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Working Paper

Medical Tourism in the Philippines: Market Profile, Benchmarking Exercise, and S.W.O.T. Analysis

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Surian sa mga Pag-aaral Pangkaunlaran ng Pilipinas

Medical Tourism in the Philippines: Market Profile, Benchmarking Exercise, and S.W.O.T. Analysis

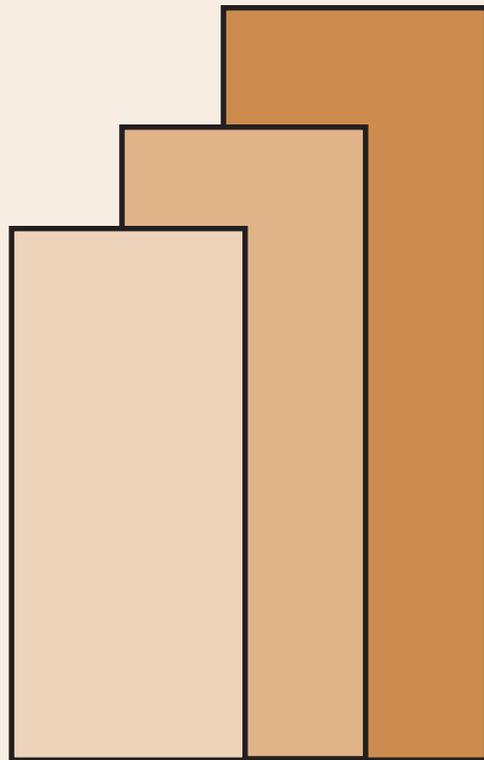
Oscar F. Picazo

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Medical Tourism in the Philippines

Market Profile, Benchmarking Exercise, and S.W.O.T. Analysis

Oscar F. Picazo

9/25/2013

This discussion paper was written with the assistance of Danica Aisa Ortiz, Melanie Aldeon, and Nina Ashley dela Cruz. It was prepared for the Department of Trade and Industry and will also be shared with the Department of Tourism and the Department of Health. The views expressed here are those of the author and not those of the board, officials, and staff of PIDS, DOT, DTI, or DOH. This is a policy research paper the contents of which are not meant to be used for individual medical or care-seeking behavior but only as an industry background.

Abstract

Medical Tourism in the Philippines:

Market Profile, Benchmarking Exercise, and S.W.O.T. Analysis

This report reviews the medical tourism industry in the Philippines. It discusses the global market for medical tourism, analyzes the demand and supply aspects of the local industry, and identifies its drivers of growth. It performs an industry benchmarking exercise by looking at benchmarks associated with strategy setting, organization and management, service quality, care, travel and accommodation, and financing. It also conducts an analysis of the strengths, weaknesses, opportunities and threats of the industry.

Keywords: Medical Tourism, Industry Benchmarks, Market Profile, Demand for Medical Tourists, Supply of Services and Facilities for Medical Tourism

Abbreviations and Acronyms

AC – Accreditation Canada	NSO – National Statistics Office
BOI – Board of Investments	OECD – Organization for Economic Cooperation and Development (shorthand for industrial countries)
CMTR – Center for Medical Tourism Research	OFW – Overseas Filipino Worker
COE – Center of Excellence	PAO – Philippine Academy of Ophthalmology
DOH – Department of Health	PAPRAS – Philippine Association of Plastic Reconstructive and Aesthetic Surgeons
DOT – Department of Tourism	PCAHO – Philippine Council for the Accreditation of Health Organizations
DTI – Department of Trade and Industry	PEZA – Philippine Economic Processing Zone Authority
EO – Executive Order	PhilASHome – Philippine Association of Health Organizations in Medical Tourism
EU – European Union	PHIC or PhilHealth – Philippine Health Insurance Corporation
FDA – Food and Drug Administration	PHC – Philippine Heart Center
FTZ – Free Trade Zone	PHP – Philippine Pesos
H2H – Hotel to Hospital	PMA – Philippine Medical Association
HEAL – Health and Wellness Alliance of the Philippines	PMTI – Philippine Medical Tourism, Inc.
HMO – Health Maintenance Organization	PMTP – Philippine Medical Tourism Program
IMTJ – International Medical Travel Journal	PPO – Preferred Provider Organization
INICC – International Nosocomial Infection Control Consortium	PRA – Philippine Retirement Authority
IPP – Investment Priorities Plan	PSIC – Philippine Statistical Industrial Classification
ISO – International Standards Organization	RA – Republic Act
ISQua – International Society of Quality in Healthcare	RP – Republic of the Philippines
JCI – Joint Commission International	SAPI – Spa Association of the Philippines, Inc.
Lasik – Laser-Assisted in Situ Keratomileusis	SWOT – Strengths, Weaknesses, Opportunities, and Threats
LGU – Local Government Unit	TESDA – Technical Education and Skills Development Authority
LSVVE – Long-Stay Visitor Visa Extension	TMC – The Medical City
NABH – National Accreditation Board for Health	UAE – United Arab Emirates
NAIA – Ninoy Aquino International Airport	
NCDs – Non-communicable Diseases	
NG – National Government	
NKTI – National Kidney and Transplant Institute	
NSCB – National Statistical Coordination Board	

UK – United Kingdom

US – United States

US\$ - United States Dollars

WHO – World Health Organization

WTO – World Trade Organization

Table of Contents

Abbreviations and Acronyms.....	i
Table of Contents.....	iii
List of Tables.....	v
List of Figures.....	vi
Executive Summary.....	vii
A. Market Demand and Drivers of Growth.....	vii
Top 15 Destinations of Medical Tourists, 2010.....	viii
B. The Domestic Industry.....	ix
Hospitals Under the Philippine Medical Tourism Program, 2013.....	ix
Comparison of Price Range for Sample Procedures in the Philippines and in the U.S. and Thailand, in US\$, Early 2010s.....	ix
Revenue and Cost Trends of Selected Health and Wellness Activities in the Philippines, PHP Billion, 1999 to 2009.....	x
C. Benchmarking Analysis.....	x
Benchmarking of the Philippine Medical Tourism Industry, 2013.....	xi
D. S.W.O.T. Analysis.....	xiii
E. Next Steps.....	xiii
S.W.O.T. Analysis of the Philippine Medical Tourism Industry, 2013.....	xiv
F. Concluding Notes.....	xiv
Chapter I. Background.....	1
Chapter II. The Global Market for Medical Tourism.....	3
A. Definition and Scope of the Trade in Health Services.....	3
B. Demand, Revenues, and Market Opportunity.....	7
Chapter III. Philippine Medical Tourism: Demand Aspects.....	16
A. Originating Countries of Medical Tourists.....	16
B. Price Competitiveness.....	18
Chapter IV. Philippine Medical Tourism: Supply Aspects.....	21
A. Hospitals.....	21
B. Stem Cell Therapy.....	23
C. Cosmetic Surgery and Beauty Clinics.....	30
D. Dental Clinics.....	30
E. Eye Clinics.....	31

F. Spas	32
G. Size of the Health and Wellness Industry	33
Chapter V. Benchmarking Exercise	35
A. Rationale	35
B. Strategic Benchmarks	36
C. Marketing Benchmarks	38
E. Organization and Management Benchmarks	40
F. Service Quality Benchmarks.....	43
G. Care Benchmarks.....	45
H. Travel and Accommodation Benchmarks.....	46
H. Financing Benchmarks.....	47
Chapter VI. S.W.O.T. Analysis	50
A. Strengths.....	50
B. Weaknesses	51
C. Opportunities.....	53
D. Threats.....	54
Chapter VII. Conclusions and Next Steps	58
References	60
Annex 1: Draft Scope of Work for Consultancy to Formulate the Roadmap of Expanding Medical Tourism in the Philippines.....	67
Annex 3: Comments on the Draft Senate Bill on Medical Tourism	70

