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Medical tourism business and evidence based practice: A review

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Abstract
'Medical tourism' is a term used to refer to a travel activity that involves a medical procedure or to activities that promote the wellbeing of the tourist. Unacceptably long hospital queues and high costs of medical procedures in western society have created a demand for medical tourism. Hence, as this new global product gains popularity, increased monitoring and greater accreditation of this service is required to keep pace with an increase in its international demand. Evidence based practice EBP is the integration of best research evidence with clinical expertise and patient values to facilitate clinical decision making. EBP helps in falls and falls injury prevention in hospital practice.

Keywords: medical tourism, evidence based practice

Introduction
Travel for health, medical and medicinal purposes can be traced back to the Sumerian, Greek and earlier civilizations, whose elite members travelled to experience hot springs, bathe in mineral waters and for general rest and relaxation. While modern civilizations still travel to hot springs and spas, the concept of medical tourism has evolved considerably from those early times. As a niche industry within the tourism domain, medical tourism is generally understood to occur when "people travel often long distances to overseas countries to obtain medical, dental and surgical care while simultaneously being holidaymakers, in a more conventional sense"(Connell J, 2006) [1].

Medical tourism
While people from less developed countries have often visited, and continue to visit, developed countries such as US and UK to avail of cutting –edge medical facilities and highly skilled physicians, this trend began to reverse in the 1990s and the term medical tourism came to refer to people from developed countries travelling to emerging economies with the intention of combining health care with holidaying. With the aging population demographic in developed countries that increases demand, and the shortage of trained doctors (Suzanne Satalien SW 2010) [2], leading to increasing health care costs results in an unfulfilled demand for medical services, a gap occurs, one that several countries seek to fill. This demand-supply gap has resulted in a lucrative business development opportunity for several countries like India, Thailand, Singapore, Turkey, Dubai and others where labour, both skilled and unskilled, and infrastructural facilities costs are considerably lower. Prices therefore differ widely between U.S. and some of these destinations; for example in 2009 a heart valve that cost $100,000 in the U.S. cost only $10,000 in India (Anand G 2009) [3].

Medical tourism thus has resulted in a 60 billion dollar global industry impacting consumers, suppliers, destinations, governments, and third party facilitators (Singh P, 2008) [4]. As a field of study it is multidisciplinary; drawing from fields of tourism, hospitality, medicine, law, ethics, sociology, and psychology, among others. In recent years it has received extensive media attention and has been the subject of numerous conferences. Consumers from developed markets, particularly from United States with discretionary medical needs seek lower cost. (Ehrbeck T *et al.*, 2008) [5] The price differential for various medical procedures and the desire to reap cost advantages is the primary motivation for medical tourism (Marlowe J and Sullivan P, 2007) [6].

Evidence Based Practice
Fall measurements have been identified as important to patient outcomes by several organizations based on the fact that falls are the most frequently reported adverse patient event among adults in the inpatient setting. (Currie LM, 2008) [7]. However, not all falls can be prevented. Falls can be categorized as anticipated, accidental, and physiological. (MorseJM, 1997) [8]. Regardless of type of fall, injuries can occur in all types of falls, and programs are designed to prevent falls as well as fall injuries. Falls represent a major public health problem around the world. In the hospital setting, falls continue to be the number one adverse event with approximately 3- 20% of inpatients falling at least once during their hospitalization. However, they require multidisciplinary support for program adoption and reliable implementation of specific at risk and vulnerable subpopulations, such as the frail elderly and those at risk for injury. (Oliver D, *et al.* 2010) [9] (Spoelstra SL *et al.* 2012) [10] Most hospitals collect data on falls for internal analysis, and many also participate in external database such as the National Database for Nursing Quality Indicators (NDNQI) as part of their management designation quality improvement program (American nurses association 2010) [11] or part of their general improvement program as this provides an external benchmark comparison. Through benchmark comparison with similar types of nursing units, organizations are then able to assess their performance and determine opportunities for improvement. However, fall risk assessment and analysis of fall rates and injury rates only serves as the foundation for program measurement and evaluation.

As part of patient safety programs, clinicians, administrators, and risk managers collaborate to set realistic target goals for reducing rates of falls and fall related injuries. They review, compare, and analyse epidemiological data that is both population and setting-specific, using both internal and external data. The American Nurses' Association's (ANA) National Database of Nursing Quality Indicators (NDNQI) enables comparison of injury fall rates based on severity of injury and other nurse sensitive indicators for participating acute care organizations. (ANA 2004-2006) [12]. NDNQI reports provide internal and external comparison with like-units in like facilities including bed size, teaching status, management status, and other parameters.

ANA quality indicators link nursing care to patient outcomes. Patient injury rate, noted to be most often caused by falls, was promoted as a nurse sensitive indicator, a measure of quality that links patient outcomes with availability and quality of professional nursing services (ANA, 1995). [13] ANA has asserted nurses' responsibility to assess patients risk for falls and injury; design and implement risk reduction care plans; and evaluate effectiveness of clinical fall prevention programs. ANA also recommended consistency of data reporting, measurement and analysis. Injury falls are often termed as "never events" by the National Quality Forum (NQF) [14]. These falls are associated with increased morbidity/mortality rates and also impact reimbursement. As falls are a nurse sensitive measure, nurses play a pivotal role in the prevention of falls and fall injuries. The NQF [14] developed 28 never events that should never occur to a patient while being cared for in a healthcare facility.

Additionally, NQF [14] captures data on death or serious disability associated with a fall as one of those never events. Recently, the NQF endorsed the ANA's NDNQI quality measures to improve patient safety in hospitals – patient fall rate and patient falls with injury. The Agency for Healthcare Research and quality provides numerous tools associated with falls prevention, but it is primarily viewed as a resource for evidence based practice. In 2013, AHRQ (Agency for Research and Quality) published targeted preventing in-facility falls (Ganz, DA. *et al.* 2013) [15]. Because most fall prevention programs are multi factorial, the best the authors could do in identifying and reviewing the evidence was to describe interventions that have been evaluated, including the following.

- Post fall review
- Patient education
- Staff education
- Footwear advice
- Scheduled and supervised toileting
- Medication review

Safe patient care in fall prevention and fall injury prevention includes a strategy for the implementation of evidence- based practice (EBP).EBP will promote standardization, reduce variation, and strengthen the focus on preoccupation with failure. In this example, the failure would be a fall, and even more serious is a fall with injury. Evidence regarding major factors that reduce errors in health care systems targets effective communication and trans-disciplinary work. Evidence for the most successful fall prevention programs suggests multi factorial and interdisciplinary components. (Oliver D, *et al.* 2010) [9]

Conclusion

Medical tourism is becoming a new and emerging international business that is gradually increasing in importance. In capitalising on the tourism infrastructure that supports this industry, nations do not need to invest much more in supporting medical tourism. As an international business, this is not too different from the subcontracting or the off-shoring of services. With higher costs and expertise, in the future, medical tourism is likely to be the new global trend for providing medical services. The rapid developments in medical tourism demands have left the policing and legislation behind. It would be imperative for this legislation to catch up in order to protect the vulnerable that are unable to make well informed research-based decisions. It remains to be seen in the future which countries will adopt the proactive stance to strategically avoid future problems to maintain and protect their country's reputation in this important and growing area of healthcare.

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