



ISTM News

ISTM Course 2008

The ISTM is pleased to offer Travel Medicine Review and Update 2008. The course will be held in Dallas/Ft. Worth, Texas, USA, March 14-16, 2008. This course provides a review of the Body of Knowledge for the Practice of Travel Medicine and highlights recent developments in Travel Medicine. The course can serve as a foundation to candidates beginning to prepare for the ISTM Certificate in Travel Health (CTH) Examination to be given in Budapest in May 2009. The curriculum will cover topics relevant to physicians, nurses, and other health care professionals who provide medical care and advice to travelers, expatriates, and migrants.

The expert faculty will present topics including epidemiology, immunizations, enteric infections, travelers' diarrhea, malaria and other vector-borne disease, environmental exposures, travel clinic management issues, and evaluation of illness in returning travelers. The care of special groups such as pregnant women, pediatric travelers, immigrants, VFR travelers, diabetics, and immunocompromised hosts will be discussed. Recent developments and advances in travelers' diarrhea, immunizations, malaria medications, and emerging infectious diseases will be highlighted. Please visit www.istm.org for course schedule, faculty, CME and CE accreditation, and registration.

Professional Educational Committee (PEC)

The PEC is working on the following projects:

> Marc Shaw is spearheading a monograph of How to Start a Travel Clinic, which we hope to have available online soon.

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Eric Caumes, Newly Elected ISTM Board Member

One of the reasons that the ISTM has become an extremely successful organization in a relatively short period of time is because its members have such varied backgrounds and interests. They are physicians representing most medical specialties, various kinds of nurses, pharmacists, PhDs, and even non-medical individuals with a keen interest in travel medicine. An unusually high percentage of our members are recognized experts in their fields, are dedicated to travel medicine and to the ISTM, and are willing to devote their time and energies into furthering the aims of the Society. Our newest Board member, Eric Caumes, elected at CISTM10 in Vancouver last year, is an example of such dedication. He will serve on the Board until 2011.



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Medical Tourism and Travel Medicine

Should travel medicine practitioners and the ISTM take positions regarding medical tourism?

This was our latest query on the ISTM listserv. Forty-three members responded, fewer than to previous surveys. As usual, the opinions of responders varied widely.

Medical tourism is individuals traveling to another country where health-related treatments are less expensive and/or more rapidly available than at home. The field is growing at an incredible rate, already involving millions of individuals and tens of billions of U.S. dollars yearly. Until rather recently, services offered were mostly cosmetic in nature. But now treatments include dental, cardiac surgery, hip replacements, organ transplants, and sex change procedures, for example. There is even a website offering assistance with suicide.

Below are some of the more interesting responses to the query. Please note that much of the information is anecdotal as data are largely lacking, and several responders identified themselves as having an interest in medical tourism.

- > Traveling for medical treatments is not a new phenomenon. The ancient Greeks and Romans traveled extensively to seek cures for whatever ailed them. ... The spa at Baden-Baden, Germany has been around for a thousand years.
- > With India and other developing countries becoming popular destinations for medical tourism is anyone looking after the illnesses that travelers to these countries may acquire? ... the vast majority of such travelers find their overseas medical facilities in the media, on the web, or from acquaintances. They communicate directly with the foreign clinic and ignore the travel aspect of their trip. ISTM should definitely become more active in this field. Do these people get hepatitis A and B vaccines, for example?
- > About 50,000 Britons travel abroad for medical treatments yearly and the number is increasing rapidly. Dental tourism to Hungary is booming; dental implants are 25% of U.K. costs. Croatia,

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“Eric Caumes, Newly Elected ISTM Board Member,” cont. from p. 1

Eric was born in Bordeaux, France, grew up in the Paris suburbs and now lives in Paris, (in Chinatown). He attended medical school at the Faculty of Medicine Bichat Claude Bernard in Paris, a school that is especially strong in the study of infectious diseases. He spent time (1983-1984) in Kathmandu, Nepal, as the French embassy physician. In Kathmandu he became interested in travel medicine and there he had the opportunity to meet David Shlim, since then a close friend. By coincidence, both have become ISTM Board members at the same time.

