INTRODUCTION

Working as a physician a few years back in Lima, Peru, I had my own perceptions of a ‘medical tourist;’ an affluent patient or patient with special health insurance plans who opted to travel abroad for a particular procedure due to state-of-the-art equipment or for cutting-edge technology not yet available in Peru. Others were in search of physicians highly trained in a certain subspecialty only found abroad. As a result, I was left believing that our healthcare professionals and services were not up to par. Besides, the only tourists hospitalized in the large private healthcare facility where I worked were those unfortunate travellers who fell ill or suffered an accident during their trip.

Five years later, the picture looks quite different. Several private hospitals around the whole country have embraced the ‘hotel-spa’ approach. Boasting large LCD TV screens in many of their suites, as well as high speed internet, en-suite office work stations, manicure services, and chef-inspired meal options, successfully contradicting the long established hospital-food stereotype, patients are now meant to feel that they are anywhere but in a hospital. These luxurious surroundings are coupled with outstanding medical care and access to modern medical infrastructure, for a fraction of the cost of a similar service in medical tourists’ home countries. Many of the staff physicians have completed training abroad, acquiring highly specialized skills, once again broadening the scope of health services offered in these private hospitals.

During these same five years, overall tourism in Peru has grown by 46 percent (MINCETUR, 2011) and, not surprisingly, so has medical tourism. Not only are independent private clinics tailoring their websites and services to include international patients’ needs, but the Peruvian government has also created the Disfruta Salud Perú® (Enjoy Health) initiative offering services in the areas of plastic surgery, dentistry, ophthalmology, and fertility.
Peru is not alone in this growing trend among Latin American countries, but it is far from being the leader in this field. According to the World Travel & Tourism Council, Latin America’s direct contribution of travel and tourism to GDP was US$133.8 billion in 2011 (3.2 percent of regional GDP) and is expected to increase to 4.7 percent of GDP by 2021 (World Travel & Tourism Council, 2012). In addition, visitor exports, also known as foreign visitor spending, generated US$35.6 billion in 2011, and is expected to reach US$70.8 billion by 2021, which would place Latin America in first for visitor exports among 12 other regions (World Travel & Tourism Council, 2012). In addition to steadily increasing tourism, factors such as geography, language, politics and healthcare systems are also playing a key role in the development and competitive marketing of medical tourism in Latin American countries. While most agencies do not specify the reason for picking a certain destination, cultural aspects may also be a contributing factor. There are reports of people residing abroad who consider returning to their home countries in search of physicians who speak their language, or with whom they have a more comfortable physician-patient relationship (Bolis, 2001). This is particularly important in the Canadian context where there are currently over a quarter of a million Canadians with Latin American origins, with the Latin American community being one of the fastest growing cultural groups in Canada (Lindsay, 2001). Patients in search of more culturally competent services may choose to return to their countries where they feel comfortable navigating the healthcare system or to seek care from providers whom they are already familiar with and trust.

Despite the recent growth of this industry in the region, several Latin American countries still struggle with the challenge of convincing potential medical tourists that the quality of medical care they receive will be similar to the standard of care available at home (Connell, 2006). Specifically targeting these concerns, hospitals in this region are increasingly seeking formal accreditation. JCI, a US-based organization, which provides accreditation and certification services to healthcare organizations worldwide, regulates hospital standards while maintaining the “highest international benchmarks for accreditation entities” (JCI, n.d.a). The JCI, which has been accrediting hospitals for over ten years, also forms part of a joint partnership with the World Health Organization (WHO) in the first World Health
Organization Collaborating Centre on Patient Safety Solutions (JCI, n.d.b). To date, the JCI has accredited 44 healthcare organizations in Brazil, Chile, Colombia, Costa Rica, Ecuador, Mexico and Nicaragua. By receiving the JCI accreditation, many countries can now provide certain reassurance that patient outcomes, safety, and quality of care will meet international standards. Despite the purported benefits of JCI accreditation, some argue that attempting to meet American standards may override local values and established ways of providing healthcare (Jenner, 2008; Johnston, Crooks, Snyder, & Kingsbury, 2010).

