

Medical Tourism in the Caribbean Islands: A Cure for Economies in Crisis?

John Connell

University of Sydney

Australia

john.connell@sydney.edu.au

Abstract: Small island states have increasingly sought new means of economic diversification. Several Caribbean states have begun to develop medical tourism, partly building on existing tourist-oriented economies. Medical tourism has boomed in this century in several states in Asia and in Central America. The Bahamas, Barbados and the Cayman Islands exemplify different strategies for medical tourism, in order to generate foreign exchange and new employment, and reduce costs from overseas referrals. Most medical tourism projects have been developed by overseas corporations and are oriented to a United States market. Business principles rather than health care dominate development strategies, notably of emerging transnational medical corporations, and raise ethical issues. Success will be difficult to achieve in a crowded and competitive market.

Keywords: Caribbean; competition; development; health care; medical tourism

© 2013 Institute of Island Studies, University of Prince Edward Island, Canada.

Introduction

The Caribbean islands have always played a key role in the global economies, from the early days of the sugar barons, to the American Civil War, to space flight. Therefore the islands are seizing the opportunity to develop niche markets for the most life enhancing spas, obesity centres and wellness destinations utilizing nature's priceless gifts of warm oceans, azure seas, natural beauty, historic landmarks, friendly people, mountains and rivers (Merritt, 2012, p. 36).

In the wake of the global financial crisis many small island economies have struggled, while the movement towards new structures of liberalised trade has raised difficulties for traditional commodity exports. Greater regulation of offshore finance centres has also posed problems for the economies of several island states, and especially Caribbean political dependencies, although tourism, and especially cruise tourism, has remained vibrant. Such difficulties and challenges have accentuated the need to diversify economies and establish new forms of development. In recent years several island states have sought to develop medical tourism as a new means of achieving economic growth, creating employment and stimulating foreign exchange flows. This paper examines the recent rise of medical tourism in Caribbean island states and assesses its potential for development.

In recent decades, development strategies have involved numerous unusual and even quixotic ventures that have often distinguished small island states from larger continental states (Baldacchino, 2010; Connell, 2013a). Island states have sought to achieve economic growth through a range of service sector activities, notably tourism and offshore finance, but also through the provision of flags of

convenience and even passport sales. Aruba, Grenada and several other Caribbean states and territories have hosted offshore gambling sites; Antigua battled with the USA to establish an offshore gambling industry, generating some foreign exchange and job creation. Generating modern economic activity let alone economic growth has proved difficult for a range of reasons stemming from limited human and physical resources, inadequate infrastructure, high energy costs and high wages but, above all, location and the lack of economies of scale. Inability to compete successfully in the more obvious components of the modern economy has resulted in less conventional strategies. Whether medical tourism is a sound basis for development or simply another quixotic gesture remains to be seen.

Tourism has long been associated with improved health, not least by passive relaxation on Caribbean beaches, but also by the rise of spas, yoga and rejuvenation treatments: loosely health tourism. More recently a more specific medical tourism has grown with increasing numbers of people travelling across national borders for various treatments, notably cosmetic surgery, dentistry and check-ups, but also for some unusual treatments, such as stem cell surgery, that are unavailable in home countries. In the past two decades a form of 'reverse globalization' has brought patients from developed countries to less developed countries for medical care, for a combination of reasons involving cost, access, service and quality. Medical tourism has been said to have grown explosively since the late 1990s with large numbers of patients moving across international borders to such countries as India, Thailand and Mexico, in search of medical care usually deemed too expensive at home (or where waiting lists are too long). While contemporary medical tourism is often regarded as having begun in Cuba (see below), it has become an almost wholly capitalist phenomenon.

Medical tourism represents a dynamic example of the transnationalization of health care, an activity once assumed to be quintessentially local, but now radically transformed through new knowledge, communication, transport, tourism and biotechnology. Many countries are now involved as sources of tourists, as privatization of medical care continues, discontent with public care increases, cosmetic procedures boom, the baby boom generation ages and disposable capital is available. Destination countries seek foreign exchange and new means of economic growth, and medical tourism, like other forms of tourism, is a source of foreign exchange and employment generation. With growing demand, response has become more enthusiastic, and governments have become supporters and promoters, through national development planning and tourism campaigns. Its global spread has gradually extended as more and more countries, and corporations, seek to become involved, overturning implicit notions of the territoriality of health care. Medical tourism has now become of particular recent interest in the Caribbean island region. This paper discusses the emergence of medical tourism in the Caribbean, and assesses its potential role in contributing to development, with particular reference to human resources and infrastructure provision.

The possibility of medical tourism

The economic benefits from medical tourism are clear. Patients pay considerable costs in local hospitals, while the whole infrastructure of the tourist industry (travel agents, airlines, hotels, restaurants, taxis etc) also benefit considerably, especially since few medical tourists travel alone. Indeed, since for a significant proportion of patients there may be a lengthy period of recuperation, the rewards to the tourist industry, and

especially the hotel and restaurant sectors, may be greater than with standard tourism. Medical tourists who are visiting relatives may stay even longer. Superior local facilities may also discourage some local people from costly travel overseas for medical care. Medical tourism has been discussed in considerable detail elsewhere for the main destinations and at a global scale (Connell, 2011a; 2013b), but it has only recently become of significance for small island states. This paper therefore provides an initial overview of medical tourism in the Caribbean region. It is largely based on an interrogation of media sources since first-hand data are extremely limited, as they are in most arenas of medical tourism.