Eric has been a dedicated member of the ISTM. He was present at the first biennial Conference in Zurich in 1988, and has attended every Conference since—a record duplicated by a surprising number of our members. He has lectured at many of the Conferences, mostly on travel-related skin diseases, has been a member of the Site Selection committee, and is on the editorial board of the ISTM's *Journal of Travel Medicine*.

In his “real” life, Eric is the vice chairman of the Department of Infectious and Tropical Diseases at the Pitié-Salpêtrière Hospital, and since 2001, Professor of Infectious and Tropical Diseases at the University Hospital Pierre et Marie Curie, both in Paris. He is involved in the research, practice and teaching of travel and tropical medicine, with expertise in dermatology and HIV infections. He is board-certified in dermatology since 1989 and infectious diseases since 1993. He is the president of the French Society of Travel Medicine (a 20-year-old Society with about 500 members), editor of “*La Lettre de l'Infectiologue*”, on the editorial board of the “*Bulletin de la Société de Pathologie Exotique*” and the co-editor of the 5th edition of “*Medecine Tropicale*”. In addition, he is author or co-author of six books on tropical dermatology and travel medicine and has authored or co-authored more than 200 peer-reviewed publications, 300 abstracts and 40 chapters for books.

Eric's main area of travel medicine-related research concerns travellers who return home ill, especially those with skin infections. He is considered an authority in cutaneous larva migrans, leishmaniasis, complicated skin and

soft tissue infections, and imported tropical diseases such as typhoid, schistosomiasis, malaria and gnathostomiasis. In his daily practice, he is very involved in the care of HIV-infected patients with focus on skin manifestations and cutaneous adverse drug reactions.

As an ISTM Board member, Eric intends to work toward seeing more emphasis placed on specific subgroups of travellers such as expatriates and migrants visiting friends and relatives in their country of origin (both groups are at higher risk of travel-related diseases), and to promote research regarding post-travel medical issues. He believes that the study of tropical diseases in returning travellers helps improve knowledge of tropical medicine, which will improve the prevention of the diseases in travellers.

His main hobby is his family: Geraldine, his wife of nearly 20 years, their two children, Melodie and Elliott, and two older children from a previous marriage. Not surprisingly, he likes to travel, and has done so extensively in North and South America, North and sub-Saharan Africa, and most extensively in Asia, the continent he knows best. He enjoys photography and listening to music from all over the world, especially the blues and Rock'n'Roll.

Here are abstracts of two recent articles by Eric:

Hochedez P, Caumes E. Hookworm-related cutaneous larva migrans. J Travel Med. 2007 Sep-Oct;14(5):326-33

“Hookworm related cutaneous larva migrans” (HrCLM), is a disease that need to be distinguished from “cutaneous larva migrans”, a syndrome, and from “creeping dermatitis”, a cutaneous sign. HrCLM is the most frequent skin disease associated with travel to the tropics and often misdiagnosed; many Western physicians are unfamiliar with it. HrCLM is usually acquired via contact with soil or sand contaminated with feces of infected cats or dogs. Feet are the predominant site but all skin is susceptible. Causative hookworms, commonly *Ancylostoma braziliense* and *A. caninum*, are found worldwide, but infection is more frequent in tropical and subtropi-

cal countries, including the southeastern U.S. Humans are incidental hosts; the larvae are unable to deeply penetrate human skin and consequently migrate within it for weeks. Symptoms develop within a few days after contamination and consist of one to three pruritic, erythematous, linear or serpiginous tracks (i.e., creeping dermatitis) approximately 3 mm wide and up to 15 to 20 mm in length. Edema and vesiculobullous lesions along tracks may be present. Untreated, the larvae finally die within a few weeks but prolonged evolution has been described. HrCLM has to be distinguished from other causes of creeping dermatitis. Oral ivermectin and albendazole are the first-line treatments. Cryotherapy is ineffective. Larvae are difficult to locate, usually located several centimeters beyond the visible end of the tract and may survive temperatures of -21°C for more than 5 minutes. Cryotherapy is also painful and can cause chronic ulcerations.