Regardless of the reasons medical tourists may have for deciding to seek care in a Latin American country, most of these countries are considered developing nations and as such, questions arise regarding the effect of the industry on exacerbating health inequities. With a few exceptions, the majority of Latin American countries have two-tiered healthcare systems. This is of particular concern where public and private healthcare organizations rely on the same resources such as equipment and personnel. With this in mind, what follows are two country case examples (Mexico and Cuba) selected because they represent fundamentally different models of medical tourism, as well as differing in terms of geography, culture and politics. An overview of each country will be provided, along with a discussion of the medical services offered, and the effects medical tourism appears to be having on the overall healthcare system of each country.

MEXICO’S EXPERIENCE

Mexico, covering almost two million square kilometres with an estimated population of over 113 million (World Factbook, 2011), is the third largest Latin American country in size, after Brazil and Argentina. It is a democratic republic consisting of 31 states and a Federal District. While Mexico’s GDP is over US$1.5 trillion (World Factbook, 2011), income is distributed unequally contributing to inequities in access to services and opportunities (World Health Organization, 2011).

Mexico’s Human Development Index (HDI) rose annually by 0.9 percent from 0.581 to 0.750 (1980-2010), obtaining a ranking of 56 out of 169 countries. Mexico’s rate of
improvement was slightly greater than the average of the Latin American and Caribbean region, where HDI rose from 0.578 to 0.706 (1980-2010); yet it still falls below average when compared to North America, Europe, and certain regions in Asia (United Nations Development Programme (UNDP, 2010).

Mexico’s total expenditure on health is 6.5 percent of its GDP (World Health Organization, 2011). Similar to most other Latin American countries, Mexico’s healthcare system is not universal and quite complex involving three principal providers: 1) Social Security, which includes the Mexican Social Security Institute (IMSS) and the Social Security Institute for State Workers (ISSSTE); 2) The Secretariat of Health (SSA); and, 3) the private sector. By 2006, it was estimated that five million families would be covered (World Health Organization, 2011). A 2007 review in The Lancet argues that despite the institution of a popular health insurance (PHI) program in 2003, that the PHI will not solve Mexico’s public healthcare problem, claiming that both families and states will have difficulty paying the insurance premiums, that there is insufficient infrastructure and staff to guarantee adequate healthcare delivery, and that private service contracting will interfere with service supply (Laurell, 2007). It is perhaps this last argument which most closely relates to medical tourism in Mexico as it is private healthcare organizations which are advertising their services to medical tourists. On the other hand, proponents of medical tourism claim that trade in health services could improve access to healthcare for all people in developing countries by properly allocating revenues earned through such trade, or by creating a specific tax for medical tourism with revenues hypothecated to the public health system. However, to date there is no evidence that either mechanism exists in Mexico (Laurell, 2007).

Focusing on tourism alone, Mexico is the second most common travel destination for Canadians, after the US (Statistics Canada, 2011). Specific information focusing on medical tourism, however, is still lacking. Because of proximity and rising domestic healthcare costs, the majority of international patients seeking care in Mexico are from the US. A survey conducted by the University of California in 2001 stated that every year over one million California residents travel to Mexico for medical services, dental services, and medications, though some of these numbers may overlap in cases where patients access more than one service. However,
the number may be an under-estimate given that the definition of medical tourist used in the survey (travel for a period of more than 24 hours yet less than one year primarily to receive medical treatment) would forcibly exclude medical tourists who cross the border for dental treatment or same-day surgical procedures (Ramirez, 2007). Likewise, the exact number of healthcare organizations providing services to international patients in Mexico is unclear.

