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Medical Tourism and Its Effect on United State Healthcare Industry in a Highly Connected Global Landscape

Katarina Hasit

Executive Summary

For centuries people have traveled to other countries to obtain the best healthcare. Traditionally these popular destinations were highly developed countries; the trend of people traveling to less developed areas for treatment is relatively new. The average person is more connected to the world around them than ever before through globalization. Information about the best practices are more widely available than ever before. The importance of physical barriers to business such as geography and time are being eliminated. Due to this “flattening” per Friedman, the competition and expertise for areas in Science, Technology, Engineering, and Mathematics (STEM) can be shifted overseas. The availability of information boosts the quality of hospital care in developing countries to a level of care rivaling that of developed countries, but without the excessive cost associated.

The hospitals and healthcare infrastructure of the United States are not ready to compete on this global scale of healthcare. A lack of transparency of costs, high administrative costs, and little proactive planning of infrastructure to accommodate to the trend each contribute to the United States falling behind in this competition. Increasing transparency and decreasing administrative costs can help improve the long-term infrastructure of the healthcare system to diminish the potential financial impact of people traveling abroad for cheaper but high-quality procedures. A medical facilitator could be incorporated into the hospital infrastructure to help retain some of the lost earnings. The facilitator would work with foreign hospitals and centers of excellence to coordinate travel, accommodations, translators, and after-care back at the domestic hospital. Legal liability would then be mitigated through education of the patient from the medical facilitator instead of a physician recommendation. By offering these services for the patient, the hospital can still receive a portion of the income and improve customer satisfaction rather than lose

out to customers traveling on their own or opting not to have the expensive procedure all together.

History of Medical Tourism

The concept of medical tourism is not a new age topic in the healthcare field. Greek pilgrims were among the first recorded occurrence of medical tourism when they traveled from the Mediterranean to Epidauria, a small territory in the Saronic Gulf (Tsolakidou, 2012). The area was the sanctuary of the healing god Asklepios and Hygeia; the healing abilities of these holy hot springs were widely believed (Tsolakidou, 2012). People were drawn to these locations in large numbers, and locations that wanted to differentiate themselves from their competition would incorporate activities such as gambling casinos, dancing, or other social activities (Weisz, 2011). Therefore, for more than 2500 years the idea of travel for health of the body and mind has been around.

During the early 1900s, Europe and the United States were known for their very progressive and forward thinking medical field. Many people from developing countries traveled for treatment in developed countries for their ailments that were beyond the medical capabilities in their home country. Due to “rapid scientific discovery and medical progress in the ensuing decades stimulated a proliferation of medical facilities in developed nations, making the latest clinical techniques and technological innovations increasingly available to the citizens of these countries” (IMTJ, 2008). These same treatments were unavailable or offered at a lower quality to those in the developing country, so people living in these countries were traditionally forced to travel for top of the line medical care. This line of thinking illustrates the traditional view of medical tourism.

Shifting Trends in Medical Tourism

Comparative to ancient times, medical tourism in recent years has changed with the global trends. In Friedman’s “World is Flat” paper, he stated that many events from 1989 to around the year 2000 lead to a flattening of the

world. His definition of a flat world refers to the ability for the anyone in the world to be able to collaborate and transfer ideas in real time no matter their geography, distance, and potentially language (Friedman, 2005). These traditional barriers to the transfer of information are becoming less significant. Information about healthcare procedures, quality, and qualifications of doctors can now easily be looked up and compared using the internet. Global competition for talent and resources will only increase if this trend continues.

Friedman suggests that in modern America, we have three issues that are causing gaps between the United States and other parts of the world. These are ambition, numbers, and education (Friedman, 2005). American children may feel a sense of entitlement when compared to other people their age in different areas of the world. The average American child then lacks ambition and devotion to do as much when compared to children in China or India and their drive for self-betterment, creating the first gap. Compounding this issue is the number gap. This refers to the number of children in the United States who are not going into STEM fields. When compared to other countries, there are less qualified people domestically in STEM fields. We are creating a shortage of these jobs within the United States, so companies are forced to look elsewhere to fill these positions. Friedman suggests that companies can get better-skilled and more productive workers, sometimes for less pay than American workers (Friedman, 2005). It is theorized the education gap is due in part to the first two issues along with less emphasis placed on the content of the United States STEM fields in lower education. This could have a major impact on the healthcare system since it falls into the STEM category.