List of Tables

Table 1. WTO’s Modes of Supply and Examples in the Trade of Health Services.....	4
Table 2. Major Products of the Medical Tourism Industry, Late 2000s.....	6
Table 3. Price Comparison of U.S. vs. Foreign Surgical Procedures, US\$, 2008.....	8
Table 4. Medical Tourists by Source and Destination, Mid/Late 2000s	12
Table 5. Top 20 Medical Tourist Destinations, 2010.....	13
Table 6. Destination Countries of Medical Tourists.....	14
Table 7. Proportion of Medical Tourists Out of Total Tourists in Selected Asian Countries, Late 2000s ..	17
Table 12. Price Comparison of Selected Medical and Surgical Procedures by Country Using Deloitte’s Study as Basis, in US\$.....	18
Table 13. Price Comparison of Selected Medical and Surgical Procedures by Country Using KPMG’s Study as Basis, US\$.....	18
Table 14. Average Prices for Selected Health and Wellness Services, in US\$, in the Philippines, the U.S., and Competing Countries, 2011	19
Table 8. Hospitals Under the Philippine Medical Tourism Program, by Location, Ownership, Number of Beds, and Accreditation Status	21
Table 9. Other Hospitals and Clinics Catering to Medical Tourists, by Location, Ownership, Number of Beds, and Accreditation Status	23
Table 10. Philippine Hospitals Involved in Stem Cell Therapy, by Stem Cell Application, Source of Cells, Origin of Technology, and Duration of Treatment	24
Table 11. Stand-alone Clinics and Laboratories Involved (or About to be Involved) in Stem Cell Therapy, 2013	26
Table 15. Revenue Data of Selected Health and Wellness Activities in the Philippines, in PHP Billion, 1999 to 2009	33
Table 16. Cost Data of Selected Health and Wellness Activities in the Philippines, in PHP Billion, 1999 to 2009	33
Table 17. Revenue to Cost Ratio of Selected Health and Wellness Activities in the Philippines, 1999 to 2009	34
Table 18. Number of JCI-Accredited Hospitals in Countries Involved in Medical Tourism, as of 2012	43
Table 20. PMTP Hospitals Providing Non-medical Services to Patients, by Type of Service, 2011	47
Table 21. Individual vs. Institutional Payor in Medical Tourism Industry, 2013	48
Table 22. Hospital Tieups with Related Services, 2012.....	49

List of Figures

Figure 1. Number of Doctors Per Eye Clinic, 2013	31
Figure 2. Growth of Revenues (PHP Million) of the Spa Industry in the Philippines, by Type of Spa, 2006 to 2012	32
Figure 3. Price Variation Among Selected Medical Procedures for Medical Tourists in Three Philippine Hospitals, in PHP, 2012	48
Figure 4. Classification of Patients by Requirement for Follow-up Care Versus Complexity of Treatment	56

Executive Summary

Medical tourism is poised to continue growing globally in the next few years due to combined economic, demographic, epidemiological, communication, and transport trends. The Philippines out-prices its Asian competitors in surgical procedures among JCI-accredited facilities, and yet it continues to get a minuscule share of the medical tourism market. Why? What needs to be done to change this status?

This discussion paper aims to provide a comprehensive view of the industry. It discusses the global market demand and the drivers of growth. It then tries to understand the domestic industry by (a) exploring its demand and supply aspects, (b) undertaking an industry benchmarking exercise, and (c) examining its strengths, weaknesses, opportunities, and threats. The discussion paper was based on a review of available materials from the Internet. Due to the tight deadline (March 2013) and lack of resources, the findings were not validated with industry stakeholders and relevant government offices. It is hoped that this can be done in the near future.

A. Market Demand and Drivers of Growth

Medical travel has been going on since time immemorial, but modern medical tourism emerged as a discernible phenomenon in the late 1990s and took off in a dramatic manner in the mid-2000s (2006 to be exact, according to industry observers).

There is no agreed-upon definition of medical tourism which leads to extreme confusion especially about the size of the market (number of medical tourists) and its revenue potential. Current estimates of people receiving care abroad vary widely. Moreover, most reputable estimates were done before the global economic crisis (2006-2007). While some have been adjusted for the global recession, others were not.

The data on cross-country cost comparisons is also deceptive as they implicitly assume out-of-pocket payments at the point of service and neglect the (potential) role of third-party financing and negotiation in either reducing or inflating costs. These medical costs also do not take account of transport, hotel, subsistence, and other associated costs that the medical tourist bears in accessing care abroad. So far, true access costs have not been calculated across countries. This is an analytic area that international agencies could take on.

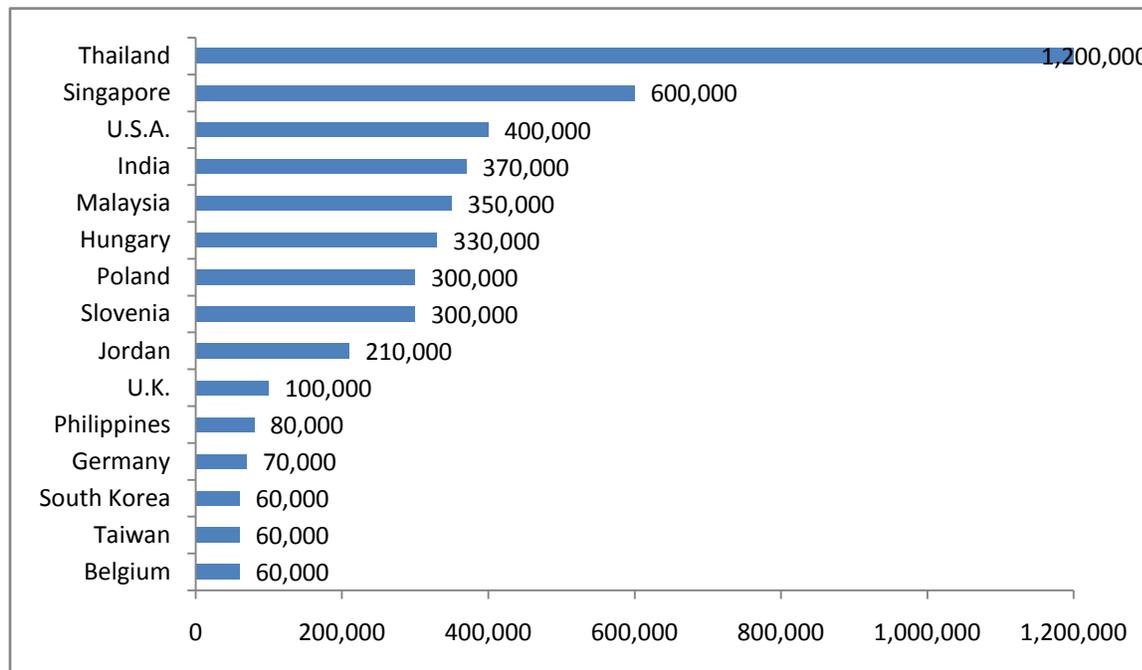
Despite these difficulties, analysis of the drivers of growth of medical tourism shows very positive prospects:

- a. Economically, the high medical costs in OECD countries are not going down any time soon. If anything, the anticipated more stringent regulatory requirements of health reforms (say, Obamacare) can lead to costs there even escalating.
- b. Demographically, OECD countries' populations are aging, and this will require more intensive use of medical care.

- c. Epidemiologically, the disease burden of the entire world has dramatically shifted to non-communicable and chronic diseases, necessitating greater hospitalization.
- d. Technologically, some procedures that in the past can only be done in OECD countries are now available in emerging economies as well, of comparable quality but at a lower cost, even adding the cost of travel.
- e. Communication media, especially the Internet, has empowered citizens all over the world that they are now taking matters into their own hands, looking for health providers with lower costs and traveling there if need be.
- f. Transport costs have made it affordable for many people to travel for holiday or for homecoming or for health care and wellness, and increasingly for combined purposes.

The Philippines trails Thailand, Singapore, India and Malaysia among Asian countries involved in medical tourism (see figure below). Taiwan, South Korea, and China are also poised to grab a larger share of the market in the near future.

Top 15 Destinations of Medical Tourists, 2010



Source: Youngman (2010)

B. The Domestic Industry

Medical tourism gravitates around 21 premier hospitals included under the Philippine Medical Tourism Program (PMTP). The table below shows their location, ownership, and total number of beds.

Hospitals Under the Philippine Medical Tourism Program, 2013

Location	Private		Public		Total	
	Number	Beds	Number	Beds	Number	Beds
Metro Manila	11	4,371	5	2,107	16	6,478
Batangas Province	1	220	-	-	1	220
Cebu	3	1,210	-	-	3	1,210
Davao	1	250	-	-	1	250
Total	16	6,051	5	2,107	21	8,158

Source: This study

The domestic industry is very price-competitive relative to the origin-countries of medical tourists and relative to its leading competitors in Asia. This is shown in the table below which compares Philippine prices for a sample of procedures with those obtaining in the U.S. and Thailand.