Spectrum of dermatoses in 165 travelers returning from the tropics with skin diseases. Am J Trop Med Hyg. 2007 Jan;76(1):184-6 Ansart S, Perez L, Jaureguiberry S, Danis M, Bricaire F, Caumes E.

The spectrum of dermatoses occurring in travelers returning from the tropics is poorly documented. We analyzed the relative frequency of travel-associated dermatoses and their possible relationships to travel characteristics in all persons who came to our hospital between November 2002 and May 2003 for a cutaneous disorder related to travel in a tropical country. One hundred sixty-five travelers were included. The main dermatoses identified were infectious cellulitis (12.7%), scabies (10.3%), and pruritus of unknown origin (PUO) (9.1%). Tropical dermatoses accounted for 33.9% of the cutaneous disorders. Univariate analysis showed statistically significant correlations of infectious cellulitis with females, PUO with older age and immigrant status, pyoderma with expatriate status, scabies with tourism and travel to Africa, myiasis with tourism and travel to Africa and America, filariasis with travel to Africa and immigrant status, and cutaneous larva migrans with tourism.

“Medical Tourism and Travel Medicine,” cont. from p. 1

Poland, the Czech Republic and India are marketing their services in the U.K. More Brits are choosing Brazil, South Africa and Malaysia for cosmetic surgery. Until recently such travel was mostly for a “nip ‘n’ tuck holiday”. Now more people go for major procedures such as heart surgery and hip replacement. Savings are usually 50% or more - and you can combine recovery with a relaxing holiday and have surgery unbeknownst to friends. ...some foreign facilities claim that they have a lower rate of hospital-acquired infections than do U.K. hospitals.

- > Sectors of medical tourism should be called “medical imperialism”. The most prestigious medical schools in the U.S. are in the process (race?) to establish “satellite” centers all over the world. One hospital in Bangkok claims to have more than 200 surgeons who are board-certified in the United States, and one of Singapore’s major hospitals is a branch of the prestigious Johns Hopkins University in Baltimore. In a field where experience is as important as technology, two hospitals in India, Escorts Heart Institute and Research Center in Delhi and Faridabad, perform nearly 15,000 heart operations every year, and the death rate among patients during surgery is only 0.8 percent - less than half that of most major hospitals in the U. S.
- > Living in the Top End of Australia, I have seen a number of patients who have travelled to Thailand for cosmetic and arthroplasty procedures. Without exception, they received excellent care. The arthroplasty cases have been followed up by local orthopaedic surgeons (at least one had a DVT), and documentation and initial management of complications was comprehensive. Less good has been the experience of travellers to other Southeast Asian countries for dental care - mainly for

prosthodontic work. Poor counselling and a disturbing infection rate has been my anecdotal experience. Market pressures will drive this phenomenon - and I believe our role as travel medicine practitioners could be to help consumers identify safe and competent facilities. Exactly how this is done in a reliable and systematic manner remains a challenge, however.

- > I am an RN, an ISTM member, and was a medical tourist in Mexico. The level of care was as good if not better than at American facilities; I’ve worked in a variety of hospitals and clinics in the U.S. for 25 years. ... I was transported from and to the airport and clinic and given an excellent hotel. The medical facility had state of the art equipment and an excellent, friendly English-speaking staff. I spent one night in the clinic/hospital. The staff was very attentive pre-op and post-op. On discharge, I was given a list of phone numbers and emails for questions and they responded promptly - unlike in the USA. The issue of complications was discussed in detail before I scheduled the procedure. The cost (self-pay) was less than 1/3 of what I would have paid in the USA; my insurance does not pay for this procedure. While researching this procedure, some American doctors I consulted had a very negative opinion of having it done in Mexico. I find real arrogance in the thought that a “foreign doctor” cannot provide quality care. Some of their arguments were valid, others were absurd. It is competition.
- > My experience with medical tourism is limited to Mexico. I have seen a fair number of people returning after medical care (generally plastic and other elective surgery) with post-operative infections. They have no recourse against the doctors and hospitals that have botched their care. Some of the care described by my patients is well beyond malpractice and borders on the crimi-



nal. These patients are angry people with bad outcomes and I never know how much of their description can be believed. It is common for these patients to be uninsured not because they cannot afford insurance but because they are simply trying to save money. They have gambled and lost. A minority of these patients goes to Mexico because they cannot afford medical insurance - it’s a shame that in some cases uninsured persons have to travel to have needed surgery.