Popular destinations, especially for California residents, include the border town of Tijuana and, to a lesser degree, Rosarito, both located in the state of Baja California, Mexico (Ramirez, 2007). Although Tijuana continues to recover from a plunge in tourism arising from the H1N1 flu travel warnings in 2009, the recession, and drug-related violence, some hospitals have managed to continue attracting patients and have increased the services they offer. One example is Hospital Angeles Tijuana, a US$60 million, 122-bed private hospital belonging to a larger network known as Hospital Angeles. This is the largest private network of hospitals in Mexico, with 22 locations all equipped with state-of-the-art technology, a total of 1,700 beds and over 11,000 specialists. This network also has the designated medical travel division, Angeles Health International, based in the US, claiming to “treat more North American medical tourism patients- Americans and Canadians traveling abroad for medical care- than any other hospital network in the world” (Angeles Health International, 2011a). Reporting over 6,000 American and Canadian patients treated over the past three years, this Network offers services in bariatric, spinal and orthopedic surgery, interventional cardiology, dental care and organ transplant, among others. According to the President of the College of General Practitioners, patients traveling to Tijuana may save from 30 to 50 percent on consults, laboratory testing and medication, and from 30 to 80 percent on surgical procedures (Sanchez, 2006). Weight loss surgical procedures in particular, have an important saving potential. The LAP-BAND® Adjustable Gastric Banding System for example, is a popular weight loss procedure which at the time of writing was not covered by provincial medical insurance in Canada, but offered through the private sector with a price range varying from CAN$16,000 to CAN$18,000 (Admin, 2008). In contrast, the Angeles Hospital offers a US$5000 LAP-BAND® Program which includes all surgeon and doctor fees, a two-night hospital stay, one-night hotel stay, standard pre-op lab testing, complimentary travel concierge services for the patient and their travel companion,
shuttle transportation to and from the airport, and a twelve-month follow-up program (Angeles Health International, 2011b).

Contributing to the growing Mexican medical tourism industry is the development of plans covering medical treatment abroad by some major US insurance companies. This gives certain groups of Americans the option of accessing healthcare in Mexico, typically with lower premiums and co-payments. Blue Shield of California, for example, has created the Access Baja® insurance plan, which is available to employees living or working in the municipalities of Tijuana or Mexicali, or in California within a 50-mile radius from the US-Mexico border (Blue Shield of California, n.d.a). While this plan is quite comprehensive, Blue Shield is keen to add the following caveat:

Legal requirements and generally accepted practice standards of medical care in Mexico are different than those of California and elsewhere in the United States. Care received through the providers in Mexico in the Access Baja® plans will be consistent with generally accepted medical standards of Mexico, not California (Blue Shield of California, n.d.b).

This statement may not pose an impediment for the majority of potential clients who tend to be Mexican residents (or of Mexican nationality) and therefore familiar with the Mexican healthcare system, yet it may deter other North American citizens. Nevertheless, the potential savings and virtually non-existent wait times make this an irresistible option for many.

Although Tijuana is a popular destination, less than 20 miles from downtown San Diego, California, patients may be hesitant to trust a hospital without international accreditation. Currently, Mexico has nine healthcare organizations accredited by the JCI, (eight are large hospitals and one a clinic), located mainly in Mexico City and Monterrey. Three of these are of particular interest: CHRISTUS MUGUERZA® Alta Especialidad Hospital, The American British Cowdray (ABC) Medical Center, and CIMA Monterrey Hospital.