Comparison of Price Range for Sample Procedures in the Philippines and in the U.S. and Thailand, in US\$, Early 2010s

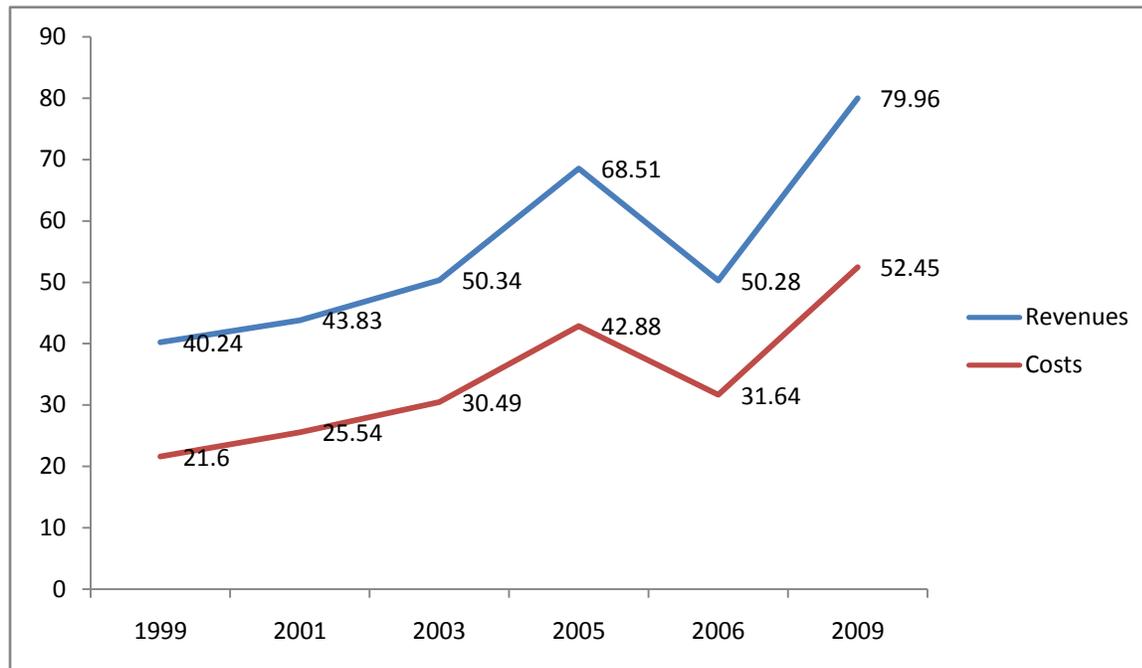
Procedures	Philippines	U.S.	Thailand
Dental bridge	360 – 600	5,500	290 – 430
Lasik eye surgery	1,000 – 1,500	3,000	650 – 900
Heart bypass	11,000 – 25,000	90,000 – 144,300	23,000 – 25,000
Nose lift	400 – 1,000	4,000 – 12,000	600 – 2,500
Spa services	11 - 100	100 - 200	45 - 100

Source: HealthCORE (2011)

The industry has also been growing for over a decade, as shown in the figure below. Except for a dip in 2006, which probably reflects stalled demand arising from the impending recession¹ in most Western countries, health and wellness activities (inclusive of domestic and tourist-oriented services) have expanded apace. Specifically, revenues have consistently outpaced costs. The industry had gross revenues of about PHP 80 billion in 2009, compared to gross costs of about PHP 53 billion.

¹ It would seem from this observation that medical tourist arrivals and expenses are a leading economic indicator as household behavior signals that the economy is going down. It was not until 2008 that the recession in the U.S. actually hit. Note, however, that the industry bounced quickly back the following year.

Revenue and Cost Trends of Selected Health and Wellness Activities in the Philippines, PHP Billion, 1999 to 2009



Sources: 1999 to 2005 from Virola and Polistico (2007); 2006 and 2009 from this study.

A major industry problem is the paucity of data to determine the parameters of the local industry and to establish baselines. While this problem has been recognized as early as 2007, it has not been acted upon. Key data such as medical tourist arrivals, expenditures, and services availed of are not readily available. There are also very few formally written accounts of the industry and its sub-sectors, with the possible exception of the spa sub-sector. There are many news items and blogs, but these are less reliable. Industry studies were not located for the medical sub-sector, and the completed reports by consultancy firms were proprietary and expensive.

C. Benchmarking Analysis

Benchmarking is the process of comparing one's business processes and performance metrics to industry best practices or to other industries' or countries' practices. In benchmarking, the best firms, industries, or countries where similar processes exist are chosen, and the results are then compared to the results of one's own firm, industry, or country. Conducting this benchmarking analysis is motivated by the need to find out where the local industry is relative to its leading competitors.

The medical tourism industry is very young, and very little published literature exists in peer-reviewed journals. As in the domestic market, the global market is also marked by scarcity of formally written literature. There are many blogs and industry press materials, often marked by hype, some of which are marked by careless analysis. Quantitative data that can be useful for metrics are scarce.

In the absence of a commonly accepted set of standards to measure the industry, Todd's (n.d.) "30 Key Findings from Medical Tourism Research" was used to assess the domestic industry relative to its counterparts in leading countries. The results are summarized in the matrix below, which shows that although the Philippines meets most of the competitive yardsticks, there are glaring deficits, notably:

- a. Strategy – There is no formal coordinating body (council or board) as in competitor countries; lead coordination is poor.
- b. Marketing – Market niching is weak, sustained promotion campaign is lacking, and local website are less attractive compared to competitors in the region.
- c. Organizational and management – Industry clustering is weak. Critical industry data are lacking.
- d. Service quality and care – There are few internationally accredited health facilities although their number is increasing.
- e. Travel and accommodation – Medical tourism airline packages from local carriers (PAL, Cebu Pacific) have not yet been developed.
- f. Financing – Pricing of services by providers is not transparent.

Benchmarking of the Philippine Medical Tourism Industry, 2013

	Benchmarks	Status
Strategic Benchmarks		
1	Development of a clear industry vision and strategic objective	20 top-echelon hospitals are involved in PMTP; lackluster performance of PMTP due mainly to its lack of marketing campaign
2	Coordination among relevant authorities	No medical tourism council or board; weak and informal coordination; many offices and agencies involved (48), not counting private providers
3	Provision of tax and other incentives	Fiscal incentives available from IPP but investment uptake is low; hotel and social work represents only 1 percent of total investment commitments in BOI between 2003 and 2011
Marketing Benchmarks		
4	Use of “competitive advantage” approach	Lacks focus and tends to cover all the bases; spoiled by Filipino diaspora captive market; efforts focused on Micronesia and East Asia; large non- <i>balikbayan</i> market in the U.S. and Europe remains to be tapped
5	Positioning for excellence in specific treatments and medical products	Weak market niching; Philippines tends to cover all the bases
6	Holding marketing campaigns	Lack of sustained and vibrant marketing campaign; innovative approaches lack scale
7	Using websites to promote medical tourism	Less attractive websites relative to those of competitor countries
8	International affiliation for QA and marketing	Some affiliations between local and international institutions exist but their full scale cannot be determined
9	Attendance at international medical tourism events	Minor presence and visibility
Organizational and Management Benchmarks		

	Benchmarks	Status
10	Adoption of “hospital management” concept that allows formation of more competitive entities that brand the country as a destination	Hospital chains and consortia not yet well established; leading hospitals branding themselves individually
11	Learning the lessons of “medical cluster” concept	Similar endeavors in other sectors wracked with difficulty; PPP initiatives struggling along
12	Consortium training	Not enough being done; cultural skills not being given enough prominence; new skills needed
13	Standardized database system	Very weak; absence of key data; hesitance of private sector to share sensitive data
14	Advancement in technology and research	No research center; stem cell research and application done in a few places, but highly localized; PHL lagging behind in CME; no research center
15	Well established ambulance system and traumatology centers	Very uneven across LGUs
Service Quality Benchmarks		
	Benchmarks	Status
16	International safety and quality accreditation	PHL lags behind competitors in the number of JCI-accredited hospitals
17	Development of national ISQua accreditation system	HealthCORE has been given local training; PHIC Benchbook 57 COEs; PCAHO accrediting special needs
18	International credentials of physicians	Philippine medical education patterned after the U.S.; many doctors have foreign credentials
19	Strong ties with international medical institutions	Number and scale of relationships not known
Care Benchmarks		
20	Good quality of nursing staff	Filipino nurses are known the world over for their technical and caring skills
21	Good base of skilled therapists in spas and health resorts	To be determined.
22	Use of local and natural approaches to health and healing	DOT promoting 7 areas with natural endowments; indigenous healing practices (<i>hilot</i> deep tissue massage and <i>dagdagay</i> foot massage) are not universally offered; use of indigenous plants and organic ingredients need to be promoted.
Travel and Accommodation Benchmarks		
23	Special visa for medical tourists	Philippines announced in 2011 that a medical travel visa will be introduced
24	Airlines providing models for best medical tourism packages	Philippine Airlines, Cebu Pacific, and other carriers slow to take up the challenge
25	Specialized medical services and facilities in airports	Highly inadequate relative to competitor countries
26	Specialized travel agencies with medical tourism logistics	PMTI provides a local model
27	Providers’ good ability to respond to the special needs of clients	Hospitals involved medical tourism are in or near central business districts; PMTP hospitals are increasingly providing

		non-medical services (Internet, tour and travel, restaurants, halal food); a significant proportion (43.8 percent) have international patient centers and language translation services
Financing Benchmarks		
28	Transparent and responsive pricing of services	Lack of transparency in pricing
29	Moving from individual tourists to corporate tieups with employers	Not known
30	Strong ties with international health insurance companies	20 PMTP hospitals have health insurance tieups with 32 international HMOs, PPOs, and other health insurance firms