- > “Medical Tourism” is here to stay. Most of us know little about it; my knowledge comes from what I have read in airline magazines. This is an excellent topic for Budapest.
- > While the driving force behind medical tourism is the desire to make money, medical tourism can help travel medicine providers. Entrepreneurs in numerous countries are upgrading their facilities to attract cash-paying patients, the first step in a network of hospitals and clinics that travel medicine practitioners can utilize as resources. Obviously quality control is a problem, but no worse than it has always been.
- > Medical tourism is not new albeit it is a much larger industry than in the past. Until recently wealthy patients from poor countries traveled to first world countries for medical procedures. Now the bulk of medical travel is from wealthy countries to poorer countries.
- > There is concern that medical tourism to developing countries harms local people by soaking up scarce medical resources. It is

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Meeting

Asia-Pacific International Conference on Travel Medicine – 24-27 February 2008, Melbourne, Australia

Please join us for an extremely exciting program! A knowledgeable faculty will focus on emerging travel medicine issues, with emphasis on the Asia-Pacific region. You will have the opportunity to take the ISTM’s Certificate of Knowledge in Travel Medicine examination. Australian doctors will be able to gain their CME requirements by attending the conference. And experience beautiful Melbourne, one of world’s greatest cities. Program and Registration details at www.apictm.com.

“Medical Tourism and Travel Medicine,” cont. from p. 3

“While the driving force behind medical tourism is the desire to make money, medical tourism can help travel medicine providers.”

more likely to help by pumping money into the local economy and may allow the host country/hospital to afford medical equipment that they could not otherwise justify.

- > Some Canadian are now reimbursed for elective medical procedures for which they travel overseas where it is less expensive or the waiting time is shorter.
- > Many years ago I was at a medical meeting where a speaker predicted that one day hospitals will have advertisement/marketing departments to attract patients. I did not believe it. Such departments now exist at most major hospitals in this country and are rapidly becoming an international phenomenon.
- > I looked up “medical tourism” on the web. What an eye-opener! Hospitals all over the world are luring people from other countries, often with outlandish claims, and mostly with only anecdotal “accreditations.” There are international meetings and journals devoted to medical tourism. There are middlemen who connect you to the hos-

pital best suited for you. One website has an airline-like scroll to match one’s disease with the country where such procedures are performed. While medical tourism involves “medicine” and “tourism”, I am not sure how travel medicine practitioners can - or should - fit into this industry. I think that ISTM should have a roundtable at one of its conferences to explore this phenomenon further.

- > I appreciate a discussion about medical tourism because I intended to be a medical tourist. Due to poor medical services available on the Caribbean island where I am currently stationed, I planned to travel to the U.S. (Miami) to give birth. Making arrangements was not easy. It included information collection, appointments with doctor(s) and medical facility, booking airline tickets and accommodation, visa issues (I am not American), and more. But this experience, I learned a lot. One hospital in Miami was very helpful - they have an International Service Department for this purpose. But I decided it was simpler to stay here, considering I have no specific obstetric risk factors. ...from this Island, many high-level government officials and executives go to the U.S. or Cuba for medical services. ...the direction of tourists is opposite for leisure travel and medical tourism.
- > My experience involves Bangkok and Singapore, both of which promote medical tourism and have excellent services. ...However, in my view, services in Bangkok cost less for similar services and there are many additional values - culture, food and Thai massages.
- > The savings in having medical and dental procedures done overseas are so great that governments and insurance companies in North America and Europe are noticing. In the U.S., legislation has been introduced in two states, Colorado and West Virginia, which would require insurance companies

for state employees to cover procedures in overseas hospitals, including travel and hotel expenses for the patient and a companion. These bills also mandate that the insurers give 20% of the savings to the patient as an incentive. Other insurance companies now “work with” overseas clinics.

