WHEC UPDATE

Briefings of worldwide activity of Women's Health and Education Center (WHEC)

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Making A Difference

Medical tourism generally involves transporting patients from developed countries to developing countries where they can get treated at lower expense. These patients do not necessarily belong to the higher social bracket in their own countries, but they (and their insurers) generally have greater purchasing power than most patients in the destination countries. Most developing country governments see medical tourism as an opportunity to generate more national income and therefore support it strongly. However, without appropriate management medical tourism can become a heavy burden for the public health systems of these countries, especially those with universal healthcare coverage. Unlike general tourists needing medical attention, medical tourists are people who cross international borders for the exclusive purpose of obtaining medical services. Medical tourism has increased in part because of rising healthcare costs in developed countries, cross-border medical training and widespread air travel. The medical tourism industry has been growing worldwide. It involves about 50 countries in all continents and several Asian countries are clearly in the lead. In Asia, medical tourism is highest in India, Singapore and Thailand. These three countries, which combined comprised about 90% of the medical tourism market share in Asia in 2008, have invested heavily in their healthcare infrastructures to meet the increased demand for accredited medical care through first-class facilities. Although medical tourists are still a small fraction of the 5 million foreigners who receive medical care outside their parent country, they are tourists group most likely to affect the destination country in a major way. The number of value added from medical tourism in 2008-2012 under high- and low- growth scenarios are: the number of foreign patients is expected to grow at a yearly rate of 16%. The assumption is based on the average geometric growth rate of foreign patients in 2001-2007. Unlike general tourists the expatriates, medical tourists are increasing at a rapid pace – from almost none to 450,000 a year in less than a decade. It is estimated medical tourism generates the equivalent of 0.4% of gross domestic products (GDP) in Asian countries, but has exacerbated the shortage of medical staff by luring more workers away from the private and public sectors towards hospitals catering to foreigners. This internal "brain drain" may also undermine medical training in future. With their much high purchasing power, medical tourists can prevent local taxpayers from accessing quality healthcare. Although higher prices for healthcare services potentially generate more foreign revenue for the country, foreigners' demand for healthcare services could undermine local patients' access to quality of healthcare. To alleviate the shortage of staff and reduce healthcare costs for the local citizens, these countries need to increase its health sector human resources, especially physicians, dentists and nurses.

We suggest 1) allow certified foreign physicians to provide medical services – at least to foreign patients – without have to take a medical certification exam in local languages (as is currently required in Thailand); 2) increase medical staff training in public universities to full capacity; and 3) collaborate with private hospitals in training more specialists. The governments have a responsibility to balance the welfare of local citizens against the extra income generated by medical tourism. The governments have strong grounds for levying a tax on medical tourists, who, unlike local taxpayers and expatriates residing in these countries, reap benefits without helping to pay the taxes that support physician training. The revenue from this tax should be used to expand the training of physicians and other medical staff and to retain the best professors in public medical schools. In the short run, the taxes could also mitigate the adverse effects of the extra demand for healthcare services on the part of foreigners with higher purchasing power.

Overview of Medical Tourism

Rita Luthra, MD

Your Questions, Our Reply

What are the negative effects of medical tourism on the Asian countries?

Effect on Healthcare Service Prices: Influx of medical tourists does not always lead to a "win-win situation" and to "windfall" income for host country governments, which may need to learn the hard way that they will have to increase their healthcare budgets to meet the rising and highly competitive foreign demand for health services. In general, the price of a non-exportable good or service is determined solely by domestic demand and supply. In India and Thailand, flux of medical tourists (in greater numbers than any increase in the number of physicians, including as a result of returning from abroad or migrating back into the country) would therefore increase the price of healthcare services in these countries. While the prices of healthcare services have increased, most local citizens in these countries now have become more dependent on the universal healthcare coverage scheme.