Sources: This study; see body of this report for details. See also accompanying paper, "The Emerging Trends in Medical Tourism." Note: The findings in this table were based solely on the review of the literature. They need to be validated by the industry stakeholders.

D. S.W.O.T. Analysis

The matrix below summarizes the results of the S.W.O.T. analysis.

E. Next Steps

To invigorate the industry, the following are the suggested next steps:

- a. Commission an international consulting firm, with local counterparts, to conduct a comprehensive study on the medical tourism industry covering its global competitive advantage and market niches, the binding constraints, its future prospects, and needed policy thrusts².
- b. Undertake follow-on information gathering and analytical work that can be included for funding under any of the three departments' (DOT, DTI, DOH) research programs, including a standard set of data that need to be produced on a regular basis.
- c. Based on the results of the study, prepare a sector-wide business strategy and plan.
- d. Mount a media campaign abroad to promote medical tourism in the country.

² The draft scope of work is in Annex 1.

S.W.O.T. Analysis of the Philippine Medical Tourism Industry, 2013

<p><u>Strengths</u></p> <ol style="list-style-type: none"> 1. Good quality care through internally driven quality improvement programs in top-notch health facilities 2. Clear price advantage in many medical and surgical procedures 3. Large pool of qualified, English-speaking, and caring health and tourism professionals 4. Captive market consisting of the Filipino diaspora 5. Proximity to the Pacific and Micronesia 6. Tropical climate/environment and cultural openness 	<p><u>Weaknesses</u></p> <ol style="list-style-type: none"> 1. Lack of data to determine the parameters of the industry 2. Lukewarm cooperation of some of the major industry stakeholders 3. Lack of strong brand recognition abroad 4. Long and costly international travel to Manila and airport infrastructure deficits 5. Lack of portability of insurance plans among OECD medical tourists 6. Downside of a strengthening peso 7. Administrative barriers to entry in LGUs and CHDs 8. Weak synergy between medical and travel-service providers
<p><u>Opportunities</u></p> <ol style="list-style-type: none"> 1. Improving global perception of the Philippine economy and tourism 2. Continued aging of the population in originating countries, thus increasing demand 3. Continued high-cost care in advanced countries that engenders medical outsourcing 4. Many segments of care can be exploited 5. Government commitment to PPP as an approach to develop sectors including health and tourism 	<p><u>Threats</u></p> <ol style="list-style-type: none"> 1. Intense competition from current market leaders as well as rapidly emerging destinations 2. Lack of price transparency and wide variation in local prices in hospital and clinic procedures 3. Slow prosecution of medical malpractice cases and lack of malpractice framework for cutting-edge procedures 4. Pre- and post-operative risks of combining health + holiday, and possible discontinuity of care 5. Potential crowding out of domestic poor patients and other adverse equity effects 6. Who will keep the savings – patients, providers, or intermediaries?

Source: This study; see body of this report for details. Note: The findings in this matrix were based solely on the review of the literature. They need to be validated by industry stakeholders.

F. Concluding Notes

Medical tourism is a complex multisectoral endeavor encompassing medical care, health care financing, travel, tourism and accommodation, trade and industrial clustering, communication including social media, and nonmedical service delivery and facilitation. It presents vast opportunities for growth, for creating local employment, for industrialization and skill-building, and for reversing the brain drain. Careful cross-subsidization can bring immense benefits to poorly funded government health facilities. Potential ripple effects exist of higher-end care improving quality in lower-end care. Finally, medical tourism provides a wonderful opportunity for global caring and multicultural exchange.

But medical tourism as a national strategy poses risks. The gains from trade realized through the exploitation of comparative advantage can be cornered by influential intermediaries who are entering the market, leaving patients and providers short-changed. ‘Outsourcing of care’ has a scary ring to it, especially among skeptics (here and abroad) who resist change from the status quo. Quality and continuity of care are medical concerns that providers, financiers, and regulators – and the patient himself – should thoughtfully consider. Ethical and legal issues come to the fore for procedures not yet approved, or considered illegal, in the patient’s originating country. Public subsidies to invigorate the industry can end up with, and cornered by, the wrong parties, if these types of incentives are not targeted well. White elephants can ensue from poorly designed and implemented industrial clustering initiatives.

Because medical tourism is a game-changing opportunity, more open conversation is needed on its prospects and concerns, even as the Philippines and the rest of the world race to embrace this phenomenon. The conversation, however, has to be informed by data, analysis, and logic rather than hype.

Chapter I. Background

“Once your treatment is over, you will be able to pamper yourself in a tropical locale of your choice. And there are many to choose from: the Banaue Rice Terraces, the Chocolate Hills of Bohol, the world’s longest Underground River in Palawan, unique wildlife... Nor do you have to recuperate on your own – Bring your family with you and let them watch over you as you recover. Now you can have your cake and eat it, too. Philippine health tourism lets you avoid the high cost of treatment and the long wait, and you can still have the holiday of a lifetime with your family.”

Allan E. Miller, retired airline pilot
writing from Bali Hai Resort, Bauang, La Union
<http://www.balihai.com.ph>

This discussion paper responds to a request by the Department of Tourism (DOT) for an analysis of the medical tourism industry in the Philippines. The report acquaints policymakers in the DOT, the Department of Trade and Industry (DTI), and the Department of Health (DOH) with the key industry issues and prospects for the purpose of initiating a longer-term effort of strategic planning that will underpin its future growth and improve its market share. Given the tight deadline, the report simply provides a quick review of the relevant literature.

Section II of the paper analyzes the market for medical tourism; section III analyzes the demand aspects of the Philippine industry; section IV analyzes the supply aspects; section V performs a benchmarking exercise; Section VI conducts an analysis of the strengths, weaknesses, opportunities, and threats (SWOT) of the industry; and section VII discusses next steps.

The paper was presented to the technical working group on medical tourism at the Board of Investment (BOI), Department of Trade and Industry on April 16, 2013 and was attended by Mr. Romulo Manlapig, DTI Assistant Secretary; Ms. Evariste M. Cagatan, Director, DTI/BOI; Ms. Cynthia Lazo, Director, DOT; Ms. Joy Lachica, DTI/BOI; Ms. Reggie Carreon, DOT; Dr. Criselda Abesamis, DOH; Dr. Butch Tiongson, DOH; Ms. Cherrie May Nuez, DTI/BOI; Ms. Patricia Bustamante, DTI/BOI; and Ms. Christine Marie Mendoza, DOH. Also in attendance were Oscar F. Picazo, Danica Aisa Ortiz, Melanie Aldeon, and Nina de la Cruz, PIDS. Subsequent meeting was held with Mr. Marc Daubenbeuchel, executive director of the Retirement and Healthcare Coalition, at DTO on September 3, 2013.

The history of medical tourism in the Philippines can be traced as early as the 1960s when the country became known as a destination for faith healing, with medical tourists coming from the U.S. and Europe. In the 1970s, then President Marcos established medical centers of excellence consisting of the

Philippine Heart Center³, the National Lung Center, the National Kidney and Transplant Institute, and the Philippine Children's Medical Center, all located within a kilometer radius of each other in the central business district of Quezon City . The original intention of turning the country into a hub for medical tourism in Asia was averted when Marcos was overthrown in 1986.