Another reason for the shift toward medical tourism is the increase in access to higher education for people in developing countries. Many opportunities for postgraduate medical education for those living in developing nations involve travel to

industrialized countries in North America and Europe. Upon finishing medical school, some certified physicians stay in the developed country to practice medicine. Others return to their home country to practice medicine and improve the current trend of healthcare in their home country (IMTJ, 2008). Through increased access to education due to globalization, physicians in developing countries can work to meet and potentially exceed international qualifications and board certification while serving domestic and international patients.

Reversal of Medical Tourism

Many medical patients in traditionally developing countries are no longer forced to travel to the United States or Europe to have more advanced procedures performed. Instead, the medical travelers now come from developed countries seeking out better value with faster treatment times and cheaper costs in less developed countries. (IMJT 2008). The traditional drivers of medical travelers of high quality procedures have been diminished. Many hospitals around the world in multiple countries are in competition on the global scale, raising the total quality offered to patients in their care. Today's conscientious patients are increasingly balancing "health needs against many other considerations, and medical concerns may even be subordinate to other issues such as allocation of personal resources (IMJT 2008)". If a patient cannot afford to pay for a treatment in the United States, the patient may settle for a cheaper procedure somewhere else that may not be top in their field, but still safe.

Drivers of New Age Medical Tourism

Costs may be the main reason for the reversal of the medical tourism trend. A movement toward free access to healthcare has recently gained support to alleviate the motivation to travel to other countries for medical procedures. While the primary driver of medical tourism would be voided, another driver would just compound the higher efflux of people that would want to travel due to avoid long wait time. To quantify the

difference in wait times: in 2005 if a person received a referral for a hip or knee replacement, they could receive treatment within a couple days if at a medical tourism destination. The same person in British Columbia, Canada would have to wait 21.8 and 28.3 weeks for a hip or knee replacement respectively (Asian Pacific Post 2005). The promptness of a cure can help prevent long term injury in the case of many medical issues. Traveling to reduce wait times can be more beneficial for the patient's health for these scenarios.

The motivation for medical tourism is further extrapolated by people who are underinsured or not insured at all. If the patient's insurance does not cover all the expenses, or the patient doesn't have insurance, the patient is more likely to seek low cost medical treatments abroad (Horowitz and Rosensweig 2007). Options for people with little to no medical insurance were to pay the excessive costs and go into debt or not getting the procedure done promptly and gamble that their health condition will not deteriorate while they come up with the difference. Through medical tourism, patients could get the procedure they need at a portion of total cost.

An additional driving force causing people to travel from developed countries to developing countries for procedures is the domestic inaccessibility of certain medical treatments. These medical treatments could be elective surgeries not covered by insurance or controversial operations that have legal barriers. These treatments could include stem cell therapy, joint resurfacing, disc replacement, reproductive therapy, and sexual reassignment surgery (Horowitz and Rosensweig, 2007). Many of these procedures are not viewed as necessary by the domestic insurance company. People who are willing to travel to a certified developing country's hospital will save money in travel costs and in the out of pocket cost of the procedure.

Medical Tourism Quality

Many people mentally associate medical tourism with high risks and unsanitary

conditions. The Center for Disease Control and Prevention (CDC) warns about general risks that patients traveling around the world may face with medical tourism but specific risks are based on the area being visited. The CDC identifies risks including a communication barrier if you don't speak the native language and do not have an interpreter, counterfeit medication, increase risk of blood clots from flying after surgery, and increase risk of antibiotic resistant bacteria. (CDC 2016). The CDC also recommends checking the qualifications and credentials of the facility where the procedure will take place. Travelers need to remember that the standard of care in the United States may not be the same when traveling to other institutions around the world. The Joint Commission International, DNV International Accreditation for Hospitals, and the International Society for Quality in Healthcare are among the few accrediting agencies that have lists of standards that facilities need to meet to be accredited (CDC 2016). When choosing a facility abroad for medical treatment, it is imperative to look for international high caliber accreditations to attempt to reduce the risk of low quality operations.