Most Caribbean island states have some potential for medical tourism. Firstly, they are familiar to tourists from what are now some of the main sources of medical tourists, notably North America and parts of Latin America, and are easily accessible from there. Having tourism oriented economies and the infrastructure that goes with that are invaluable. Secondly, English is the main language (though Spanish dominates Cuba, Dominican Republic and Puerto Rico, all seeking to enter or expand the market). Thirdly, most island states have relatively modern health care systems (though few offer specialized medicine). Fourthly, diasporic tourism is becoming significant in many Caribbean states, as migrants return for a variety of reasons linked to nostalgia and kinship (e.g. Stephenson, 2002; Duval, 2003; Connell & Niaah-Stanley, 2008), and diasporic tourism has been the basis of the medical tourism industry in several states, especially India and Mexico. Fifthly, higher transport costs to more distant medical tourism destinations, notably the Asian ‘big four’: Malaysia, Thailand, Singapore and India, may boost the Caribbean, but also Central America.

At the same time, island states have certain disadvantages. Firstly, while their health care systems are usually adequate they are not comparable with those in such potential source countries of medical tourists as the United States and Canada. Concerns over clinical outcomes and aftercare are critical to medical tourism. Where quality of care is essential, marketing the facilities of small states is particularly difficult. Secondly, they face strong competition from established regional players, such as Mexico, where costs (of travel, treatment and hotels) are generally lower, since some economies of scale are possible. Thirdly medical tourism destinations are substantially boosted by word of mouth (Merritt, 2012) and that takes time to develop. The Caribbean has both advantages and disadvantages.

Early days?

One of the first places in the world to develop medical tourism was Cuba, a country in search of much needed hard currency, which attempted to divert residents of Latin America and the Caribbean from travelling to United States hospitals (Goodrich, 1993). It had some successes in the 1990s but subsequently lost ground to more competitive new players. It was estimated to have attracted about 20,000 medical tourists in 2006, for a range of activities from joint replacements to eye surgery and addiction rehabilitation. Michael Moore’s film *Sicko* (2007), where he took a group of uninsured Americans for medical treatment in Cuba, significantly increased awareness of Cuban health care facilities, and emphasized the role of the media in diffusing information on overseas medical care. Venezuela’s president, Hugo Chavez, has been a regular recent visitor to Cuba for cancer treatment; Diego Maradona has detoxed there. The state owned company, Servimed, offers foreigners access to 16 hospitals and clinics that provide over a hundred types of health service, ranging from cancer treatments and drug addiction programmes, to dentistry and cosmetic surgery.

Despite Cuba pioneering contemporary medical tourism other Caribbean countries were slow to follow and the regional industry has been dominated by Mexico and to a lesser extent Costa Rica, with Panama and El Salvador trailing. Expansion in the region was particularly rapid around the end of the twentieth century, especially in Mexico, though the global industry remains dominated by south-east Asia (Connell, 2011a). The Dominican Republic has developed a medical tourism industry centred on hair loss therapy and hair transplants, with a market oriented to the United States (Stephano, 2012a). A substantial part of Mexican medical tourism is distinctive in being based on diasporic tourism: the return of Mexicans resident in the United States. Guyana has developed plans for a specialist surgical hospital, that would undertake organ transplants and cosmetic surgery, primarily oriented at the Guyanese diaspora (Anon, 2011f). Although the idea became increasingly alluring, smaller Caribbean island states and territories found it difficult to enter the medical tourism market, despite close proximity to the United States, the existence of a substantial tourist industry, low prices and language advantages, through having inadequate facilities and being unable to compete with Latin America on prices (Huff-Rousselle, Shepherd, Cushman, Imrie, & Lalta, 1995). Governments offered little support.

By this century, the Caribbean had begun to benefit from the return of some diaspora patients for medical treatment, and several states revitalized their interest in medical tourism. In 2005, the Jamaican Minister of Tourism argued that

There were opportunities to capitalise on the health tourism nexus and [he] suggested that perhaps this was a niche to which some of the hospitals could look to establish business opportunities and develop centres of excellence ... there was a huge market for cosmetic surgery, fat farms and indigent services (quoted in Chambers & McIntosh, 2008, p. 920).

Such considerations in countries with weak economies initially remained no more than contemplations, in the face of superior resources and intense competition from elsewhere, the inability of several countries to adequately service the national population, and concern for political discontent that might follow such an external orientation of health care. Hospitals were poorly equipped (especially in costly ‘cutting-edge’ equipment) and consultants lacked adequate experience of the procedures in greatest demand (de Arellano, 2011). Consequently a Montego Bay consultant argued that “only when the quality and range of services offered in public hospitals achieves internationally acceptable levels will we be able to compete with current destinations” and medical tourism become acceptable (East, 2009). Attempts to develop cosmetic surgery at MoBay Hope in Montego Bay failed (Anon, 2012c) and optimism proved unfounded. Specialised skills were lacking and there was strong regional competition, despite an established (if localized) tourist economy. Grand gestures however remained in place; in 2011, the president of the Medical Association of Jamaica called for a restructuring of the medical ‘industry’ so that Jamaica might be designated and recognized as a medical tourism destination:

We need to expand health tourism to levels exemplified by developing models like Korea and Singapore to a level where Jamaican health care will share and sustain the reputation of being the best in the world. This will allow health care to be a new foreign exchange earner that will underwrite the provision of proper health care for the poor and help to stem the brain drain (quoted in Anon, 2011a).

Such a status is implausible and one not reached in either Korea or Singapore, where human resources are vastly superior, whereas in Jamaica “a myriad of structural, institutional and behavioural barriers” impeded the development of “high quality health service programs” (Madu, 2011, p. 56). No facilities in Jamaica have international accreditation, skilled human resources are in very short supply and below internationally approved ratios (Lewis, 2011); and “the public-health sector is ailing and creaking with concerns about the level of resources provided by the government” (Anon, 2012c).