In the mid- to late-1980s, Dr. Alfredo Bengzon began putting together a team dealing with stem cell therapy at the Medical City. Since the early 1990s, the National Kidney and Transplant Institute and the Lung Center of the Philippines have also pioneered the use of stem cell therapy for kidney and lung conditions.

In the field of cosmetic surgery, in late 1990s/early 2000s, leading doctors (notably Dr. Francisco Lucero and Dr. Carlos I. Lasa) used the Internet to market their plastic surgery services to patients in the U.S. and Europe (Porter, et al., 2008). In 1993, Dr. Vicki Belo's Dermatology and Laser Clinic began catering to foreign patients particularly Filipino-Americans.

In 2004, riding on the wave of rapidly growing number of global medical tourists, President Gloria Macapagal Arroyo launched the Philippine Medical Tourism Program (PMTP) under the Department of Tourism (DOT). She then issued Executive Order 372, series 2004 which aimed to develop the communications, logistics, and health and wellness industries involved in medical tourism. The EO created the Public/Private Sector Task Force for the development of globally competitive Philippine service industries. She then issued Executive Order 571, series 2006 which created a Public/Private Task Force on Philippine competitiveness.

In 2005, the BOI included health and wellness products and services as preferred activities in the Investment Priorities Plan (IPP). The Philippine Economic Zone Authority (PEZA) also issued Board Resolution No. 06-512 approving the guidelines for the registration of medical tourism special economic zones (medical tourism parks/centers) and medical tourism enterprises under Republic Act 7916, as amended.

In 2006, the Philippines held its first Medical Tourism Congress, followed in 2007 by the Second International Medical Tourism Conference. Many observers note that medical tourism became a truly global phenomenon starting in 2006.

³ Established in 1975, PHC became an important center for cardiac care in the Asia-Pacific region because of its foreign-trained medical personnel, state-of-the-art facilities, and advanced medical care and research. PHC was at the forefront of developing bio-prosthetic valves and prototype medical equipment. It was a trailblazer in coronary angioplasty in the region (PMTI, 2010).

Chapter II. The Global Market for Medical Tourism

“The aging of the population globally and the fact that people are living longer and enjoying more retirement time means ... that there is growing number of people with higher discretionary incomes and more time to travel.”

Paffhausen, Peguerro, and Roche-Villareal
cited by Vequist (n.d.)

“Mercedes product at a Toyota price.”

Dr. Milstein, Bumrungrad International Hospital
Bangkok, quoted by
Libby Peacock (n.d.)

Traveling outside one’s residence to seek medical treatment in another place where care is available has been going on for centuries. At an individual level, there is nothing new in the 21st century phenomenon of health-related mobility. However, the upsurge in the number of medical tourists over the past decade is new at a collective level, for it is being driven by demographic, economic, and technological forces outside the individual patient or individual provider. While medical travelers from poor and emerging economies have traditionally sought more sophisticated medical treatments in advanced or industrial economies, the trend is being reversed. This reversal is the marked characteristic of modern medical tourism.

Medical tourism has also sparked debate about the wisdom of globalizing health care through trade. Piazzolo and Zanca (2010) use conventional Ricardian model of international trade for health care industries in the U.S. and in India to illustrate that specialization and free trade result in gains from international trade. By adopting the model of comparative advantage to the costs of medical surgeries, the authors show that trade between the two countries is beneficial to both of them. They conclude that “by specializing on the type of surgery they are most efficient in producing, it {medical tourism} will enhance the well-being of both nations.”

Of course, medical tourism is far more complex than what neoclassical economic theory suggests, as we will show in this paper.

A. Definition and Scope of the Trade in Health Services

Health tourism was first categorized as a commercial activity by the International Union of Travel Officials in 1973 (Paffhausen, Pequero, and Roche-Villareal, 2010). The term emerged in the Tourism Management Journal in 1987 (cited by Ko, 2011). The World Trade Organization later identified

it as one of the four modes of supply (Mode 2) through which services can be traded⁴ (Table 1). Under the WTO guidelines, a country that offers medical tourism services to foreign patients (the destination country) therefore becomes an exporter while the patient’s home country (the originating country) becomes the importer of health services. Today, the phenomenon is more commonly referred to as medical tourism, although there is no agreement on what the term covers.

Table 1. WTO’s Modes of Supply and Examples in the Trade of Health Services

Modes	Trade in Health Services ⁵	Trade in Ancillary Services ⁶	Associated Trade in Goods ⁷
Mode 1 – Cross-border supply	Shipment of lab samples, diagnosis, and clinical consultation via mail or electronic delivery (e.g., telemedicine)	Distance medical training; medical transcription	Health and health care equipment, pharmaceuticals, medical waste, prostheses
Mode 2 – Consumption abroad	(a) Medical tourism; (b) Educational services provided to foreign students (c) Medically assisted residence for retirees ⁸	Hotel, restaurant, paramedical services, etc. associated with medical tourism; training of foreign nationals; foreign owned or sponsored medical education or research facilities	
Mode 3 – Commercial presence	Foreign investment in the health services sector in another country, establishment of hospitals, clinics, etc.	Foreign owned or sponsored medical education or research facilities	
Mode 4 – Presence of natural persons	Movement of health personnel, including both temporary and permanent flows, e.g., US hospital recruiting foreign nurses	Cross border movement of medical personnel for purposes such as training	

Sources: WTO, GATS Part I, Article I.2; Cattaneo (2009) as cited by Vequist (n.d.)

Definition and Classification – Medical tourism “refers to the act of traveling to another country to seek specialized or economical medical care, well-being and recuperation of acceptable quality with the help of a support system (Deloitte, n.d.) (b). Medical tourists can be classified according to the point of reference, type of services availed of, and concerns of the patient.

⁴ Two other types of health services need to be mapped in the WTO matrix: (a) the increasing outsourcing by American and European pharmaceutical firms and research institutes of clinical trials in emerging economies; and (b) medical missions from advanced countries going to poorer countries.

⁵ This column was lifted from WTO.

⁶ Cattaneo (2009) as cited by Vequist (n.d.).

⁷ Cattaneo (2009) as cited by Vequist (n.d.).

⁸ From Cattaneo (2009) as cited by Vequist (n.d.).

A major industry weakness is the absence of an agreed upon definition and classification of medical tourists. Deloitte (2008) classifies medical tourists on the basis of their origin: (a) outbound medical tourists – U.S. and European patients traveling to other countries to receive medical care; (b) inbound medical tourists – patients from other countries traveling to the U.S. and Europe to receive medical care; and (c) intrabound medical tourists – U.S. patients traveling within the U.S. to receive medical care outside their geographic area, typically to the center of excellence in another state/region; these are sometimes referred to as domestic medical tourists. (The same holds true for Europeans seeking care within Europe.)

Gonzales, Brenzel, and Sancho (2001) ignore the holiday dimension of medical travel and define medical tourists as those going to another country to consume health care services. However, others argue that because patients travel, medical tourism inherently includes a tourism aspect, i.e., the consumption of associated services such as international and local transport, lodging, and hospitality (Stackpole and Associates, 2010). Finally, post-operative rest and recuperation, whether for major surgery or minor cosmetic or dental surgery, involves lodging and other hospitality expenditures.

Some analysts see the need to distinguish medical tourism from medical travel (Peacock, n.d.): medical travelers travel primarily because of medical reasons while medical tourists obtain medical and related care (e.g., cosmetic, dental, or minimally invasive procedures) as incidental to their being tourists.

Horowitz, Rosenzweig, and Jones (2007) distinguish medical tourists by their type of motivation for traveling to seek care:

- a. Price-oriented – those who avoid the high cost of domestic medical care and search for low-cost alternatives in other countries;
- b. Non-insured – includes (i) those who lack insurance coverage and therefore search for cheaper care elsewhere on the basis of out-of-pocket payment, or (ii) those who lack procedural insurance, i.e., those who seek care for non-covered procedures elsewhere;
- c. Displeased with medical policy – includes (i) those dissatisfied with public health care system such as those in Canada and the U.K. , and (ii) those suffering from long waiting times in such countries as the U.S.;
- d. Controversial-issue related – those who seek care for non-FDA⁹ approved novel treatments, or for procedures which they cannot obtain from their home countries on ethical, moral, legal, cultural or social restrictions, e.g., abortion, in-vitro fertilization; and
- e. Protection of privacy – those requiring privacy regarding certain procedures, e.g., gender reassignment or drug rehabilitation.