- > A travel guidebook on Germany says: Munich International Airport has become a center for medical tourism. Patients from other countries fly in, have tests or treatments at the airport, and then fly home, often the same day. This clinic has two surgery rooms and 13 beds. Individually designed packages can include diagnosis, surgery, hotel accommodation, transfer to a partner clinic for long-term treatments, and sightseeing programs for patients and families. The clinic collects patients at the aircraft and takes them through immigration. Specialties include orthopedics, hand surgery, plastic surgery, endocrine surgery, minimally invasive surgery for various conditions, ophthalmology, ear-nose-throat medicine, urology, gynecology, gastroenterology, and treatment of cardiovascular conditions. Imaging is available. The airport has a pharmacy. The pharmacist gives vaccines.
- > Many medical tourists have little understanding of the potential risks. I had a patient come back with acute hepatitis B that was traced to cosmetic dentistry done in Cambodia.
- > How do we evaluate quality of care and outcomes in other countries when it is difficult for us to do in our own community? Do we unjustly criticize the quality of care abroad just because we can’t endorse it or don’t know about it? Our role as travel doctors is to provide Hepatitis A and B and other destination-specific immunizations. I just saw a man who will be accompanying his brother to Bangkok for a pacer/defibrillator. Evidently they researched it. I told him to be sure his brother was immunized for hepatitis A and B.
- > The problem with international oversight activities is that diplomacy trumps objectivity.
- > One has to be wary of bigotry, fear of competition, and simple reactionism from “first world” medical practitioners when dealing with foreign medical care. On the other hand, there is no doubt that the professionalism and expertise of some healthcare facilities is questionable.

Welcome to a new regional travel medicine society!

The Sociedad Latinoamericana de Medicina del Viajero was incorporated in Buenos Aires in December 2004 with the mission of working in Latin America to promote and develop the field of travel medicine. Mario Masana Wilson, MD, MPH is the President.

The Society is holding its first conference, I Congreso Latinoamericano de Medicina del Viajero, April 10 - 11 in Buenos Aires. The program will include topics relevant to specialists, focusing on prevention, diagnosis, epidemiology and international recommendations and guidelines. Program details can be found at the society website: www.slamvi.org or at I Congreso Latinoamericano de Medicina del Viajero. The official language of the Congress is Spanish.

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“Medical Tourism and Travel Medicine,” cont. from p. 4

- > U.S. National Public Radio recently had a two-part presentation on Americans traveling globally for health care. This would be a “must have” presentation for the next ISTM international conference.
- > There was an informative presentation on medical tourism at the October meeting of the American Society of Tropical Medicine and Hygiene in Philadelphia. The speaker was David Jaimovich, the Chief Medical Officer of the Joint Commission International (JCI), an entity that performs accreditation of international medical facilities. JCI is a division of the Joint Commission on Accreditation of Healthcare Organizations, which accredits medical facilities in the U.S. The JCI declares overseas hospitals have standards very similar to those in the U.S. The number of hospitals seeking accreditation from the JCI has increased tremendously since it was founded in 1999. They currently accredit almost 200 facilities in 22 countries. This number is expected to reach 300 by the end of 2008. For a list of accredited facilities, see: www.jointcommissioninternational.com/23218/iortiz

Another statistic presented was the number of medical tourists visiting the largest provider countries. In 2005, Thailand, more than 1 million; Singapore, 375,000; Philippines, 250,000; India 150,000; Malaysia 100,000. Also, in 2005, an estimated 500,000 American were medical tourists. One hospital in Bangkok claims to treat more than 50,000 a year.

- > My intent is not to be rude nor chastising, but in my opinion personal anecdotes are interesting but of no use in decision-making. We should make decisions about quality of care based on unbiased high quality

data. This applies to all health care providers regardless of country.