Hospital Alta Especialidad, a CHRISTUS Muguerza® Hospital, located in Monterrey, Nuevo Leon, Mexico was the first healthcare organization to receive JCI accreditation in 2007 and was recently re-accredited in 2010. This hospital is affiliated with Christus Health in Dallas, Texas, a Catholic non-profit health organization. The hospital’s strength lies in their cardiovascular
service department, which they describe as “the leading cardiac care center in all of South America,” (CHRISTUS® Muguerza, n.d.a) while highlighting that all of the physicians on their Medical TravelSM team are internationally trained (CHRISTUS® Muguerza, n.d.a). CHRISTUS Muguerza® Hospital has also obtained flattering reviews from media such as Men’s Health magazine, Newsweek, and the Los Angeles Times. Maintaining a firm commitment to the local community, the CHRISTUS® Muguerza group operates five social assistance clinics in five communities improving access to high quality care, through their Adelaida Lafón Foundation (Sisters of Charity of the Incarnate World, 2007). These clinics provide services in primary and emergency care, nutrition and education programs, mental and dental health, physical rehabilitation and speech therapy, among others. They also organize medical and surgical brigades, which include services in surgery, paediatrics, gynaecology and ophthalmology. In 2005, a comprehensive telemedicine program was developed to provide remote populations with immediate access to specialized care (Sisters of Charity of the Incarnate World, 2007). This is an example of how private, for-profit institutions can facilitate access to healthcare for disadvantaged and vulnerable populations using revenues generated by private healthcare and medical tourism. However, despite the interesting model of care that the Foundation presents, we were unable to find additional information about the numbers of patients treated, if any costs are attached to the services and payable by patients, and if there are any advantages that accrue to the philanthropic status of the foundation.

The ABC Medical Center, whose aim is to be recognized as the leading health system in Mexico and Latin America, is a not for-profit organization with two JCI-accredited campuses, one in Mexico City, and one in Santa Fe, New Mexico (MHL USA, n.d.). In addition, the Center is affiliated with Methodist International, the international division of the Methodist Hospital in Houston, Texas. Emphasizing their intention to participate at multiple levels, they state on their website:

*Through its affiliation with Methodist International, ABC Medical Center will be integrated into a global network of hospitals-the first in Latin America. This network will become model and benchmark for hospitals at the local, national and international level (Centro Médico ABC, 2009).*
Through a user-friendly website, available in both Spanish and English,\(^5\) the ABC Medical Center readily conveys a strong sense of security, professionalism and trust. Contrary to many medical tourism websites, the centre does not provide a single quote or price comparison for their services offered. Potential patients are asked to contact the centre directly to speak with a representative. While to some this may initially appear to be a barrier, it is common practice particularly among the larger hospitals and does not seem to create a disadvantage. Similar to CHRISTUS® Muguerza, the ABC Medical Center has two private clinics exclusively devoted to providing private medical assistance to nearby underserved communities whose population lacks insurance through social security. Both of these clinics combined, provide approximately 27,000 medical consults per year, as well as assistance during natural disasters.

Finally, the CIMA Monterrey Hospital is owned by the US-based, private, for-profit International Hospital Corporation (IHC) and is affiliated with the Mayo Clinic, the University of Texas Southwestern Medical Program, and the Children's Hospital Boston. The IHC is a Texan company and owns several healthcare facilities throughout Latin America, including in three other Mexican cities, and in Costa Rica and Brazil. International patients are drawn to this hospital not only because of its international affiliations but also, as with the CHRISTUS® MUGUERZA hospitals, because it is located in Monterrey, Mexico's wealthiest city. Unlike the previous two examples (both of which are non-profit organizations), there is no indication that this hospital has any social commitment with the local community. In November 2011, the parent US company (renamed DTF Corporation) filed for bankruptcy reorganization under Chapter 11 with reported liabilities exceeding assets. Some of these liabilities include a lawsuit filed by the family of its deceased former CEO (Hethcock, 2011).

The number of accredited hospitals and services directed towards medical tourists has grown over the past years and is projected to continue increasing rapidly. In August 2011, during the first Forum for Medical Tourism, held in Monterrey, Mexico, both the Minister of Health and the Minister of Tourism affirmed that Mexico possesses the necessary conditions to be a leader in this field. The Minister of Tourism further announced that tourism has a central role in the national agenda, as it represents nine percent of Mexico’s GDP and generates 7.5
million jobs (SECTUR Secretaria de Turismo, 2011). Targeting specifically North American citizens, the Minister of Health recognized that

...despite geographic proximity to the US and Canada, a large proportion of these citizens travel all the way to Asia for health services, while [in Mexico], these issues could be resolved perfectly or even better (Garcia, Mendoza, 2011).