Other analysts have added new classifications, or are questioning these new classifications (Youngman, 2012) including:

- a. Diaspora medical tourists – those who seek treatment back in their own original country;
- b. Accidental medical tourists – those who unexpectedly get sick while on a holiday;
- c. Retirees – elderly expatriates in a foreign country and accessing health services there;
- d. Cosmetic/leisure tourists – those who consider vacation and convenience in obtaining procedures as key elements during travel; and

⁹ U.S. Food and Drug Administration.

- e. Others – including overseas students who obtain care while schooling, long-term expatriates, transient military personnel, and diplomats.

Cormany (2008) and several authors distinguish six types of medical tourists according to services, as shown in Table 2.

Table 2. Major Products of the Medical Tourism Industry, Late 2000s

Major surgeries	<ul style="list-style-type: none"> • Orthopedic surgeries: hip replacement, hip resurfacing, knee replacement • Spinal procedures: spinal fusion, spinal disc replacement • Limited cardiac procedures: angioplasty, cardiac diagnostic procedures • Gynecological surgeries: partial, total, or radical hysterectomies • Hysterectomy, bilateral salpingo oophorectomy • General surgeries: vascular, stomach and bowel, kidney and urinary, gallbladder removal, hernia repair, cataract surgery, Lasik surgery, hemorrhoid removal, Endo-laser vein surgery • Other medical procedures: bariatric surgery, fertility treatment, oncology, transplants, stem cell treatments, sex reassignment, addiction treatments
Minor surgeries	<ul style="list-style-type: none"> • Dental procedures: dental work, cosmetic dentistry, crowns, bonding, veneers, whitening, bridges, bone grafts, root canals, tooth extractions • Eye, ear, nose and throat treatments
Cosmetic/plastic surgeries	<ul style="list-style-type: none"> • Facial cosmetic surgery: rhytidectomy, eyelid surgery, nose reshaping, brow or forehead lift, ear surgery • Body contouring: liposuction including tummy tuck, breast augmentation, breast lift, thigh lift, lower-body
Diagnostic services	<ul style="list-style-type: none"> • Annual checkups
Alternative therapy treatments¹⁰	<ul style="list-style-type: none"> • Chinese medicine, acupuncture, herbal treatments, ayurvedic treatments • Pancha Karma, tai-chi
Wellbeing/lifestyle remodeling services	<ul style="list-style-type: none"> • Spa therapy, yoga therapy, meditation therapy, holistic therapy, thermal therapy (mineral springs, balneo therapy), thermo therapy, thalasso therapy • Algae therapy, aroma therapy, cryotherapy, electrotherapy, magnetotherapy, mud healing (fango therapy), occupational therapy (stress management), massage, diet and nutritional programs, detoxification, New Age, spiritual tourism

Sources: Gahlinger (2008), Marsek and Sharpe (2009), Smith and Puczko (2009)

The lack of a commonly accepted definition of medical tourism and its various terminologies (travel tourism, transient medicine, international patients, globalized medicine, and outsourced care) has also influenced the design of survey instruments used to assess the size of the industry. Youngman (2013) observes that a survey question asking residents of Western countries whether they would consider going abroad for medical treatment is simplistic if not deceptive as it is highly contingent and assumes the only reason for going for medical treatment abroad is to save money, which is rarely the case.

¹⁰ Stem cell therapy is often included under alternative therapy.

B. Demand, Revenues, and Market Opportunity

The unclear measure of global demand for medical tourism follows from the murkiness of the definition of the term, as explained above. A second source of murkiness is the timing of the study when the demand figures were calculated. Almost all of the global or regional medical tourism studies were done prior to the recession that started in 2006 and lasted well into 2008 and still continues in some European countries. Some of the original studies have been recession-adjusted by their respective analysts, but the original studies are still in the Internet and being quoted.

Some estimates of the measure of demand for medical tourism are as follows.

- a. Using a restrictive definition, McKinsey (2011) estimated the number of global medical tourists in 2008 to be between 60,000 to 85,000. The figure for outbound Americans in the same year was only 5,000 to 10,000.
- b. KPMG (2011) estimated global medical tourists to reach 3.0 million by the early 2010s.
- c. Using a very liberal definition, Deloitte (n.d.b) estimated 750,000 outbound Americans who sought medical care¹¹ in 2007/08. The base model showed this number to grow to 15.75 million in 2017 with an upper bound of 23.20 million and a lower bound of around 10.43 million. Deloitte scaled down these forecasts using a factor of -20 percent for 2007 and -10 percent for 2008, but rebounding back starting in 2009 onward.
- d. Rush (n.d.) estimated U.S. outbound medical tourists in 2007 to be between 50,000 to 121,000.
- e. Using international passenger survey data, Intuition Communication, Ltd. estimated the U.K. outbound medical tourists in 2009 to be 54,000.
- f. Using international passenger survey data, Keith Pollard (2012) of Treatment Abroad estimated that 60,000 U.K. patients traveled abroad in 2010, 41 percent for cosmetic surgery, 32 percent for dental, 9 percent for obesity, and 4.5 percent for infertility treatment.
- g. Josef Woodman in his book "Patients Beyond Borders" estimated more than 2 million international medical patients a year, of whom about 400,000 are Americans (quoted by www.wheremydoctor.com).

Global estimates of revenues from medical tourism also show large variability. For the late 2000s/early 2010s, Deloitte (2008) estimated the revenues from U.S. outbound medical tourists at US\$2.1 billion (2008) and forecast it to grow to US\$27.6 billion in 2013. HealthCORE (2011) cited a global revenue figure of US\$40 billion (2010). The NCPA (2007) cited US\$ 60 billion global revenues in 2006 and projected it to reach US\$100 billion in 2012. Bloomberg was cited by the media as having estimated US\$5 billion revenues in 2012. The Confederation of Asian Industry cited a figure of US\$2 billion revenues in 2012.

¹¹ Those who traveled within the US are called intrabound medical tourists. Foreigners traveling from abroad to seek care in the US are called inbound medical tourists (Deloitte, n.d.).

Factors Affecting Demand – Despite wide variations in the estimated numbers of medical tourists and the revenues they generate, the global market for medical tourism is indeed growing rapidly, and this can be explained by demographic, epidemiological, economic, technological, communication, and transportation factors.

(a) Economic factors – Increasing medical costs in industrial countries is the main reason driving medical tourism. Medical costs in emerging Asian economies can be as little as 10 percent of comparable care in the US (Deloitte, n.d.)(b). Table 3 shows estimated price differences of 15 surgical procedures frequently used in outbound medical tourism programs. From the point of view of insurance plans, falling profit margins due to high cost of providers in industrial countries provides incentives for them to seek comparable care elsewhere.

Table 3. Price Comparison of U.S. vs. Foreign Surgical Procedures, US\$, 2008¹²

Procedures	U.S. Inpatient Price	U.S. Outpatient Price	Ave. of 3 Lowest Foreign Prices ¹³
Knee surgery	11,692	4,686	1,398
Shoulder angioplasty	6,720	8,972	2,493
Transurethral prostate resection	4,669	3,737	2,698
Tubal ligation	6,407	3,894	1,412
Hernia repair	5,377	3,903	1,819
Skin lesion excision	7,059	1,919	919
Adult tonsillectomy	3,844	2,185	1,143
Hysterectomy	6,542	6,132	2,114
Haemorrhoidectomy	5,594	2,354	884
Rhinoplasty	5,713	3,866	2,156
Bunionectomy	6,840	2,706	1,682
Cataract extraction	4,067	2,630	1,282
Varicose vein surgery	7,993	2,685	1,576
Glaucoma procedure	4,392	2,593	1,151
Tympanoplasty	5,649	3,787	1,427

Source: Deloitte Development LLC 2008, as quoted in Deloitte (n.d.) (b).

Lengthy waiting time for elective surgeries in industrial countries is also forcing patients to look outside their country of residence. The publicly-funded systems of the U.K. and Canada are associated with long waiting times in elective surgeries. In Canada, the average waiting time for patients undergoing joint replacement surgery is 253 days; cataract surgery, 128 days; coronary arterial bypass graft surgery, 71 days; and MRI examination, 29 days (CMA, 2008 as cited in Grail Research, 2009). Among Canadians needing knee replacement surgery, 30 to 40 percent wait longer than the government benchmark for acceptable care of 26 weeks (KPMG, 2011).

