms of ethics, morality and human uniqueness— the unacceptable incorporation of medical care into the mercantile framework of profit and economic efficiency.

Thus, health and medical care cannot be treated as simple commodities, they cannot be described in terms of attributes such as price, fungibility or instrumental value (not intrinsic) (18,19). Expanding market rules to health care or medical tourism reduces everything— including human beings, their labor and their reproductive capacity— to the status of commodities which can be bought, sold, traded and stolen (20).

With an impeccable assessment, Pellegrino states that "(i) Health and medical care are not, cannot be, and should not be commodities; (ii) the ethical consequences of commodification are ethically unsustainable and deleterious to patients, physicians and society; (iii) commodification does not fulfill its economic promises; and (iv) health care is a universal human need and a common good that a good society should provide in some measure to its citizens" (21). Human universal benefit of the remarkable advances made by medical sciences in recent decades will not take place "unless a combination of moral, legal and religious ethical issues are carefully considered" (22).

However, these positions do not solve, not at least theoretically, the rational foundations of market rules' expansion in health care sector, also in the medical tourism, where, as we have already noticed, the main engine is the search of cost differential by keeping, at least presumptively, the quality of care and subsequent recovery. It is less likely that these assertions should be able to temper the increasing tourist flows, the specific investments in this area or the expectations for a rapid recovery and high return of the huge expenses.

A theoretical explanation of these implacable market realities can be found in the fact that, while contemporary conventional medical ethics

easily blow off the ancient perception of virtue in suffering and death, bioethics principles failed to make a clear distinction between ethical choices and the context (essentially un-ethic) of market transactions.

The right to life and decent care has been transformed (obviously for those who can afford it, for those who enter into market transactions) in the right (and principle) of saving and prolonging life at any cost. From here, the step to transform the life into a commodity, canceling a global social ethics, was very easy to do (20). Thus, traveling to countries where medical procedures and treatments are cheap, the possibility to skip the queue or to procure affordable organs for transplant, accessing miraculous rejuvenating treatments etc. were simply shifted from stringency into transaction area, with or without the will of purchasers. Scheper Hughes conclusions' (2002) cover quite suggestively (and critically) these statements: "In the rational choice language of contemporary bioethics the conflict between non-maleficence ("do no harm") and beneficence (the moral duty to perform good acts) is increasingly resolved in favor of the libertarian and consumer-oriented principle" (20).

Conclusion

Commodification of health care, by transforming medical staff "from healers to dealers", should not be attributed to entrepreneurship, or to small and medium businesses growing in the shadow of international flows of medical tourists. The entrepreneurs could not be held responsible for cost differential, which makes medical treatment in developing countries to be several times cheaper than in developed countries. Much of the tourism business accompanying the movement and residence of foreign patients are not very large and, very important, they do not concern nor affect medical act. Similarly, neither physicians from receiving countries should not be held by adverse effects of tourist flows, even if their services are (or should be) rewarded considerably better than in public systems from the recipient countries.

We consider that the causes reside first in the weaknesses of public health systems, the complicity – profitable for the few, disastrous for the many – of these systems decoupled from the realities and needs of taxpayers with large international capital. Together, they have the power to transform, promote and capitalize in an extremely onerous manner the combination of cheap medical services, luxury hotel amenities and exotic destinations. As we have asserted above, the step begins to be made by large public and private health insurance companies. It will certainly lead to increasing medical tourism flows, to an increasing number of citizens from rich countries searching for medical procedures and treatments abroad. On the other hand, the social and economic effects on the medical units' capability to serve people in undeveloped countries, the extremely unequal redistribution of income from medical tourism, and the health systems crisis in tourist emitting countries could prove to be excessive costs borne by the majority of citizens.

Ethical considerations

Ethical issues (Including plagiarism, Informed Consent, misconduct, data fabrication and/or falsification, double publication and/or submission, redundancy, etc.) have been completely observed by the authors.

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