A new national agreement will begin by promoting the certification of hospitals particularly along the US-Mexico border (SECTUR Secretaria de Turismo, 2011).

CUBA

Cuba is an archipelago located in the Caribbean Sea with a total land area of 110,860 km². It is made up of 14 provinces, divided into 169 municipalities and has a separate Special Municipality known as the Isla de la Juventud (World Health Organization, 2009). With a population of 11,241,161, approximately 75 percent of Cubans live in urban areas (Oficina Nacional de Estadisticas - Republica de Cuba, 2010). In terms of health indicators, Cuba’s public expenditure on health is 9.9 percent of GDP and its total expenditure on health is 11.8 percent of GDP (World Health Organization, 2009). Cuba’s HDI only became available in 2010, reporting a value of 0.7606, and ranking 53rd among all other countries. Although there are no values from prior years, it ranks above the rest of Latin America and the Caribbean, notably three spots above Mexico.

As a socialist, collectivist state, Cuban social policy expects the State to be accountable for the health of its citizens. As such, all policies are geared towards promoting and maintaining human development in all areas, such as health, education, culture, safety, employment, and social welfare (World Health Organization, 2009). Indeed, over 60 percent of Cuba’s budgetary expenditures have been destined to assist in the areas of health, education, safety, and social welfare throughout the period of 2000-2005, after recovering from the economic downturn in the early 90’s (Pan American Health Organization, 2007).

Like many other Latin American countries, Mexico included, Cuba is experiencing an epidemiological transition where chronic diseases are becoming more prevalent as
Communicable diseases gradually decline. In 2009 infectious diseases account for only 0.1 percent of deaths as opposed to non-communicable diseases accounting for 90 percent of deaths (World Health Organization, 2009). This has been accompanied by a demographic transition, resulting from a rapidly aging population and low fertility rates. Cuba now shares the common challenge of providing complex healthcare delivery services to a rapidly changing population.

Cuba is well recognized for placing health as a priority, assuring equitable healthcare delivery through universal coverage and access. Recent changes have included the creation of programs geared towards bringing highly specialized services to the primary level of care, which had previously only been offered at the secondary and tertiary levels. This has required careful allocation and investment of resources, along with proper personnel training. Relying heavily on the delivery of primary care, the National Health System has 70,594 physicians, of which 33,769 are family physicians providing care to 99.4 percent of the entire population (Pan American Health Organization, 2007). In addition, Cuba is also recognized for the provision of medical personnel abroad. According to some reports, in March 2006, there were 25,000 Cuban medical professionals working in 68 nations, “representing more than the World Health Organization can deploy” (Calvo Hospina, 2006). Cuban medical staff has been deployed to provide aid during several recent catastrophic events such as the 2005 earthquake in Kashmir and the 2010 earthquake in Haiti, as well as assisting Venezuela in providing primary care in rural and poorer urban areas. This has enabled Cuba to use healthcare as a diplomatic tool, allowing it to strengthen political ties with many other nations (Ramirez de Arellano, 2011).7

Despite the historic political tensions between the US and Cuba, and the longstanding US trade embargo, Cuba manages to attract a large number of tourists. Each year, nearly two and a half million people travel to Cuba, and of these, almost a million are from Canada, the leading visiting country. Following in frequency but to a much lesser degree are England, Spain, Italy, Germany, France and Mexico (Oficina Nacional de Estadisticas- Republica de Cuba, 2010). Approximately 52,000 US citizens visit Cuba every year as well, but usually do so by traveling through Toronto, Montreal or Mexico.
As previously discussed, information is lacking regarding the exact number of people traveling to Latin America for health tourism, and this holds true for Cuba as well. One report indicates that between 1995 and 1996, over 25,000 international patients sought medical services in Cuba, generating approximately US$25 million in revenues (Chanda, 2001). Other, more recent, reports state that Cuban medical tourism generates an estimated US$40 million per year (Fawthrop, 2003).