Nonetheless, a year later, both the Jamaican Minister of Tourism and the Minister of Health had turned to medical tourism, arguing that “the strategic development of the sector is critical to the country’s development” and supported by the “global competitiveness of the health service” and the ‘legendary’ reputation of Jamaican doctors and nurses in the United States, UK and Canada (Reynolds-Baker, 2012, np). Proximity to the United States and the English language were further seen as significant advantages. The Minister of Health argued that medical tourism would create new employment, that it would not widen the gap between local rich and poor but create new centres of excellence by offering services, some not locally available, and would thus cut costs for those seeking such treatments overseas. Jamaicans would not need to travel to Miami and New York, whereas the diaspora in the United States and elsewhere would return home for treatment, and might also be investors in medical tourism (Anon, 2012d). Although the small private sector in Jamaica attracts some patients from St Lucia, the Cayman Islands and parts of the United States, most are from the Jamaican diaspora, and Jamaica would “have to improve the safety and infrastructure of the island” to attract more medical tourists (Anon, 2012c). Jamaica thus retained a strong interest in medical tourism, but without obvious signs of the private sector funding that would enable successful development of physical and human resources, a familiar problem in small island states, and in the face of concerns over equity. What was true of Jamaica was broadly true elsewhere in the region.

However interest continued to grow because of the need for greater economic diversification and through greater familiarity with the medical tourism industry. Indeed in the present decade alone most English speaking Caribbean states have expressed interest in its development. Prominent amongst these have been Bermuda and the Bahamas, Barbados and the Cayman Islands. The last three countries are discussed in more detail below.

In Bermuda, the King Edward VII Memorial Hospital has developed a specialised prostate cancer facility (based on High Intensity Focused Ultrasound (HIFU), unavailable in the United States) which has brought several hundred medical tourists. Other specialists offer cosmetic and weight-loss procedures, in partnership with the Bermuda Hospitals Board. The Board has sought to develop an exclusive drug and alcohol rehabilitation facility, while its subsidiary, Healthcare Partners Limited, offers concierge services to people going to Bermuda for treatment (Anon, 2012e). The geographical location and transport infrastructure of Bermuda have ensured a focus on the United States market. However that focus typifies the orientation throughout the Caribbean to the United States (despite the Turks and Caicos being more focused on Canada), the commercial orientation (where actual health care is subsidiary to revenue generation), the private ownership of most facilities, but also their support by the public health sector and through government subsidies, despite public health services usually being limited.

The British Virgin Islands have expressed interest, to reduce the flow of patients to the US Virgin Islands and Puerto Rico, but that is unlikely without more locally trained doctors, and the establishment of a medical school, improbable in a dependent territory of no more than 25,000 people (Anon, 2011b). The Turks and Caicos Islands have sought to develop medical tourism based on orthopaedic surgery, where 'state-of-the-art' facilities are underused, surgeons and other staff brought in from Canada and the hospital run by InterHealth Canada; moreover "renting the facilities to outside firms would create a potential new revenue stream for the cash-strapped government" (Anon, 2012e np). Puerto Rico – which also has a very substantial diaspora population – has faced similar economic pressures and has sought to be a regional medical tourism centre based on low cost regional airfares; the director of the Puerto Rico Tourism Company has stated:

Medical tourism from the Caribbean is very important, and we have a new law right now that allows for additional promotions and allows for service providers in Puerto Rico to become more aggressive since they will be receiving incentives – credit incentives and tax incentives – from the government of Puerto Rico (quoted in Anon, 2012e; *also* Connell, 2013b).

In St Kitts and Nevis, a US\$15 million medical centre is being established in Nevis in partnership with Princeton Health Care of Atlanta group, to be completed in 2013, with 22 beds focused on bariatric, orthopaedic, cosmetic and dental surgery. While one objective is to discourage local people from leaving St Kitts and Nevis for treatment overseas, the real objective is to attract patients from other Caribbean islands and the United States (Anon, 2012f). Trinidad and Tobago launched plans for 'five star medical centres' in 2012 to be funded by the United States private sector; the Minister of Health observed that the new centres will be invaluable for medical tourism:

You will find a movement will be coming from America to Trinidad and Tobago and from South America and the rest of the Caribbean. This will result in a high level of health care for our Trinidad population and for the region (Rambally, 2012, np).

Yet another island state was thus developing somewhat amorphous plans for a range of private sector services, largely overlapping those being developed elsewhere, and designed to bring income into the country but under the guise that this would improve local health care (though the cost of this was, invariably, unstated). At the same time it was also suggested that "the Tobago sub-economy aggressively pursue the development of a medical tourism strategy" (Guytan, 2012, np). Grenada is presently constructing a new hospital that will allow it "to position itself as a destination for medical tourism" (Anon, 2012i), linked to a private proposal for "a University Hospital Town and Medical Resort with a flagship Four Seasons Hotel" (Pearce, 2012, np). Curaçao has vague proposals where medical tourism is linked to health tourism (Stephano, 2012b). Hope springs eternal.

An even more recent trend is cruise ship medical tourism. However, like cruise ship tourism it brings fewer economic benefits to island economies, and cruise ship medical tourism is likely to bring even fewer economic gains since patients (though not their kin) are more likely to remain on board. Cruise ship medical tourism may therefore take patients out of countries but not into new ones.

The three rather different BBC states (Barbados, Bahamas and Cayman Islands) that have been at the forefront of developing medical tourism in the Caribbean can be examined in more detail. The Bahamas and Barbados, independent states with populations of about 355,000 and 275,000 respectively, and the Cayman Islands, a British overseas territory with about 56,000 people, have sought distinct means of developing medical tourism, spearheaded by an overseas private sector and supported by the governments, as a means of generating foreign exchange. All three have general health services that lack some of the sophisticated and specialised services of larger states hence patients with critical problems are often treated offshore usually in the United States. In the Cayman Islands it is estimated that about US\$30 million per year is spent on health care overseas (Anon, 2012a), a considerable cost to a small territory. In terms of medical tourism the implication is that no BBC country has the human or physical resources to deal with complex medical problems, and that medical tourism will bring in foreign exchange and the possibility of more sophisticated local medical treatment.