Centers of Excellence Example

Many accreditation organizations have given accreditation to locations around the world known as Centers of Excellence. One such center is Bumrungrad International Hospital in Bangkok, Thailand. Bumrungrad opened its main facility in 1977 and outpatient clinic opened in 2008 (Bumrungrad 2017). Their website is easy to navigate and offers multiple services for medical tourist. Their special international services include "over 150 interpreters, international/airport concierge service, embassy assistance, VIP airport transfers, e-mail contact center, international insurance coordination and international medical coordinators, visa extension counter, and Muslim prayer room (Bumrungrad 2017)". The hospital was the first Asian hospital accredited by the Joint Commission International (JCI) which also accredits

hospitals in the United States. Bumrungrad International Hospital was accredited in 2002, 2005, 2008, 2011, and 2014. Furthermore, Bumrungrad International Hospital was awarded “Best Website for International Medical Travel” award during the 2008 Consumer Health World Awards, USA.

Bumrungrad International Hospital is also recognized as a referral center. Their medical coordination office is open 24 hours a day to assist with referrals from around the world. Their team of seven doctors and 12 nurses work to coordinate schedules and procedures, family questions during treatment, and follow-up care planning. (Bumrungrad 2017). By having interpreters for many different languages, the communication risk is reduced for the medical tourist. Medical tourists who travel to centers of excellence know they are in good hands based on the communication, certification, and transparency of care.

Tourists should research into the country, hospital, and doctors to help mediate some of the concerns of lower quality care that occur abroad. Through research, tourists can learn that the Bumrungrad International Hospital is an excellent example of the capable services offered overseas. Having the misconception that the quality of medical care is the same no matter where patients go within another country can have detrimental lasting effects on their medical health. Other hospitals in Thailand may try to compete for traveling medical customers but may not have the same qualifications. Therefore, the patient needs to be cautious when making the decision to seek professional medical attention abroad.

Medical Tourism Association

The Medical Tourism Association (MTA) is a nonprofit international organization to help people interested in medical tourism. MTA works with “healthcare providers, governments, insurance companies, employers and other buyers of healthcare-in their medical tourism, international patient, and healthcare initiatives. (MTA 2017)”. MTA wants to see an increase in consumer awareness

about their international healthcare options and an increase in the number of medical tourists.

MTA Educational Curriculum Collaborations

The MTA offers education and certification to people and colleges who are interested in incorporating the medical tourism industry into their curriculum. MTA specifically offers cross-training programs for educational institutions for multiple academic paths including medicine and healthcare, tourism and hospitality, wellness and business (MTA 2017). Some programs can be on topics detailing physician leadership, quality improvement, patient safety, cultural competence and patient experience. As more universities across the country see the increase in the industry of medical tourism, the demand for these kinds of programs can be inferred to increase.

MTA strategic alliance Global Healthcare Accreditation

Global Healthcare Accreditation (GHA) Program is an accreditation for hospitals, dental clinics, ambulatory centers, or independent practitioner offices when serving medical tourist and medical travelers (MTA 2017). The GHA evaluates overall performance and streamlined function for an overall positive experience for patients and their families. GHA suggests “the rising health tourism and medical travel industries provide opportunity for many medical institutions to develop strong profit centers around services offered to traveling patients and health and wellness seekers (MTA 2017)”. As people share their experience at facilities specializing in international health such as at facilities like Bumrungrad International Hospital, more people will follow suit.

Recommendation for United States Hospitals

Centers of excellence such as Bumrungrad are becoming an increasingly viable option for those living in the United States. Domestic hospitals may face a decrease in profits from elective procedures because of

this. A study done by Gill and Singh explored the interest in medical tourism in the United States travelers. The study identified three main factors when deciding to receive care domestically or abroad: competent doctors, high quality medical treatment facility, and prompt medical treatment when needed (Gill and Singh 2011). The first two factors can easily be found in the United States at facilities such as John Hopkins or other top medical facilities. These international centers of excellence must compete internationally for clients in the modern era of globalization. The competition and comparison of “competent” doctors and “high” quality is necessary not only with other domestic hospitals, but in comparison to Bumrungrad and similar competitors. The quest for quality and competitive advantage must continue to innovate and push the expectation to retain and potentially gain clients as international locations become more a more feasible option.

Long Term Solution for Hospitals in the United States

If the international standard of quality is similar, many people may not want to pay for a heart bypass that could cost around \$123,000 in the United States when patients could go to facilities in Thailand and receive the same treatment for \$13,000 (Lunt et al, 2011). In the United States, the per capita healthcare costs are far beyond those of any other nation in the world. In 2002, the cost per person for healthcare in the United States averaged \$5267 (Bodenheimer 2005). Thus, if the quality of the hospitals is similar, the wait time is probably less, and the procedure is around a tenth of the cost, the international option in Thailand is a feasible option. Furthermore, the patient can usually bring their family and have a mini-vacation in another country while they are healing post-operative. Domestically the hospitals need to do something to combat the potential loss of revenue as more people start to see the viability of this option.