To maintain the quality of the services these public schemes provide, in late 2008 the Ministry of Public Health drastically changed its compensation scheme by practically doubling physicians' total salary in all community hospitals and by substantially increasing dentists', pharmacists' and nurses' compensation. In late 2009, the same hikes were also applied in the Ministry's provincial and regional hospitals. Initially hospitals had to finance their pay hikes with their own savings, but after the first year the government provided additional budget to community hospitals and subsequently gave an emergency funds to remaining Ministry hospitals. Eventually, these pay hikes will substantially increase the capitation budget for the universal healthcare coverage scheme, which was already more than doubled between fiscal years 2001 and 2011, even before the inclusion of the pay hike. The negative effects for India and Thailand society stem from having to provide healthcare services for 420,000 to 500,000 medical tourists annually with the same number of healthcare staff. These negative effects are evidenced by both a shortage of physicians and by increased medical fees for self-paying local citizens, which are likely to undermine their access to quality medical services.

Medical tourism in India and Thailand, despite some benefits, has negative effects that could be mitigated by lifting the restrictions on the importation of qualified foreign physicians and by taxing tourists who visit the country solely for the purpose of seeking medical treatment. The revenue thus generated could then be used to train physicians and retain medical school professors. 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. 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 centers. 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.

United Nations At A Glance

UN and Civil Society

The United Nations is both a participant in and a witness to an increasingly global civil society. More and more, non-governmental organizations (NGOs) and other civil society organizations (CSOs) are UN system partners and valuable UN links to civil society. CSOs play a key role at major United Nations Conferences and are indispensable partners for UN efforts at the country level. NGOs are consulted on UN policy and programme matters. The UN organizes and hosts, on a regular basis, briefings, meetings and conferences for NGO representatives who are accredited to UN offices, programmes and agencies.

Over 13,000 CSOs have established a relationship with the Department of Economic and Social Affairs (DESA). The vast majority of these CSOs are NGOs; there are also institutions, foundations, associations and almost 1,000 Indigenous Peoples Organizations (IPOs) listed as CSOs with DESA - which maintains a database of registered CSOs. Once registered with DESA, CSOs can also apply for consultative status with the Economic and Social Council (ECOSOC). If consultative status with ECOSOC is granted, the organization can participate in relevant international conferences convened by the United Nations and in meetings of the preparatory bodies of these conferences. The Women's Health and Education Center (WHEC) was granted its affiliation with ECOSOC in 2008 and is actively involved with the United Nations to improve maternal and child health.

CSO Net - Economic and Social Council (ECOSOC) Civil Society Network

The Secretary-General's Panel of Eminent Persons on Civil Society and UN Relationships, which concluded its work in 2004, produced a set of practical recommendations on how the UN's relationship with civil society, as well as with the private sector and parliaments, could be improved.

Collaboration with World Health Organization (WHO)

WHO Guiding Principles On Human Organ Transplantation Report of the Regional Meeting

Transplantation of various human organs, tissues and cells to prolong and improve our quality of life has increased worldwide in the recent past. Globally, about 66,000 kidneys, 21,000 liver and 6000 heart transplantations take place every year. Data from 2007 shows that the estimated number of kidney transplants were around 11 000, performed in about 400 centers in the Western Pacific Region. Almost 50% of kidney donors in the Western Pacific Region are live unrelated donors and the number of heart and liver transplants in the Region is also increasing.

The shortage of available organs and the huge gap between supply and demand have prompted many countries to develop procedures and systems to increase supply, but at the same time, have also led to unethical practices like commercial trafficking of human organs, particularly from living, unrelated donors. The inadequate number of donors is a major challenge and public awareness of the dangers of commercial trade and trafficking of human organs has become highly essential. WHO/HQ developed the "Guiding Principles on Human Organ Transplantation" in 1991 to assist national authorities in developing robust national programs for organ transplantation. Since then, these Guiding Principles have been utilized by more than 50 countries in developing their national policies and plans.

Accordingly, WHO undertook an extensive process of consultation in the form of several global and regional meetings with multiple partners. These included health authorities (policy makers, national transplantation coordinators and national regulatory authority); scientific and professional societies; ethicists and lawyers; patients (both donors and recipients); and, finally, representatives of civil society from every region of the globe and level of development. The process led to updating the WHO Guiding Principles which pertain to the following 11 key elements:

1. Consent for deceased donor's donation;
2. Clear definition and determination death;
3. Consent from deceased, and live donors;
4. Protection of minors and incompetent persons;
5. No sale or purchase of organs, tissues and cells;
6. Altruistic promotion of donation, no advertising or brokering;
7. Responsibility on origin of transplant;
8. Justifiable professional fees;
9. Allocation rules;