As several Latin American and Caribbean countries have come to realize, competitiveness in this field is better achieved by specializing in certain services that others cannot (or will not) offer. While some countries focus on weight loss surgeries, such as Mexico, or plastic surgery in Brazil, Cuba has found its niche as well. One of the most solicited medical services in Cuba is treatment for retinitis pigmentosa, an eye disease causing difficulty seeing at night and in many cases, leading to permanent blindness. For many years, Cuban physicians have been conducting research in this field. In the world of ophthalmology, the ‘Cuban Treatment’ for this condition is well known yet highly controversial, with many North American physicians remaining skeptical about the results of this procedure, and refraining from practicing it or suggesting it as treatment for their patients. Developed by Cuban physician, Dr. Orfilio Pelaz Molina, data for this procedure suggests 75 percent of patients remain stable post surgery, meaning the progression of the disease is halted, 16 percent show improvement, and 9 percent continue with the natural progression of the disease (Garcia Layana, 2003). Although long-term results properly documented in peer-reviewed journals have yet to back this claim, many patients faced with the possibility of permanently losing their sight are willing to take the risk of surgery, especially in the absence of alternative treatment (Garcia Layana, 2003). Sample ‘packages’ for this procedure tend to go as follows: 1) Basic Retinitis Package which includes an evaluation only, for US$1,441; 2) Standard Retinitis Package offering both evaluation and surgery for a total of US$7,070; and, 3) Premium Retinitis Package which includes evaluation, surgery, follow-ups and transfers totalling US$10,140 (Cuba for Health®, September 2011).

Other areas of specialization in Cuba include the treatment of several dermatologic diseases such as vitiligo and psoriasis, treatment for neurologic conditions, and drug rehabilitation programs. While there are individual hospitals and clinics offering these medical
services, the most recognized hotel operator group in Cuba, Cubanacan S.A., does this through its subsidiary tourism and health company operating under the trademark of Servimed. Most of the medical tourism agencies have chosen to deal directly with Cubanacan, such as the Canadian agency, Go Cuba®, based in Toronto, Ontario. Other Canadian agencies, such as Choice® Medical Services® based in Winnipeg, Manitoba, do not specify the exact medical organizations tourists will be dealing with in Cuba, but do provide a clear breakdown of what is included in the medical package. In addition, patients are assigned a ‘Personal Patient Consultant’ (PPC) who assesses the client’s medical situation and gathers documentation, acts as a liaison with the medical team in Cuba, and makes all necessary travel arrangements and payments. Upon arrival, patients are greeted by a secondary PPC in Cuba to assure a smooth transition and quality of service delivery (Choice® Medical Services, 2007a). According to Choice® Medical Services, medical tourists are expected to save anywhere from 20 to 80 percent when accessing medical services in Cuba (Choice® Medical Services, 2007b). Perhaps due to their high quality medical care and outstanding health indicators, Cuba has managed to place itself as a growing leader in this field, even without international accreditation of its hospitals by the JCI or others.

When considering the impact of medical tourism on the Cuban health system and health equity, it might be assumed that because of its social responsibility to its citizens, revenues from medical tourism are reinvested in public healthcare. Certain medical tourism agencies address this issue directly on their websites. The agency Cuba for Health® for example, clearly expresses:

The Cuban Health Care system is organized in such a way that the funds obtained through foreign health tourism helps to cover the costs of the services that are offered to the nationals. In this way the health care for the Cuban nationals is entirely for free. Reserving the treatments with our agency not only gives you access to the best medical care but also you are guaranteeing the health care of others (Cuba for Health®, 2008 August).

As with the case of Mexico, it is difficult to ascertain the veracity of these statements. In fact, in 1994 Dr. Hilda Molina, an internationally renowned Cuban neurosurgeon and founder of
the country’s Centre for Neurological Restoration, stepped down from her position after hearing the government’s plan of turning the Centre into a foreigner-exclusive institution (de Albornoz, 2006). She has been quoted as saying:

I am not a politician. I am a doctor. Cubans should be treated the same as foreigners. Cubans have less [sic] rights in their own country than foreigners who visit here (Vincent, 2004).