Medical Reform

The medical care system of the United States must be reformed to lower costs. The

United States faces a growing loss in patient numbers as more people are traveling out of country for medical treatment than those traveling to the United States from other countries. The excessive costs associated with medical care is one of the main reasons medical tourists look outside the United States for medical treatment (George 2013). While many blame the pharmaceutical companies, around 14% of healthcare costs in the nation were administration costs. Of that 14%, around half was estimated to be wasteful, or around \$180 billion annually in 2012 (Wikler et.all 2012).

Completely free access to healthcare will not fix the drive for medical tourism, but lowering the costs may deter some people from the cost savings for the inconvenience of traveling. The difference of \$110,000 for similar quality of care in heart bypass costs is an easy decision, but if the difference was only \$5000 or so the drive would not be as strong. According to patient behavior, customers of the healthcare industry are savvier when spending their own money instead of insurance companies’ (Herrick 2003). This means that if the patient is fully insured and not spending their own money, they are more likely to accrue the \$110,000 extra cost compared to if they had to pay that out of pocket. By using a third-party payment method through an insurance company, employer, or government, cost analysis is reduced for the consumer when seeking quality of care.

Transparency

Another reason why customers also may not seek the best costs is the lack of transparency in medical costs. For example, when people in the United States think of the last time they had to go for a doctor visit, they usually go somewhere that has been recommended by others and takes their insurance. Rarely do people compare what the cost difference between doctor offices are when making decisions. The MTA is working towards a Quality of Care Project that will look for one methodology to quantify healthcare cost reporting. The program would allow multiple stakeholders such as insurance

companies, employers, and patients to compare international hospitals' quality of care with others around the world (MTA 2017). The research will also allow patients to obtain information about quality, costs, patient volumes and patient safety. Through an increase in transparency, the global market can be completely open to competition for top quality doctors and affordable costs.

Short term solution

Policy reform and changing infrastructure for the healthcare system will take significant time and planning. In the meantime, the healthcare industry is potentially still losing the race for healthcare quality at affordable prices in the global market. Currently, the medical tourism threat is not pressing enough to give many hospitals cause for alarm. Instead of waiting until it is too late, hospitals in the United States should begin to implement changes to be proactive in the global market of healthcare. One potential avenue is expanding options in the hospital to include a medical facilitator office.

Medical Facilitators

The role of a medical facilitator is to work to bridge patients who are interested in being medical tourists with facilities rated for high quality and patient safety (Synder et. All 2011). Their role can include: "booking transportation and hotel accommodation; arranging for medical services and tourist packages; transferring medical records and arranging for follow-up care in the home country (Synder et. All 2011)". Because the role of the facilitator is to work with hospitals and patients around the world, one can infer that medical facilitators would have the ability to screen the facilities with inadequate quality to increase the likelihood of a positive experience for the patient in comparison to the patient researching the topic on their own.

There are multiple ethical dilemmas that come from the role of medical facilitators. One of the main concerns is commission received from sending patients to facilities paid by third-party sources (Synder et. All 2011). Some third-parties may pay more as

commissions for medical facilitators that they have worked with in the past. Therefore, a medical facilitator may face an ethical dilemma to channel patients through that third-party to certain programs instead of a program that may be better for them. Patients may trust the facilitator to have their best interest at heart, but the medical facilitator could be sending the patient to the place that will pay the biggest commission instead of the best quality for the patient.

If a hospital was to incorporate a medical facilitator branch into the hospital infrastructure, the hospital can help mediate people coming to the United States for treatment. Furthermore, the facilitator branch can help patients who are interested in traveling abroad for medical care. The idea may seem counterintuitive to offer information for sending patients away from the institution, but a partial payment is better than receiving a net income of zero from the patient who travels for the procedure. Furthermore, the hospital can create a culture of improving care to customers that may not be able to afford the procedure at the hospital. These customers may be the underinsured or the unemployed. The hospital can make a contract and liability waiver for the patient who will travel to another country for the procedure and the hospital can perform the aftercare on the patient. Therefore, the hospital will net a portion of the administrative costs that would normally be received from the medical facilitator office outside the hospital infrastructure and make money on the post-operative care received by the patient upon their return home.