10. Quality, safety, efficacy of procedures and transplants; and,
11. Transparency and confidentiality.

Details: http://www.who.int/transplantation/organ/en/

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Collaboration with UN University (UNU)

UNU-WIDER (World Institute for Development Economics Research) *Expert Series on Health Economics:*

Growth and Recovery in a Time of Default

International narratives on Argentina's recovery from the crisis of 2001-02 tend to emphasize the role of rising commodity prices and growing demand from China. Argentina is said to have been 'lucky', saved by global demand for its agricultural exports. The international narrative has also been used by local agricultural exporters to justify their objections against higher export taxes during periods of high commodity prices. These narratives are not correct. Data on the country's recovery show that it was not led by agricultural exports but was fuelled by urban demand and production. When the Convertibility period ended and the peso was devalued in 2002, price increases for imports stimulated the production of domestic goods and services for consumers. This production in turn generated multiplier effects which supported small and medium-sized firms and helped to create many new jobs. This later produced a revival of the construction and then the manufacturing sectors as well.

The contribution of the campo (rural sector) to the recovery came later in 2004 and thereafter, as the prices of commodities increased and the planting of larger and larger areas to grow soya and other crops had huge payoffs. These exports certainly helped build up the country's reserves and fiscal strength, but they cannot be credited with playing the key role in stimulating the recovery. Agricultural exports later generated much additional income and eventually public revenue, but Argentina's recovery was largely a 'demand-led recovery', located in urban areas where 80 per cent of Argentines work and live. The Argentine case is significant because it suggests that the urban locus of macroeconomic phenomena in Latin America deserves much more research and appreciation from policymakers. The historical foci in Latin American urban studies have included squatter settlements and infrastructure deficits, social exclusion, civil society mobilization, decentralization, and the 'right to the city' claimed by excluded groups. But these bodies of work have ignored the central fact that more than 60 per cent of GDP in all Latin American countries comes from urban-based economic activities. The economic and social futures of Latin America lie in urban areas which are at once the sites of productivity and the loci of urban poverty. The impacts of high intra-urban inequality are key factors in undermining needed improvements in productivity. The capacity of Latin American economies to withstand the impact of global economic crises and other exogenous events will depend on how economic policy takes into account the constraints and opportunities in urban areas.

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(Details of the paper can be accessed from the link of UNU-WIDER on CME Page http://www.womenshealthsection.com/content/cme/)

EVERY WOMAN EVERY CHILD

The Effort to Advance the Global Strategy
(Continued)

India (September 2010)

India is spending over US $ 3.5 billion each year on health services, with substantial expenditure on services aimed towards women's and children's health. Currently, India is focusing on strengthening its efforts in the 264 districts that account for nearly 70% of all infant and maternal deaths. Between now and 2015, India will provide technical assistance to other countries and share its experience, and will support the creation of a platform for global knowledge management to oversee the dissemination of best practices.

Indonesia (September 2010)

Indonesia will ensure all deliveries will be performed by skilled birth attendants by 2015. This universal access intervention is aimed at reducing the maternal mortality ratio from 228 per100.000 live births in 2007 to 102 per 100.000 live births in 2015. In 2011, at least one and a half (1.5) million deliveries by poor women will be fully funded by the government. Central Government funding for health in 2011 will increase by USD 556 million compared to 2010. This fund will be available to support professional health personnel and to achieve quality health care and services in 552 hospitals, 8,898 health centers and 52,000 village health posts throughout Indonesia.

Mongolia (May 2011)

Mongolia commits to implement a policy on increasing salaries of obstetricians, gynecologists and pediatricians by 50%; increase financial allocation to national immunization program; improve provision of micronutrients to children under 5; ensure reproductive health commodity security; and increase the number of health facilities for women and children, including the construction of a new Women's and Children's Health Centre in Ulaanbaatar.

To be Continued……..