Her concerns have been shared by others, and have made it to the Canadian press (Vincent, 2004). Other Cuban analysts suggest that the problems the country is now encountering are a result of the many ‘tourist-only’ hospitals, which have reoriented the public health system (Vincent, 2004).

CONCLUSION

While most Latin American countries have been receiving medical travellers for many years, medical tourism has only recently been gaining momentum and, for some countries, is being seen as a key platform for economic development. The impact that this growing industry is having on Latin American countries varies, and depends greatly on socio-political and cultural factors. Countries that have long relied on tourism for economic growth, such as Mexico and Cuba, are now actively investing in the medical tourism sector to encourage exports as a source of foreign investment.

Certain aspects of medical tourism have been identified as potential solutions for health systems problems. Improvement of existing medical infrastructure, for example, is one of them. Keeping in mind that international accreditation bodies require health institutions to maintain a certain standard, many hospitals have invested in improving and maintaining their hospital’s infrastructure. This can lead to positive benefits for the local population in countries where foreign patients and local patients make use of the same hospitals. The same does not hold true, however, for countries with designated ‘foreign-only’ hospitals, or for services offered at a cost that the local population can rarely afford. In addition, this may lead to the improvement of only the hospitals that care for foreign patients. Acknowledging that this may lead to important
health inequities, certain hospitals, such as CHRISTUS® Muguerza or the ABC Medical Center in Mexico, have developed several programs specifically targeting underserved populations with no access to social insurance benefits. In the case of Cuba, where access to healthcare is universal and is the responsibility of the government, revenues generated through medical tourism are reinvested in the public health system, yet the exact percentage is unclear or unknown.

As waiting times and insurance non-coverage of ‘medically unnecessary procedures’ remain pressing issues in the Canadian healthcare system, and as US healthcare costs continue to rise, North American patients may increasingly turn to cross-border care to address their needs. Latin American countries have recognized this market opportunity and are actively courting medical tourists. The Latin American region has historically struggled and experienced challenges around healthcare system reforms. As such, it is important to consider the implications that medical tourism is having on current healthcare delivery of the local population. While it is clear this industry presents an important economic opportunity, countries should proceed with caution to ensure that the health of their nation is not compromised in the process.

1 This is an initiative of the Commission for the Promotion of Peru Export and Tourism (promperu). It is through the program for Promotion of Export of Services. For more information see http://www.peruhealth.org/Main.asp?T=20120. This initiative is designed to identify the best Peruvian clinics through an extensive evaluation, and provide a complete portfolio for medical tourists. For more information see http://www.peruhealth.org/Main.asp?T=20281.

2 See, for example, the October 2008 Issue of Men’s Health Magazine, pp. 150-57.

3 See, for example, the 2008 article of The Daily Beast, “Ultimate Outsourcing,” found at http://www.thedailybeast.com/newsweek/2008/11/18/ultimate-outsourcing.html.

4 See, for example, the 2008 article of The Los Angeles Times, “Ticket to treatment,” found at http://articles.latimes.com/2008/nov/02/business/ft-cover2.


6 The 2010 HDI value and ranking reflect the inclusion of one or more HDI indicators that were not available at the time of the preparation of the 2010 Human Development Report.

7 A similar use of cross-border public health care as a form of ‘health diplomacy’ has been used by South Africa (see the chapter by Crush, Chikanda and Maswikwa, this volume); and it is
interesting that South Africa also employs a large number of Cuban-trained physicians to help meet human resource shortfalls, particularly in its rural areas.

8 For more information on Go Cuba, see http://www.gocuba.ca/client/home/index.php.
9 For more information on Choice® Medical Services, see http://www.choicemedicalservices.com/index.html.
REFERENCES