In the United Kingdom, the average waiting time for trauma and orthopedics is 10.9 weeks; oral surgery, 10.5 weeks; neurosurgery, 9.5 weeks; plastic surgery, 7.5 weeks; general surgery, 7.4 weeks;

¹² Last two columns of the table were added by the author.

¹³ Including travel costs.

dermatology, 6.8 weeks; and cardiology, 5.2 weeks; most other specialties record average waiting times in excess of 2-3 weeks (Alten, Singal, and Kara, n.d.).

The U.S., with a largely private system of funding, performs better. Only 8 percent of surveyed American patients in the 2007 Commonwealth Fund study of 6 OECD countries (cited by Doherty, 2010) reported a waiting time of four months or more for elective surgery, compared to 33 percent in Canada and 41 percent in the U.K. However, the U.S. had the largest percentage of patients (61 percent) who said that getting care on nights, weekends, or holidays without going to the emergency room was very difficult or somewhat difficult.

Waiting time has high opportunity costs in industrial countries because of the higher salaries and standards of living. In contrast, in the Philippines, one hospital reported no queue time, i.e., the patient is cared for immediately, while another hospital reported a queue time of only 3 days to 1 week depending on the procedure to be done (BOI TWG, 2012).

The size of the uninsured and underinsured populations also accounts for some of the medical tourists' surging number. Prior to Obamacare¹⁴, it was estimated that 47 million American residents (including illegal aliens) were uninsured. In Western Europe where the immigrant population is also growing, the proportion of uninsured population may also be growing. For this population segment, out-of-pocket spending is the only recourse to health care financing, forcing uninsured people to be cost-conscious and to seek less expensive providers outside their residences.

Under-insurance can also drive patients to medical tourism. Elective surgery is not usually covered by basic health insurance. Cosmetic surgery and some dental procedures are not covered either. These procedures have to be paid for through out-of-pocket means, and the patient needs to seek inexpensive providers to economize.

Interestingly, health reforms are being cited as a key driver of medical tourism. In a survey done by ExHealth and reported by Stephano (2011), 31 percent of the key informants interviewed said that the U.S. health care reform will greatly increase outbound patients, while 21 percent opined that the E.U. directive on health care reforms will see increased movement of patients outside the European Union.

Teh and Chu (2005) noted that the tightening of immigration rules and security checks in the U.S. contributes to increasing medical tourism in emerging economies. According to them, "the U.S. has seen a decline in the number of foreign patient visits. More patients especially those in the Middle East are moving to other alternatives," initially to Europe and lately to Asia and other Middle Eastern countries.

The changing dynamics of demand and greater consumer role in health care decisions is an under-appreciated factor driving medical tourism, which used to be limited to the wealthy. Today, the middle classes in advanced and emerging economies also travel for care as airfare has become more affordable, and as less expensive medical care of comparable quality became available in middle-income countries. Because of this trend, consumers now have a greater say in health care decisions than they were in the past. In a survey of Americans done by Deloitte (n.d.), almost 39 percent said they would go

¹⁴ The U.S. health insurance reform initiated by U.S. President Barack Obama mandating all Americans to obtain health insurance coverage.

abroad for an elective procedure if they could save half the cost and assured quality was comparable. This figure is as high as 56.8 percent among Asian-Americans.

Total economic savings from medical tourism are significant. The 2008 study done by McKinsey estimated 710,000 procedures performed outside the U.S. with an average savings per procedure of US\$15,000, which yielded US\$10.7 billion total estimated savings for patients, payors, and employers. Because of outsourcing, the total loss for US hospitals was estimated to be US\$35 billion. Because savings to the patients, payors, and employers translate to losses of U.S. hospitals, medical tourism would have major political repercussions in the health sector of industrial countries.

(b) Demographic and epidemiological factors – The aging population in industrial countries is feeding the growth of global medical tourism. The baby boomer generation has aged; in the U.S., there were 78 million people born between 1946 and 1964. By 2030, this population (age 66 to 84) will reach 61 million and in that year, there will be an estimated 9 million Americans born prior to 1946. By 2030, 19 percent of the American population will be 65 years or older. The same aging trend is also occurring in Western Europe, Canada, Australia, and New Zealand (Wendt, 2012). This baby boomer population will require expensive medical treatment and care, much of which has become prohibitive in advanced countries.

Generations X and Y – those born in the latter 1960s and in the 1970s – have also gotten old. They are now in their 50s and 40s, and will reach retirement age in a decade or two. Thus, Generations X and Y will continue to feed the growing medical tourist market well into the next two decades. Indeed, some observers note that Generations X and Y may well dominate medical tourism market in the next few years, rather than the baby boomer generation.

Studies have confirmed the willingness of these American age cohorts to seek care abroad. Karuppan and Karuppan (2010) found that 81 percent of medical travelers were under the age of 50. In their survey, Keckley and Underwood (2009) found that 37 percent of baby boomers, 42 percent of Generation X, and 51 percent of Generation Y were willing to undergo surgery abroad.

Add to these is a little known fact that more than half of the U.S. workforce will be of second- or third-generation foreign descent in the next 25 years (Deloitte, n.d.)(b). For foreign-descent residents in the U.S. and Europe, homecoming visits are often planned with elective or cosmetic surgeries. Filipino residents in the U.S. alone are estimated to number more than 2 million.

The aging population in Western countries also means increasing health-service supply constraints because of (a) large number of retiring health workers, and (b) increasing number of health workers who are leaving the health profession much earlier than expected. The U.S. is currently experiencing a severe doctor shortage, and one study in 2010 found that 14 percent of U.S. physicians will retire in the next five years while 34 percent will do so in the next ten years (Wendt, 2012). The American Dental Association also expects a significant proportion of dentists to retire over the next 20 years (Deloitte, n.d.)(b).

The changing burden of disease in the world is also contributing to movements of people seeking care, for instance, from poorer countries to more advanced ones. Non-communicable diseases (NCDs) have rapidly risen globally, leading to greater hospitalization. The global burden of disease study of 2010 published in *The Lancet* (Volume 380, December 2012) reveals three massive shifts in health

trends globally since 1990¹⁵: (1) The world has grown considerably older. (2) Where infectious disease and childhood illness related to malnutrition were once the primary causes of death, now more people are dying from heart disease, cancer, and other chronic disorders. (3) Disease burden is increasingly defined by disability instead of premature death, with more of the burden now being caused by musculoskeletal disorders, mental health conditions, back and neck pain, and injuries.

(c) Technological, communication, and transport factors – New medical and health technologies have allowed patients greater leeway in sourcing care, and not being limited to their residential cities and towns. For instance, many medical procedures have become less invasive (e.g., lithotripsy), decreasing the discomfort of recovery and thereby allowing patients to travel for care. Moreover, many former inpatient procedures can now be done on an outpatient basis. Between 1996 and 2006, the number of outpatient procedures in the U.S. tripled (Deloitte, n.d.)(b), and some patients are finding that it is cheaper to have these procedures in emerging economies.

The easy availability of information from the Internet and social media has empowered consumers to seek care where they can. Vequist (n.d.) reports a 2009 Pew study finding that 55 percent of American Internet users in 2008 looked for online information about treatments and procedures, up from 47 percent in 2002. In the same study, 60 percent of e-patients (or 37 percent of American adults) have done at least an Internet search related to health. Vequist (n.d.) also reports a 2010 study of the Center for Medical Tourism that among medical tourists, the overwhelming majority (75 percent) sourced their information from the Internet; the competing sources of information were minor, e.g., friend (25 percent), family members (16 percent), magazines (15 percent), doctor (14 percent), newspapers (12 percent), advertisements (11 percent), colleague (11 percent), and medical tourism facilitator (7 percent). Vequist (2008) also notes that according to a 2008 Pew Trust study, the online health tools found to be useful by medical tourists were general search engines (67 percent reporting), health portals (46 percent), social media (34 percent), medical association sites (25 percent), and health plans (22 percent).

The increasing sophistication of the travel industry enables patients to move. It is far easier to travel now than decades ago. The elimination of visa restrictions among many countries as well as more affordable airfares has also contributed to the increased volume of medical tourists.

(d) Legal, ethical, and social factors – Some medical tourists are also prompted by the availability of certain cutting-edge technologies in destination countries, e.g., stem cell therapies, sex-change reassignment, and organ donations, which are not approved by regulatory authorities or are difficult to avail in their home countries. Procedures which require anonymity and discretion, e.g., drug rehabilitation and mental health, can also push patients to travel outside their cities or countries.