The benefits to incorporating a medical facilitator to domestic hospitals go beyond building relationships with patients and customers. Hospitals can build a positive working partnership with other hospitals around the world. They can share best practices and work to continue pushing the standard of care. Innovation can flourish with positive competition, and such a partnership would allow the correspondence of ideas

across nations. The ethical dilemma would be reduced from the biggest commissions since the medical facilitator's job would be a part of the hospital infrastructure. A pay schedule with a lowered focus on commission would lower the risk of an ethical issue of sending someone to a lower quality location for a higher pay check.

Case Study (Weiss et. all 2010)

The following case study published in the journal *Surgery* in 2010 can emphasize the importance of having a medical facilitator within the hospital to move the decision of a referral from a surgeon to the facilitator. With the suggested new infrastructure, the patient will still receive the best care and the surgeon can focus on medicine instead of tourism, advice that the surgeon may not be fully aware of all the aspects.

A surgeon was presented with an ethical dilemma from a 45-year-old underinsured man under consideration for bariatric treatment for morbid obesity. The surgeon recommends a gastric banding procedure that was denied multiple times by the man's insurance company. The insurance company offers the option for the man to travel to Bangkok for the procedure that would also include 4-star accommodations for the man and his wife at a seaside rehabilitation center. The man asks his surgeon for his medical opinion for what he should do. (Weiss et.all 2010).

The surgeon can either give a positive or negative recommendation. The case study identifies four options that the surgeon can do. The negative recommendation can be due to bad medicine from medical tourism or that medical tourism is bad for Thailand's healthcare system. The positive recommendation is to say yes and agree that the surgeon will resume care upon return. Furthermore, the surgeon can decide if they should require a release form or not to waive liability of any faulty medical work done in Bangkok. The main predicament for this case study is that the morbidly obese man has tried multiple times and simply cannot afford the

procedure in his home country. He seems out of options and is looking for assurance from his surgeon.

Option One

If the surgeon says that medical tourism is bad medicine, the logic may be in line with the ethical principle of non-maleficence. Non-maleficence means that physicians should not inflict avoidable harm, or set a patient in harm's way (Weiss et.all 2010). This ethical principle can arguably be avoided by the potential location of the hospital that the man is considering. For example, if the man went to the Bumrungrad Hospital in Bangkok, Thailand that advertises the accreditations the hospital has through internationally acknowledged organizations such as Trent International Accreditation Scheme or the (JCI). The idea of potential harm would be mediated by the standard of care offered compared to another hospital in the region that may not have the same standards.

Furthermore, if something happened to the patient, there lacks a precedent for suing an insurance company for directing a patient to acceptable care that has the potential to be suboptimal care for either a domestic or international case (Weiss et.all 2010). Instead there are precedents for suing a health maintenance organization for going against a consulting surgeon's recommendation that results in adverse effects for the patient. Consequently, the patient may push to sue the surgeon instead of the insurance company if there were any issues with the gastric banding procedure because the surgeon gave his recommendation. Therefore, the surgeon could have legal liabilities of a referral if something went wrong.

Option Two

The surgeon does not give his recommendation due to medical tourism being bad for Thailand's healthcare system. The ethical principle of justice is under consideration for option two. Justice related to how the healthcare resources be allocated in equitable fashion (Weiss et.all 2010). This argument takes into consideration the effect of

crowding out that can occur when too many travelers are coming around the world to one location. These travelers can inadvertently be taking resources away from the domestic population in need of high quality health services. Why should one person be favored for international medical tourism instead of the population of the home country if healthcare resources are in high demand? For example, if the gastric banding appointment takes precedence over someone in Thailand there may be cause for concern of injustice to the domestic population.

Some argue that medical tourism spurs a trickle-down effect for both economic and technological advances while enhancing the quality care centers in the home country by operating at (or beyond) Western medical standards. The opposition to this idea is that the benefits to medical tourism do not outweigh the costs to the local populations. These costs could be as simple as “brain drain”, implying that the trained professionals time and efforts are diverted from local patients to those abroad. Furthermore, that the trained professionals could get worn out from the excess amount of work from medical tourist and then lower their quality to all visitors to their clinic. (Weiss et. all 210). The main two questions then become “are the global economic strategies put forward by prosperous nations also in the best interest of the rest of the world’s people” and “do the economic benefits of medical tourism accrue to local populations” (Weiss et.all 2010). During an evaluation of Thailand’s medical tourism, Ramirez de Arellano found health personnel moving from the public to the private sector is already occurring, which resulted in the reinforcement and worsening of a health-care system that was two-tiered. His claim is currently being evaluated by international organizations. Among them are the World Health Organization and the World Bank. (de Arellano 2007)