Bahamas

The Bahamas is one of the richest Caribbean island states, the closest to the United States and perhaps the Caribbean country that is most familiar there. It has recently lost some economic ground with the stagnation of cruise ship visiting and the decline of offshore finance. According to the local Doctors Hospital's medical director, the attractions of medical tourism are

Increased revenue streams, pure and simple. The Bahamas is a very small population, and to provide service to a small population we can see the effects of the recession. Impact has been especially heavy on the business generated from providing treatments to visiting stopover and cruise ship tourists. While tourists normally accounted for 18% of the hospital's patient activity, this had dropped to 11% due to the recession and reduction in travel demand and an almost 25% drop in activity cross the board. Medical tourism will reduce the reliance on residents and transient visitors. I'd like to see us get to a 50/50 ratio, 50% local, 50% medical tourism. It is a very competitive business, so we want to focus on niche markets, and no-one else is looking to bring the surgeons over (quoted in Anon, 2011a, np).

Underpinning medical tourism is commerce; even the Director of the Public Health Authority has stated:

I have no doubt medical tourism will play a key role in the economic expansion of this country. We need to think of ways of attracting investment and expanding the economy (quoted in Anon, 2011c, np).

The economic rationale for medical tourism is starkly depicted, as is the rationale for seeking to develop a specific niche market, rather than the more vague and aspirational global coverage of Jamaica and other Caribbean states.

One key hospital, Doctors Hospital, owned by a group of Bahamian doctors – and which claims to be “the best hospital in the Caribbean” – has pioneered medical tourism in the Bahamas, and in 2010 was the first hospital in the Anglophone Caribbean to gain Joint Commission International (JCI) regulation, a major boost to

medical tourism. It has developed facilities for spinal surgery and prostate cancer treatment, staffed by United States specialists, and a small number of patients have arrived from the United States, with the objective being a flow of about 250 international patients a year to each of these facilities (Anon, 2011a). The same HIFU treatment that Bermuda has brings around 15 patients per month (Anon, 2012g). The Public Health Authority was intending to add some “high quality individual rooms, separated from the standard hospital rooms, to specifically cater to foreigners” (Anon, 2011c). Doctors Hospital is linked to similar hospitals in Washington DC and Florida, with specialists moving between them, and patients having the option of treatment in the United States or the Bahamas, where costs are about 25% less than in the United States. By 2012, Doctors Hospital was reported to have “begun aggressively working on its marketing strategy and campaign to attract its core target markets in the United States, Canada and the Caribbean” and to develop “key partnerships with local hotels that are suitable for accommodating surgical patients and providing the level of concierge services that will be necessary”. Some 16% of its patients were non-Bahamians (Anon, 2012g).

In mid-2012, the Bahamas Ministry of Health approved the establishment of a clinic specialising in stem cell therapy and Doctors Hospital was also proposing to develop this controversial area. A group of Bahamian doctors have invested in the construction of a second hospital offering specialist services to both local and international patients. The ‘boutique hospital’ was intended to be a “pioneer for medical tourism in the Bahamas”, established in a context where the Bahamas was noted to provide the largest international client base for several hospitals in South Florida, with “thousands of patients every year”. The first stage of the hospital was a 10-bed facility, subsequently intended to become a 40-bed facility. As one of the doctors stated:

We continue to send a lot of patients to the USA for rehabilitation care following strokes, brain injuries and traffic accidents. We aim to compete with the US so Bahamians no longer need to go abroad for care. Once established we want to target patients from the USA (quoted in Anon, 2012g, np).

Given the relative numbers, the likelihood of the hospital serving Bahamians remains minimal.

Barbados

Barbados has been a pioneer of fertility treatments, as have other island states such as Cyprus. In this context, unlike many medical tourism contexts where health and ethical considerations are significant, some standard tourist potential is apparent and it has even been termed a ‘procreation vacation’. The website of the Barbados Fertility Centre, founded in 2002 and immediately oriented at an international market by providing ‘A Holiday with a Purpose’, previously stated:

In between your appointments you have constant access to our team of experts by cellular phone but with the freedom of being on holiday. You can enjoy the soothing sound of the lapping Caribbean Sea, go for a long romantic walk along the white sandy beaches and then enjoy the tantalizing tastes of the Caribbean’s cuisine (quoted in Martin, 2009, p. 251).

The Barbados Fertility Centre is JCI accredited and claims a higher rate of success than similar facilities in the United States and the UK. About 80 per cent of the clients are medical tourists, of whom about half are from within the Caribbean region (so that the Centre has established satellite offices in Antigua, St Martin and Trinidad) and half primarily from Britain and North America. It is estimated that the Centre had about 260 clients in 2011, more than double that of the previous year (Johnston, Crooks, Snyder, Fraser, Labonté, & Adams, 2012). Success with fertility tourism has encouraged Barbados to diversify into other elements of medical tourism.