- > Medical tourism and travel medicine are quite different entities and the ISTM should not get involved other than making our members aware of what is going on in that field.
- > Another kind of “medical tourism” are groups that help health care professionals who want to serve in poor countries but, in fact, merely offer tax deductible vacations with poorly conceived, sometimes counterproductive, medical interventions. I went to Nepal with a group that didn’t register us properly with the Nepalese authorities, took the medications we had brought along, and sold them on the black market. A medical student friend went with a group to provide medical care in Kashmir but upon arrival the medical agenda was abandoned and the group leaders began to proselytize the group members. With faith-based groups, the faith aspect may totally overshadow medical care. Some overseas hospitals/clinics claim to have Western-trained physicians and nurses but they may be only there an occasional week or two. And I know of a Canadian chiropractor/teacher couple that practices medicine/nursing in Zanzibar although neither is qualified under the laws of Canada or Zanzibar.
- > The outsourcing of medicine from first world countries to developing countries is probably a good thing in the long run for the quality of medicine practiced in the developing world. From an economic point of view, paying workers very low wages in poor countries to produce goods for wealthy people is better than no wages for these people.

“Another kind of ‘medical tourism’ are groups that help health care professionals who want to serve in poor countries but, in fact, merely offer tax deductible vacations with poorly conceived, sometimes counterproductive, medical interventions.”

Sources of information on medical tourism suggested by different responders include:

- “Med to Go” a book by two U.S. physicians evaluating medical facilities in Mexico.
- “Patients Without Borders: Everybody’s Guide to Affordable, World-Class Medical Tourism,” also written by a physician.
- “International Medical Travel Journal” (website <http://www.imtjonline.com/>)
- The Health Tourism International Chamber of Commerce (HTICC). It claims to be the voice of health tourism with a ‘comprehensive global strategy to cultivate the growth of the industry by fostering the development of synergy among all the players in this vibrant and dynamic industry.’ Members believe that the free enterprise economic system should be applied to the health and tourism industry.

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Meeting

Northern European Conference on Travel Medicine, Helsinki, Finland, 21-24 May, 2008

The 2nd Northern European Conference on Travel Medicine (NECTM) is intended for health care professionals and others interested in travel and migration medicine. The program includes “hot” topics in travel health, “all time favorites”, and special themes such as Arctic medicine and traveler’s health issues in the Baltic countries and in Russia. There will also be presentations about Finnish tradition in architecture, music and dance, and about the unique Finnish obsession for sauna. (In fact, a sauna evening is scheduled as part of the program, likely a first at an International Travel Medicine meeting.) For further information: E-mail: nectm2008@congrex.fi Conference secretariat: www.nectm.com.

“Medical Tourism and Travel Medicine,” cont. from p. 5



Photo courtesy of Filmmakers Library, 124 East 40th Street, NY, NY 10016

Medical Tourism: Destination, India

This article is excerpted from the Bulletin of the World Health Organization. Volume 85, Number 3, March 2007, 161-244.

The Indian Ministry of Tourism's 13 overseas offices are stocked with information for those intending to travel to India for medical treatment. Indian consulates and missions abroad face a growing number of inquiries about "M" or medical visas, visas that are valid for a year and cover companions. India's medical tourism sector is a growing source of foreign exchange as well as prestige and goodwill outside the country, say Indian authorities. But having supported medical tourism's rapid growth, the government is now under pressure to find ways to make this sector benefit the public health services used by most of India's 1.1 billion people.

Medical tourism is part of Incredible India, the government's big-budget marketing campaign to attract tourists. The campaign took off in 2002, when the Confederation of Indian Industry (CII), in collaboration with international management consultants, produced a study that outlined immense potential for this sector of tourism. The following year, the finance minister called for the country to become a "global health destination" and urged measures, such as improvements in airport infrastructure, to smooth the arrival and departure of medical tourists.

Medical tourism is an example of how India is profiting from globalization and outsourcing. It is also a new form of consumer diplomacy, whereby foreigners who receive medical services in India help the country to promote itself as a business and tourism destination.