Option Three

The surgeon agrees to give his recommendation and agrees to resume care to

the man upon his return from Thailand. The ethical principle in option three that is under debate is beneficence. Beneficence means that the surgeon should promote wellbeing and what is best for the patient (Weiss et.all 2010). This recommendation recognizes the patient’s autonomy. This decision would support the American Medical Association and American Cancer Society guidelines for medical tourism that clearly states that patients must be able to pursue care at a location of their choosing (Weiss et. all 2010)

An article by Rhodes and Schiano dealing with the ethics of transplant tourism claims that surgeons have a fiduciary responsibility for their patient instead of all other individual opinions, political agendas, or justice for the medical system. For a physician to be acting ethically per this article, the physician must choose to act within the ethical principle of beneficence for the patient instead of any personal reasons to decide differently. The physician then may be advocating for the patient potentially at the cost of personal beliefs for the physician.

Advocating for the patient may include education for the patient themselves. The patient must be educated on the requirements for post-operative care and what the doctor would need from the foreign surgeon. The foreign surgeon would have to send copies of records, images, and potential treatment plan to the physician in the patient’s home country. The transferring of documentation has the potential for communication issues from cultural differences, language barriers, or what seems like small misunderstandings, which could be a determinate for the patient. The patient would have to be aware of the potential for miscommunication when deciding where to have the post-operative care. (Weiss et.all 2010).

Option Four

The surgeon agrees to give his recommendation for the surgery abroad and offers to continue follow up care for the patient if they sign an informed consent document. The compromise in option four

allows the physician to satisfy both the ethical principles of beneficence and physician autonomy. The physician would follow the same discussion about follow up care as with option three, but option four limits the liability to the physician if the patient had some issues with the foreign surgery. This option primarily differs from the previous in legal terms rather than a difference in medical procedure. The jurisdiction for issues concerning medical care is the location of the hospitals and the physician, not the patients' national origin (Weiss et.all 2010). The level of compensation for cases of malpractice is a lot lower in developing countries than in the United States. Thus, if the surgeon chooses option four, an ethical surgeon would explain the potential for compensation for a serious case of malpractice abroad would be insignificant compared to what the patient would receive from a domestic case. The ethical surgeon's pursuing beneficence might require support of an operation in a foreign country, then the prudent surgeon must understand the legal implications of shifting the decision to the patient (Weiss et.all 2010).

The informed consent document should be provided for the patient before the patient decides to have the surgery abroad instead of within the United States. The document should contain an explicit list of likely and unlikely risks involved in foreign medical care, the surgeon's lack of control or potential lack of knowledge in qualifications of the foreign doctor or hospital staff, and potential for the surgeon not being able to fix any issues involved from the surgery if a case of severe malpractice occurs (Weiss et.all 2010). A very detailed document would likely prevent the surgeon from being liable in a U.S court; informed consent documentation does not offer protection from being named in the lawsuit. In consequence, the surgeon could have indirect costs from another surgeon's malpractice because he gave the recommendation for the patient. (Weiss et.all 2010).

Conclusion

If the current trend of medical tourism continues, the health care system in the United States needs to make changes to be able to effectively compete on the global scale. The United States needs to actively be increasing transparency of costs while lowering administrative costs to decrease inflation of overall costs. Customers can now travel abroad for the same high quality procedures that are performed in the United States, potentially leveling the playing field of competition. The healthcare industry must increase productivity and quality after reducing costs to stay globally competitive.

On a short-term scale, hospitals should move to adding medical facilitators to the infrastructure of the healthcare system. This will allow legal liability to shift from physicians and help advocate and educate patients who are in need of a procedure that is difficult to obtain in the United States for a variety of reasons. Instead of having patients go through third-party facilitators to find information and resources for your competitors, maintaining them within the hospital can help retain some revenue and build partnerships around the world with centers of excellence.

The healthcare system in the United States can continue to be successful in the globally competitive, modern world by working on both a short-term and long-term scale toward solutions. Medical tourism will only continue to increase in popularity as more people hear and share positive experiences compared to the costs found domestically. The United States must be productive and proactive in making changes in the healthcare system before they lose revenue and customers for elective surgery abroad.

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