Between 2004 and 2010, there was a prolonged effort to construct a new private hospital that would partly cater to medical tourism and involve part ownership and management by the Indian hospital chain, Apollo. However disagreements over the goals and objectives of the hospital prevented any development (Johnston et al., 2012). Nonetheless the Government of Barbados set up a Health and Wellness taskforce in 2008 to support the expansion of both health and medical tourism. Plans were developed in 2011 for a new ‘world-class’ hospital as part of a longer term programme to bring several specialized treatment centres, including 12 operating rooms and ICU capability, biotechnology research companies and patient accommodation facilities to Barbados. The project was aimed at generating “foreign exchange, international investment and tax revenue, as well as employment and skills training and technology transfer” in Barbados (Anon, 2011c). It was being undertaken by American World Clinics (AWC), a corporation using United States and Canadian doctors in international hospitals; the doctors would “buy time-share style membership in the hospital and bring their patients there for surgery”, such as hip and knee replacements, with some doctors being in Barbados permanently but most flying in for short periods and continuing to run their American practices (Anon, 2012e; 2012h). AWC, based in Arizona, “has created a unique business model designed around the exportation of US acute care medical expertise to desirable global locations” (Anon, 2012h). The hospital was expected to gain JCI accreditation. The primary markets were intended to be the United States, Canada and the United Kingdom; “but treatment will also be available to Barbadians and other international clients seeking private medical care” (Anon, 2011c). Most doctors and dentists were expected to come from the United States; “but others will be considered”. AWC chose to locate in Barbados because of

the availability of the site, proximity to USA, low risk of liability, support for development of the international medical sector, and interest among leading Barbados doctors in supporting the new hospital. In addition to its mild climate there is no language barrier, a stable government, friendly people, personal safety, excellent tourism amenities and a range of places to live for both high and low paid staff (Anon, 2011c, np).

While such grandiose projects may place burdens on national bureaucracies, and on local infrastructure (that may need to be specially developed) and be dependent on tax concessions and cheap land, they may function independently of local public health care systems, as the Barbados Fertility Centre does, if they do not draw human resources from it. However wages and salaries are likely to be significantly higher than those in the local (and regional) public health systems and may prove attractive for many, and Barbados currently has a shortage of skilled health workers. Health care workers, who can migrate freely in the CARICOM region, may be drawn from lower wage nations.

Cayman Islands

In recent years, the economy of the Cayman Islands, heavily dependent on offshore finance, has come under new pressures following strengthened global regulation. Like other small island states and territories, Cayman has sought new development opportunities. That objective has coincided, as in Barbados, with the thrust of multinational medical corporations seeking a more global presence.

In 2010, the Indian hospital chain, Narayana Hrudayalaya (NH), signed a joint venture with the Cayman Islands government to build a Health City staffed by Indian specialists, alongside a “large facility for assisted living for elderly Americans” and a “world-class medical university” to train doctors and nurses from the Americas. Starting from a 140-bed hospital, focused on heart, cancer, orthopaedic and gastrointestinal surgery, the fourth phase of the project, over between 10 to 15 years, was intended to conclude with the Narayana Cayman University Medical Centre, including a grandiose 2000 bed hospital, and assisted living homes for retirees, on a 600 acre site. By then operations were expected to include organ transplant surgery. As the company’s Chairman, Dr Devi Shetty, stated:

The main purpose of building a hospital in this region is based on the impact of health reforms in USA. We believe that the waiting list for operations will force the insurance companies to send their patients to Cayman Island [sic] which is a first world country less than one hour from Miami. We believe that these patients will find it very inconvenient to travel to India because of the distance (Express Healthcare, 2010, np).

He later observed:

We believe that unless something dramatic happens in the US there will be a number of Americans travelling outside their boundaries seeking quality affordable health care. Since the Cayman Islands is a very close destination we believe that they will use these facilities, and we are going to have an American partner to help their decision-making process and to increase their comfort (quoted in Anon, 2012f).

The objective was to provide various advanced surgical procedures at about half the cost of the United States (Doyle, 2012). The Cayman Islands was also an attractive destination because of the absence of income and capital gains taxes, the lack of taxes on non-residents and of legal restrictions on foreign ownership of property (Anon, 2011e). Such legal exemptions, designed for an economy oriented to offshore banking, are less obviously suited to medical tourism.

About 700 patients a year travel from the Cayman Islands to Miami, at a cost of about \$30 million, for medical treatment because of the limited local medical infrastructure (Anon, 2012i; 2012a) and it was anticipated that such numbers would decline, as Health City developed, and local patients have faster access to care. Its Chairman has however pointed out that it would be “the safest hospital in the region” but not necessarily the cheapest (quoted in Anon, 2012f). The project was supported by the Cayman Islands Health Services Authority on the grounds that:

This will provide an enormous economic boost during the development of the infrastructure and an influx of a new and educated workforce who will, as local consumers, boost local economy. Additionally it is an excellent business model for medical tourism in an English-speaking country with low crime rate, similar culture and a very short flight from the US (quoted in Anon, 2012a).

NH established a joint venture with the United States-based Ascension Health Alliance (AHA); the joint venture partners argued that the project would:

... create thousands of jobs on Grand Cayman, diversify the island's economy, provide ongoing research and education opportunities, contribute to the health of the citizenry and bring new industry to the country (Anon, 2012k).

It was also likely to put pressure on existing infrastructure, and especially housing and water, in a territory where a majority of the population are immigrants.

NH has 14 hospitals in 11 Indian cities, with 5600 beds. AHA, the United States' largest Catholic health system, with over 35 hospitals (and many other health facilities) in the US, entered into the joint venture "to bring first rate healthcare provided in a world-class setting [by supplying] supply chain management and biomedical engineering services" (quoted in Anon, 2012k, np). Such a large project required new infrastructure. The AHA Chairman pointed out that there would need to be improved transport, housing and public services, and additional hotel capacity: "once we have a facility for 2000 beds everything has to change in this country. The current infrastructure will not sustain that" (quoted in Anon, 2011d, np). Construction was to be led by a Cayman based company, assisted by the DeAngelis Diamond Health Care Group of Florida. The Cayman Islands passed a Health Practice law to enable nurses and doctors trained in India to work in the country, a law opposed by the local Cayman Islands Medical and Dental Society, and also changed malpractice laws. Although much additional infrastructure was not required in the first phase of creating a 140-bed hospital, it was expected to cater to 120 patients a day initially, with some pressure on local road and air transport. The government agreed to upgrade the national airport to handle the proposed increase in medical tourist arrivals, but the company was expected to pay for and build their own feeder roads.