Presently most such tourists come from industrialized countries, such as the United Kingdom and the United States, but also from its neighbours Bangladesh, China and Pakistan. There is intense regional competition for medical tourists, primarily from Malaysia, Singapore and Thailand.

Ministry of Tourism brochures advertise a wide-range of services including cardiac surgery, minimally invasive surgery, oncology services, orthopedics and joint replacement, and holistic health care. The services are provided by about 45 hospitals promoted as "centres of excellence".

Health tourism is often hailed as a sector where developing countries, such as India, have huge potential due to their comparative advantage based on providing world-class treatment at low prices combined with attractive resorts for convalescence. About 150,000 medical tourists came to India in 2005.

Indian authorities predicts a "phenomenal expansion" of the total Indian health-care industry in the next five years, from US\$ 22.2 billion, or 5.2% of gross domestic product (GDP), to between US\$ 50 billion and US\$ 69 billion, or 6.2% and 8.5% of GDP.

But while these figures are impressive they do not address the divide between facilities oriented towards private medical facilities, which are improving rapidly, and those that cater to the health needs of the average, usually rural, Indian. And many fear that medical tourism will increase the divide. Presently, fewer than 50% of India's primary health centres have a labour room or a laboratory, fewer than one in five have a telephone, and fewer than one in three is stocked with essential drugs. Health care in India's rural districts is poor, dogged by shortages of trained health workers, a lack of funds and corruption. Many patients resort to quacks or seek no medical care at all, since private practitioners are beyond the means of most.

In contrast, to provide a guarantee of service quality for medical tourists, the Indian Ministry of Health has begun accrediting hospitals and recommending prices for services. So far 35 hospitals have applied for accreditation. CII has a certification system and has already approved 30 of its 120 hospital members. Under the CII system, certified hospitals must agree to limit charges to foreigners as part of a dual pricing-system that offers domestic patients lower prices. Non-resident Indian medical tourists are charged the same as any others from abroad. Still, even these lower prices are

too high for the vast majority of India's 1.1 billion population.

The CII group, which also has an ethical code for member hospitals, is establishing a regulatory framework for its own members, raising questions about how effective such self-imposed rules can be. CII lawyers are also drawing up a standard contract to ensure that any litigation arising from treatment is dealt with in Indian courts. Currently, neither medical tourists nor Indian patients can take their cases to Indian courts. Their only recourse is India's State and National Consumer Disputes Redressal Commissions, which have a huge backlog.

But while helping to strengthen medical tourism, the Indian government is coming under increasing pressure to use these foreign exchange revenues to benefit the ailing and under-resourced public health system. The private sector hospitals argue that trickle-down payments for hotels and other services will improve the economy as a whole. But public health advocates say that, unless the Indian government actually allocates more of its revenues to public health systems, the impact will be negligible. "The government has not examined how our patients will benefit [from medical tourism] or whether they will lose out," said the dean of one of Mumbai's largest public hospitals. "The need to benefit Indian patients is the main goal, and medical tourism cannot be at their cost."

As the medical tourism sector grows, however, little is known about the impact this is having on its health workforce. Private hospitals argue that medical tourism reverses the brain drain and that health workers, who are migrating to economies where salaries are higher and career opportunities more attractive, will stay in India if they can work in the medical tourism sector. There are fears, however, that medical tourism could worsen the internal brain drain and lure professionals from the public sector and rural areas to take jobs in urban centres. "Although there are no ready figures that can be cited from studies, initial observations suggest that medical tourism dampens external migration but worsens internal migration," said the Dr Manuel Dayrit, director of WHO's Human Resources for Health department. "It remains to be seen how significant these effects are going to be. But in either case, it does not augur well for the health care of patients who depend largely on the public sector for their services as the end re-

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“Medical Tourism and Travel Medicine,” cont. from p. 6

sult does not contribute to the retention of well-qualified professionals in the public sector services,” Dayrit said.

Dayrit disagreed with medical tourism proponents, who argue that some revenues from medical tourism will find their way into public coffers to help retain staff in the public sector. “Unless national laws or regulations are set up so that these revenues are taxed explicitly and channeled to the public sector to augment salaries, the likelihood of this happening is very slim,” he said.