Top Two-Articles Accessed in October 2012

1. Exercise During Pregnancy and Postpartum Period;
   http://www.womenshealthsection.com/content/obs/obs031.php3
   WHEC Publications. Special thanks to our reviewers for helpful suggestions

2. Female Sexual Dysfunction;
   http://www.womenshealthsection.com/content/gyn/gyn032.php3
   WHEC Publications. Special thanks to WHO and NIH for contributions and our reviewers for helpful suggestions.

From Editor's Desk

Every Woman Every Child Has Mobilized $20 Billion in New Money, with $10 Billion Already Disbursed, But More Remains to Be Done to Reach Health Goals by 2015

NEW YORK, NY: Tuesday September 25, 2012— Since its launch in September 2010, the Every Woman Every Child movement, led by UN Secretary-General Ban Ki-moon, has helped catalyze

new attention and investment to some of the most neglected causes of women's and children's mortality. Through unprecedented global coordination and partnerships, the movement has leveraged more than $20 billion in new money to save the lives of 16 million women and children by 2015. As of now, $10 billion has already been disbursed. The movement counts more than 250 individual commitments by more than 100 partners, including low-income countries, donor governments, the UN, the private sector and civil society. Results of the joint efforts of these partners, and new commitments to spur even greater progress, will be announced tonight at a special dinner in New York to be hosted by the UN Secretary-General for senior leaders attending the UN General Assembly.

"In just two years, Every Woman Every Child has achieved important results in accelerating progress for women and children," said UN Secretary-General Ban Ki-moon." I am encouraged that so many global leaders have galvanized action around key issues like family planning, child survival and access to essential commodities. Even in these times of austerity, there is no better investment than the health of women and children."

Despite faltering investment in development overall, the past year has seen remarkable energy relating to women's and children's health, including the launch of A Promise Renewed, a sustained, global effort to save children's lives, and $2.6 billion in new commitments to family planning made at the London Summit for Family Planning in July. This push was led by a wide number of donors from both high-income and low-income countries, including the UK Government, the Bill and Melinda Gates Foundation, UNFPA, the governments of Norway, France and others. Other commitments this year have targeted key issues such as improving the prevention and care of preterm births, as well as the launch of recommendations to support the UN Commission on Life-Saving Commodities in improving access to vital commodities proven to reduce deaths of women and children.

This week's announcements in New York also include an additional US$52m million for women's and children's health in Africa from the Government of Sweden, as well as a pledge from World Bank Group President Jim Yong Kim to establish a special funding mechanism to enable donors to scale up their funding to meet the urgent needs related to MDGs 4 and 5, leveraging the International Development Association (IDA), the Bank's fund for the poorest.

About Every Woman Every Child

Every Woman Every Child aims to save the lives of 16 million women and children by 2015. It is an unprecedented global movement that mobilizes and intensifies international and national action by governments, multilaterals, the private sector and civil society to address the major health challenges facing women and children around the world. The movement puts into action the Global Strategy for Women's and Children's Health, which presents a roadmap on how to enhance financing, strengthen policy and improve service on the ground for the most vulnerable women and children.

Comings and Goings

Comings: **Joanne Rivera** will resume her duties as New York Main NGO Representative at UN for Women's and Education Center (WHEC) from January 1, 2013. We all are looking forward for her to start in this challenging role. She has been with WHEC since 2007.

Goings: Faustine-Margret Arel has contributed significantly in this role to the organization and its mission, for the last two years. She is still part of the team but will not be able to play an active role. We all wish her a great success in her new career in Florida. Best Wishes.

Words *of* Wisdom

OLDER WOMAN'S VOICE

I am an older, an elderly, woman
The lines on my face are etching of the seasons of my life.

I am not pretty anymore. My hair is grey, my skin sagging,
In a world fixated on youth and beauty.

I am frailer now, more fragile, more often ill.
I cannot afford all the medical care I need.

I want to tell my children stories of my life.
But they are busy, not so interested in my legacy.

I am lonely. My husband, also old, has dementia.
I feel isolated, ignored, forgotten.

What has happened to the respect for elders,
To the valuing of life from cradle to grave?

Where is social justice to care for old women
And provide for their special needs and rights?

I am an older woman, but I am very much alive.
Hear me, care about me, help me, treasure me.

– The Women's UN Report Program & Network (WUNRN)

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Monthly newsletter of WHEC designed to keep you informed on the latest UN and NGO activities