International investment in medical tourism has thus become geographically strategic, with transnational medical corporations in other world regions making similar decisions to ensure market access close to the sources of patients (Connell, 2011a). NH has 14 hospitals in India, its first being in Bangalore. Its major equity investors include JP Morgan and the global insurer American International Group (AIG), indicating how ownership goes far beyond the health arena. Its Director, Dr Devi Shetty, has described NH's approach to 'cost-effective' patient care as being:

the 'WalMart-ization' of medicine: making quality health care more accessible and affordable, through its doctors working longer hours and performing more surgeries than American doctors (quoted in Doyle, 2012).

He added that he has sought to apply Henry Ford's philosophy towards the Indian health care system: using mass production techniques to cut costs through specialization and economies of scale (Anon, 2012f). The Cayman Islands Medical Centre was intended to be a prototype and blueprint for extending this model beyond

India and in turn resulting in a hospital chain across Africa, where building and management costs are lower, human resources are cheaper and there is greater flexibility and fewer regulations since ‘the governments are desperate’ (Anon, 2012f). The 2011 Annual Report of AHA made no mention of the new venture, and there were local concerns over its potential impact on the public health care system, and on Grand Cayman island infrastructure.

Issues

Medical tourism raises numerous ethical and development issues, many of which are centred in source countries or are linked to particular unusual forms of ‘tourism’ such as stem cell and transplant surgery, and including refugee movements across borders, where conventional notions of ‘tourism’ are steeped in irony (Connell, 2011b, 2013a). Despite the existence of an Institute for Regenerative Medicine in Barbados between 2002 and 2006, that was engaged in illegal stem cell imports (Johnston et al., 2012), and present Bahamian interest in stem cell surgery, these have no present parallels in the Caribbean. Commerce drives medical tourism development, both in small island states seeking foreign exchange and exclusively private sector corporations seeking profitability. Indian investment in the Cayman Islands has little to do with the needs of the Cayman Islands and is not directed or managed from there. NH, like other emerging transnational health corporations, is part of a complex global chain, where profits are diverted from destinations (Connell, 2013c). Island states and territories are incidental to the development plans of large corporations like AWC and AHA, whose main business lies elsewhere, as long as they are stable and reasonably attractive, as the AWC’s rationale for its location in Barbados indicates. AHA’s decision to invest in the Cayman Islands because of their stated commitment to ‘those who are poor and vulnerable’, was criticised since they were locating in a country with a standard of living ranked 14th in the world (Doyle, 2012). The new language of corporate health care involves aggressive marketing, profitability, time-share and business models, with some similarities to the mainstream tourist industry (Connell, 2013c). But such themes are otherwise still unusual in most small island states and territories, in part because they are unrelated to local needs and interests, and still unusual within health care. This gradual ‘multinationalization’ of health businesses reflects very similar but more long-established practices in the tourism industry.

Particular concerns over social justice and health equity exist in destinations where health care is limited, and where human resources are stretched. Indeed the Caribbean, even including the BBC states, has been widely characterised as a region where outmigration of skilled health workers has left poorer island states with human resource shortages, especially of the nurses required for adequate and effective care (Connell, 2007, 2010; Lewis, 2011). Diversion of more such workers to providing services for relatively wealthy non-residents, while generating revenue, is likely to worsen existing access to health care as it has done elsewhere (Connell, 2011b). Barbados has typically had a shortage of nurses and also specialists, and there is some local concern that medical tourism will exacerbate this, and demand longer waiting times (Snyder, Crooks, Turner, & Johnston, 2013, Johnston et al., 2012). Even the Bahamas, which has not experienced a significant loss of skilled human resources, unlike most island states, will have to invest considerably in training and development of medical and other service staff (Anon, 2011c). However, if all skilled workers are sourced externally, as may be possible in Barbados and the Cayman Islands, such concerns are minimized, though economic leakage would increase.

Providing exclusive rooms and beds for medical tourists also foments discontent (Connell, 2011b). Lavish hospitals that include tourist hotel characteristics (sometimes called ‘hospitels’) can also be problematic. When the Belize government sought to develop medical tourism, beyond the existing small-scale dental tourism, local doctors warned that the country had inadequate spare capacity, since most doctors came from abroad and had little time or resources for additional special care, despite the emergence of a small private sector. Moreover, many locals travel to Mexico where costs were lower, facilities better and more procedures were available. Belize has few specialist doctors and few hospitals, none with international accreditation (Anon, 2012b). Such predicaments are faced by many small island states and territories.

Similarly, where governments develop infrastructure, ranging from supportive services such as water supplies, sewerage and transport systems to the hospitals and clinics themselves, or provide taxation benefits or advertising services, concerns arise over the distortion of national economies. In the Cayman Islands, there was local concern over agreements to provide water to Health City at preferential rates acceptable to the company (Anon, 2012i), on a limestone island where water shortages are not unusual and health facilities make particularly high demands. Indeed in this sense medical tourism may derive similar kinds of benefits as the standard tourism economy has done in some countries, and been criticized for it (e.g. Britton, 1991), with modern infrastructure centred on tourist regions.

Underpinning the success of medical tourism is the necessity for good clinical outcomes. International accreditation is essential to marketing, and that takes time to achieve. Moreover, even with international accreditation, many prospective tourist-patients are uncertain about the quality of treatment and post-operative care in unfamiliar countries (Connell, 2011a). During health crises most people become conservative, hence diasporic patients often dominate, and are likely to continue to do so in regions whose health care systems are scarcely beyond criticism. That is likely to slow the development of medical tourism in the Caribbean.