Medical Tourism, Cuban Style

At Cuba’s eye hospitals tens of thousands of people per year, nearly all from poor countries, have their cataracts removed, says the *New York Times*. While the Cuban economy is not exactly booming, the government pays for air transportation, housing, food and follow-up care for these and other individuals who come to Cuba for medical care. The government calls the program Operation Miracle. Hundreds of thousands of people from Central and South America and the Caribbean have benefited from the program since it was started in July 2004, and for the people who benefit from it, it is aptly named.

Yet the program is no simple humanitarian effort, and it has not come without a cost. The campaign against vision loss serves as a poignant advertisement for the benefits of Cuban socialism, as well as an ingenious way to export one of the few things the Cuban state-run economy produces in abundance: doctors. Cuban doctors abroad receive much better pay than in Cuba, along with other benefits from the state, like the right to buy a car and get a relatively luxurious house when they return. As a result, many of the finest physicians have taken posts abroad. And the doctors and nurses left in Cuba are stretched thin and over-worked, resulting in a decline in the quality of care for Cubans, some doctors and patients said. At the same time, Cuban doctors



have set up 37 small eye hospitals in Latin America, the Caribbean and Mali. Twenty-five of the centers are in Venezuela and Bolivia, whose leaders have close ties to the Castros. The hospitals are staffed with more than 70 top-notch eye surgeons from Cuba and hundreds of support staff.

But according to a top Cuban ophthalmologist, the heavy flow of foreign patients through the hospital, combined with the exodus of physicians to other countries has hurt his department’s functioning. “It disturbs our work. Sometimes our eye surgeons worked in three shifts, keeping the hospital’s operating rooms going all day and all night. It is not uncommon for one surgeon to perform 40 operations in a shift.” This hospital trains new eye doctors at an astounding rate of 2,100 a year, half of them surgeons. The hospital’s budget has been increased tenfold and its equipment upgraded. It now has 34 operating theaters with state-of-the-art equipment, including two outfitted for advanced laser surgery techniques.

One advantage of the program is that it has given young surgeons a steady flow of patients on whom to hone their skills. Last year, they performed 394 cornea transplants at the hospital, he noted. “Our specialists have an incredible amount of experience,” he said. “What specialist in the world can do dozens of cornea transplants a year?”

In recent years, the program has allowed Cuba to use its doctors as barter for subsidized Venezuelan oil and to forge closer relations with other countries in the region, including those, like El Salvador, that have not been historically close to the Communist regime here.

Of course, the people who have their sight restored could not care less about the political and economic repercussions of the program. For them, the offer of free surgery was a dream come true. Many say that they would be blind if not for the care they received in Cuba.

— "ISTM News," cont. from p. 1 —

Lin Chen is putting together another Travel Medicine Course, this one in Dallas/Ft. Worth. (See above.) Last year's course was so popular that participants had to be turned away.

- > David Hill has updated the original Travel Medicine slide set - maps and facts. This is now available free to 2008 paid members via a download on the ISTM website.
- > Michele Barry has finished a slide set on Travel during Pregnancy and one on Travel with Children. These will soon be available to membership
- > Joan Ingram is working on a slide set on Altitude and Travel.
- > Nancy Piper Jenks and Lin Chen continue to submit pertinent questions to experts to post on our interactive Expert Case Opinion. The last one, responded to by Elizabeth Barnett, deals with the nuances of yellow fever vaccination. The response is a well-referenced thoughtful opinion. See the PEC section on the ISTM website. Old cases are archived on the website for members. Mary-Lou Scully will be replacing Lin as Nancy's co-editor. This site has been extremely popular with our email listserve.

The PEC committee had recommended that all slide sets be offered free to members with a charge to nonmembers. This recommendation was accepted by the Executive Board in Vancouver.

*Respectfully submitted
by Michele Barry,
Chairperson PEC*

NewsShare

the Newsletter of the International Society of Travel Medicine

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