Conclusion

Caribbean interest in medical tourism is unsurprising: it has contributed to economic growth in several developing countries including, on a small scale, other island states such as Mauritius (Connell, 2011a). Several other islands and island states such as Bali, the Seychelles, Cyprus, Guernsey and Fiji, where tourism is sizeable, have also expressed recent interest. The number of island states seeking to develop medical tourism continues to grow despite the challenges of simultaneously breaking into a most competitive and crowded global market, where costs matter, experience is critical and word of mouth vital. The economic rationale for entry is clear.

Caribbean island states and territories face enormous challenges in developing medical tourism, especially because of competition from such dominant regional players as Cuba, Mexico, Panama and Costa Rica, and possible new challenges from Belize and Guyana. Hospitals in traditional tourist destinations, such as Cancun, have recently promoted price-discounted surgical procedures for retirees based in Florida and the Gulf (Connell, 2011a), and also therefore from Caribbean states. New trends in health insurance in countries like the United States may make access to some kinds of health care easier and so reduce the demand for overseas travel. Previous projects in Jamaica and Barbados have been abortive. Success is likely to come through particular specialisms, where competition is less and standards are higher, such as

addiction therapy in Antigua, fertility tourism in Barbados, and prostate cancer and spinal surgery in the Bahamas. In a highly competitive regional market, with Puerto Rico and Jamaica both seeking to be regional centres, however improbably, and ‘aggression’ prominent in marketing, specialization is essential. The small-scale Barbados fertility centre ‘model’ has demonstrated the success that may elude the grandiose Cayman Islands proposal. The small numbers that measure success in Barbados directly contrast with the projected numbers in the Cayman Islands. Developing a particular niche is crucial, especially if that niche is unavailable in the United States, by far the dominant market. The development of medical tourism also faces local opposition where it is seen to disadvantage the public health sector, put excessive strain on local human and physical resources, and be unlikely to significantly reduce overseas referrals.

The island states and territories of the Caribbean where medical tourism has been given greatest attention – notably the BBC countries – and where it may be successful, are some of the most developed in the Caribbean region, with relatively sophisticated health care systems in tertiary, tourism-oriented economies. Consequently their costs are relatively high and many other central and southern American countries “already offer an existing product from a much lower treatment and staff cost base” (Anon, 2011c). By global standards the island states are very small compared with the most successful medical tourism players; this limits the “number of procedures that can be economically performed on the islands and it would be difficult to increase the number of procedures without bringing in medical staff [and others] from overseas” (Anon, 2011c). Developing sophisticated and expensive facilities without any guarantee of success, in a sensitive industry plagued by boom and bust cycles, is at best risky. Small island states and territories, even with prominent tourism industries, are disadvantaged in access to some global markets, especially with substantial deficits of skilled workers in that sector.

Whether future demand for medical tourism will meet expectations is uncertain. New American insurance regimes do not include medical tourism outside the United States, while medical tourists tend to choose low-risk procedures offshore, rather than more complex operations involving surgery or cancer treatment. Cayman has a small diasporic population unlike Barbados and Jamaica. However a 140-bed hospital in the Cayman Islands – or anywhere else – would need to attract about 10,000 patients a year to achieve profitability (while an improbably large 2,000 bed hospital would need over 150,000 patients a year) (Anon, 2012j). How advantageous such numbers might be is uncertain, despite their high spending power. Even 10,000 patients would place enormous pressure on local resources, notably personnel and water, since most medical tourists travel with family members. Elsewhere in the world, projections of future numbers have been inflated by industry boosterism and this may well be the case in the Caribbean. Certainly, competition is intense and not all projected current developments are likely to succeed. Caution is warranted.

Medical tourism will always be uneven because of an intense competition for patients, while every part of the tourism industry is liable to shifts in fashion, finance and flight paths. It is unlikely to be a panacea for any island, may distort national health care systems, and even disrupt regional systems. The ‘early days of the sugar barons’, an era that did little for the welfare of most Caribbean islanders, is an awkward precedent for medical tourism. It is both more symbol than substance of the need for new forms of economic growth, and a distinctive new expression of the particular difficulties faced by small islands. Quixotic it may be, quintessential it is not.

References

- Anon (2011a). Medical tourism development in the Caribbean. *International Medical Travel Journal*, 19 January.
- Anon (2011b). Caribbean islands see potential in medical tourism. *International Medical Travel Journal*, 13 October.
- Anon (2011c). Investment opportunity in new Barbados medical tourism hospital. *International Medical Travel Journal*, 22 July.
- Anon (2011d). Future of medical tourism project may be in hands of UK government. *International Medical Travel Journal*, 25 November.
- Anon (2011e). Seychelles and Cayman Islands seeking medical tourism investors. *International Medical Travel Journal*, 4 August.
- Anon (2011f). Innovative cosmetic procedures propel global medical tourism. *International Medical Travel Journal*, 11 March.
- Anon (2012a). Cayman Islands Healthcare City: insights from the Health Authority and Project Innovator. *Medical Tourism Magazine*, 24, 54-55.
- Anon (2012b). Can Belize become a medical tourism destination? *International Medical Travel Journal*, 23 August.
- Anon (2012c). Jamaica sees potential in health tourism. *International Medical Travel Journal*, 4 May.
- Anon (2012d). Jamaica to promote health and wellness tourism, *International Medical Travel Journal*, 12 July.
- Anon (2012e). Moves to expand Caribbean medical tourism, *International Medical Travel Journal*, 14 June.
- Anon (2012f). Medical tourism developments in the Caribbean, *International Medical Travel Journal*, 7 September.
- Anon (2012g). Bahamas seeks to reverse flow of medical tourists, *International Medical Travel Journal*, 9 February.
- Anon (2012h). American medical centre for Barbados will target medical tourists, *International Medical Travel Journal*, 20 September.
- Anon (2012i). Medical tourism hospital in Caymans is test bed for a chain across Africa, *International Medical Travel Journal*, 27 January.
- Anon (2012j). Ascension Health Alliance invests in Cayman medical tourism project, *International Medical Travel Journal*, 23 April.
- Anon (2012k). Ascension Health Alliance to build Cayman's health city. *Medical Tourism Magazine Newsletter*, 17 April.
- Anon (2012l). Grenada Moving Forward With New Hospital. *The Barnacle*, 29 October.
- Baldacchino, G. (2010). *Island enclaves: Offshoring strategies, creative governance, and subnational island jurisdictions*. Montreal, QC: McGill-Queen's University Press.
- Britton, S. (1991). Tourism, capital and place: towards a critical geography of tourism. *Society and Space*, 9(4), 451-478.
- Chambers, D. & McIntosh, B. (2008). Using authenticity to achieve competitive advantage in medical tourism in the English-speaking Caribbean. *Third World Quarterly*, 29(5), 919-937.
- Connell, J. (2007). Local skills and global markets? The migration of health workers from Caribbean and Pacific island states. *Social & Economic Studies*, 56, 67-95.
- Connell, J. (2010). *Migration and the globalization of health care*. London: Edward Elgar.

- Connell, J. (2011a). *Medical tourism*. Wallingford: CABI.
- Connell, J. (2011b) A new inequality? Privatisation, urban bias, migration and medical tourism. *Asia Pacific Viewpoint*, 52(3), 260-271.
- Connell, J. (2013a). *Islands at risk: Economies, environments and contemporary change*. Cheltenham: Edward Elgar.
- Connell, J. (2013b). Contemporary medical tourism: conceptualization, culture and commodification. *Tourism Management*, 34(1), 1-13.
- Connell, J. (2013c). Transnational health care: global markets and local marginalization in medical tourism. In B. Parry, T. Brown & B. Greenhough (eds.) *Bodies across borders*. Farnham: Ashgate (in press).
- Connell, J., & Niaah-Stanley, S. (2008). Remembering the fire: music tourism and the Bob Marley heritage in Jamaica. *Caribbean Geography*, 15(1), 76-90.
- Corbin, S. (2011). Medical tourism in Barbados. *Medical Tourism Magazine*, 20, 22-25.
- De Arellano, A. (2011). Medical tourism in the Caribbean. *Signs*, 36, 289-297.
- Doyle, J. (2012). Ascension Health plans \$2 billion Cayman 'health city' project. *Medical Tourism Magazine Newsletter*, 1 May.
- Duval, D. (2003). When hosts become guests: return visits and diasporic identities in a Commonwealth Eastern Caribbean community. *Current Issues in Tourism*, 6(4), 267-308.
- East, J. (2009). Jamaica as a health tourism destination: pipe dream or opportunity? Mimeo.
- Express Healthcare. (2010). Narayana Hrudayalaya to build health city in Cayman Island. Retrieved from <http://healthcare.financialexpress.com/201005/market30.shtml>
- Goodrich, J. (1993). Socialist Cuba: a study of health tourism. *Journal of Travel Research*, 32(1), 36-42.
- Guytan, A. (2012). Medical tourism as a development option for Tobago, unpublished paper, SALISES Conference, Kingston, Jamaica: University of the West Indies.
- Huff-Rousselle, M, Shepherd, C, Cushman, R, Imrie, J and Lalta, S (1995). *Prospects for health tourism exports for the English-speaking Caribbean*. Washington, DC: World Bank.
- Johnston, R., Crooks, V.A., Snyder, J., Fraser, H., Labonté, R., & Adams, K. (2012). *An overview of Barbados' medical tourism industry*. Vancouver, BC: SFU Medical Tourism Research Group (mimeo).
- Lewis, P.(2011). Training Nurses for Export: A Viable Development Strategy. *Social and Economic Studies*, 60(1), 67-104.
- Madu, E. (2011). The challenges of implementing high quality healthcare in Jamaica. *Medical Tourism Magazine*, 21, 56-57.
- Martin, L. (2009). Reproductive tourism in the age of globalization. *Globalizations*, 6(2), 249-263.
- Merritt, L. (2012). Transparency and certification in the Caribbean: how it enhances health and wellness marketing. *Medical Tourism Magazine*, 24(1), 36-37.
- Moore, M. (2007). *Sicko*. Dog Eat Dog/Weinstein Co./Lionsgate.
- Pearce, B. (2012). Grenada University Hospital Project Presentation for Grenada. Retrieved from <http://www.slideshare.net/brupearce/grenada-hospital-project>
- Rambally, R. (2012). Cabinet agrees to specialized medical centres in Trinidad and Tobago. *Medical Tourism Magazine Newsletter*, 13 March.
- Reynolds-Baker, A. (2012). Health tourism critical to country's development. *Jamaica Information Service*, 12 July.

- Snyder, J., Crooks, V., Turner, L., and Johnston, R. (2013). Understanding the impacts of medical tourism on health human resources in Barbados: a prospective qualitative study of stakeholder perceptions. *International Journal for Equity in Health* 12(2) (in press) doi: 10.1186/1475-9276-12-2
- Stephano, R. (2012a). The Dominican Republic for health, wellness and luxury. *Medical Tourism Magazine*, 26, 53-55.
- Stephano, R. (2012b). Curaçao: using the island's natural beauty to heal. *Medical Tourism Magazine*, 26, 40-42.
- Stephenson, M. (2002). Travelling to the ancestral homelands: the aspirations and experiences of a UK Caribbean community. *Current Issues in Tourism*, 5(5), 378-425.