(e) Rise of emerging economies as alternative providers of modern health care – The growth of comparable care in emerging economies is one of the most dramatic phenomena in health care in modern times. Increasing investments in the number of internationally-accredited facilities in emerging economies have improved the quality of care and their apex hospitals and thereby improved the perception among prospective patients. Grail Research (2009) noted that over 220 health care organizations in 33 countries have received JCI accreditation. Deloitte (2008, n.d.) noted that supply is the binding constraint for higher demand in the future.

¹⁵ Summary lifted from the poster published jointly by The Lancet, the University of Washington, and the International Health Metrics and Evaluation. www.healthmetricsandevaluation.org/gbd.

The removal of key bottlenecks that consumers in industrial countries were formerly concerned about literally opened the gates to large-scale migration of medical tourists in the late 1990s and throughout the 2000s. The rapid economic growth in emerging economies has improved sanitation and environmental hygiene as well as safety and security in these countries, issues that were foremost in the minds of potential medical tourists in years past.

Major Destinations of Medical Tourists – According to Wikipedia (2013), 50 countries are now involved in medical tourism, but the president of the U.S. Medical Tourism Association cites a smaller number of 35 (Stephano, 2011).

Grail Research (2009) quotes a Malaysian hospital manager that traced the origins of modern medical tourism in Latin American countries which “have been in it for more than 15 years...” However, in 1997-2000 the current of medical tourists changed dramatically when they began streaming into India, Thailand, and later to the other Southeast Asian countries (notably Singapore, Malaysia, and in the late 2000s, the Philippines). One analyst (Peacock, 2013) observed that medical tourism hit big-time in Thailand in 1997 as a result of the Asian financial crisis when Bumrungrad International Hospital ran out of domestic patients and re-directed its marketing efforts abroad and struck gold. Today, Asia garners the lion’s share in the global market for medical tourists, as illustrated in Table 4. Asian countries attract medical tourists from all continents except Latin America.

Table 4. Medical Tourists by Source and Destination, Mid/Late 2000s

From	To				
	Asia	Europe	Latin America	Middle East	North America
Africa	95%	4%	1%	-	-
Asia	93%	1%	-	-	6%
Europe	39%	10%	5%	13%	33%
Latin America	1%	-	12%	-	87%
Middle East	32%	8%	-	2%	58%
North America	45%	-	26%	2%	27%
Oceania	99%	-	1%	-	-

Source: The McKinsey Quarterly, Health Care (2008), Mapping the Market for Medical Travel¹⁶, as cited in Grail Research (2009)

Where do medical tourists go? There are so many figures floating around in the Internet about the numbers of medical tourists going to specific destinations. However, Table 5 appears to be the most comprehensive listing of medical tourist destinations (Youngman, 2010). It places the Philippines 11th in the world and 5th in East and South Asia, with Taiwan and South Korea on the heels of overtaking the Philippines. In the last column, the other estimates gathered from various sources are also shown.

¹⁶ The author was unable to obtain the original article from which this table appeared. However, reviews of the McKinsey study by other analysts indicate the use of a restrictive definition of “medical tourists.” The Deloitte global study appears to use a more liberal definition, but unfortunately no similar table as the one above is available from that study.

Table 5. Top 20 Medical Tourist Destinations, 2010

Country	Rank Worldwide	Rank in East/South Asia	Number	Other Estimates from Various Sources
Thailand	1	1	1.2 million	1.25 million in 2005; 1.2 million in 2006
Singapore	2	2	600,000	410,000 in 2006
U.S.A	3	-	400,000	
India	4	3	370,000	450,000 in 2007
Malaysia	5	4	350,000	300,000 in 2006
Hungary	6	-	330,000	
Poland	7	-	300,000	
Slovenia	8	-	300,000	
Jordan	9	-	210,000	
U.K.	10	-	100,000	
Philippines	11	5	80,000	60,000 in 2007
Germany	12	-	70,000	
South Korea	13	6	60,000	
Taiwan	14	7	60,000	
Belgium	15	-	50,000	
Brazil	16	-	40,000	
Turkey	17	-	40,000	
Mexico	18	-	35,000	
Israel	19	-	30,000	
Colombia	20	-	27,000	

Sources: Columns 1 and 4 are from Youngman (2010), as cited by HealthCORE (2011). The last column is from a variety of sources, but not from Youngman (2010).

The above ranking is based solely on medical tourist arrivals. Forbes, a business magazine, had made its own top-ten list for medical tourism and came up with the following: 1. Australia – for affordable cardiology, neurology, and orthopedic surgeries; 2. China – for advanced stem cell treatment; 3. South Africa – for dental procedures and proximity to the U.S.; 4. India – for price competitiveness especially of orthopedic and cardiovascular surgeries; 5. Israel – for some of the best doctors in the world; 6. Japan – for extremely advanced cancer treatment; 7. South Korea – for orthopedics and advanced cancer treatment; 8. Mexico – for dental procedures and hip replacement; 9. Singapore – for the services of the Parkway Hospitals network; and 10. Thailand – for the services of Brumungrad Hospital (www.forbes.com).

Another ranking, done by www.whereismydoctor.com in 2011, puts the Philippines 7th in the top ten. The ranking is as follows:

- #1 Mexico, for bariatric surgery, plastic surgery, hair transplant surgery, dental care, and infertility treatments;
- #2 India, for heart surgery, orthopedic surgery, infertility treatments, and surrogacy;
- #3 Costa Rica, for dental care, plastic surgery, and infertility treatments;

- #4 Turkey, for eye care, hair transplant surgery, bariatric surgery, plastic surgery, heart surgery, orthopedic surgery, organ transplants, and dental care;
- #5 Malaysia, for plastic surgery, dental care, bariatric surgery, and hair transplant surgery;
- #6 Colombia, for plastic surgery and infertility treatments;
- #7 Philippines, for dental care and plastic surgery;
- #8 Thailand, for dental care, plastic surgery (especially for gender reassignment), bariatric surgery, heart surgery, and orthopedic surgery;
- #9 Panama, for plastic surgery and infertility treatments; and
- #10 Brazil, for plastic surgery and neurology.

In Asia, the key players in medical tourism are Thailand, Singapore, India, and Malaysia (see Table 6).

Table 6. Destination Countries of Medical Tourists

Countries	Cost	Remarks on Services Offered and Treatment Options	Remarks on Clientele
Thailand	Ave. 30% of US	Alternative medicine, cosmetic surgery, dental care, gender reassignment, heart surgery, obesity surgery, oncology, and orthopedics	Medical tourism hub in Asia owing to its central location and well-developed tourism industry; popular among Western Europeans
Singapore	Ave. 35% of US	Organ transplants, stem cell therapy, and other high end procedures	Modern state and technology advantage,
India	Ave. 20% of US	Alternative medicine, bone marrow transplant, cardiac bypass, eye surgery, and hip replacement	Major hub for medical tourism centered in Pune; specializes in more complex procedures due to cost advantage
Malaysia	Ave. 25% of US	Cardiovascular surgery, cosmetic surgery, dental care, eye surgery, general surgery, orthopedics, and transplant surgery	Caters to U.K. patients, Muslim patients, and those coming from nearby countries; relative nearness to African countries provides it and Singapore with travel cost advantage, relative to the Philippines, which require another leg of travel lasting 3-4 hours.
Philippines ¹⁷	n.a.	Dental and cosmetic surgery, hip and knee replacements, heart bypass and other cardiac procedures, eye care, stem cell therapy, cosmetic surgery	Has a large Filipino diaspora market; most foreign patients come from Pacific Rim and Micronesia
South Africa	30% to 40% of US	Specializes in safari tours involving cosmetic surgery	Largely sub-Saharan Africans ¹⁸
Hungary	40% to	Mainly dental and cosmetic surgery	Mainly Europeans, especially U.K.

¹⁷ Datum not in the original Deloitte (n.d.) study, and was added by the author.

¹⁸ Fact added by the author.

	50% of US		
Mexico	25% to 35% of US	Mainly dental and cosmetic surgery	Mainly US
Brazil	40% - 50% of US	Reliable cosmetic surgery	Attractive to US due to proximity
Costa Rica	30% - 40% of US	Mainly dental and cosmetic surgery	Mainly US

Sources: Figure 5, Medical Tourism and Medical Traveling, of Deloitte (n.d.)(b) and Grail Research (2009) for column 3; other sources.

Factors Influencing a Patient’s Destination Choice – Jotikasthira (2010) developed an empirical model to analyze potential patients’ choice of medical destination, and then compared Thailand with its Asian competitors (India, Singapore, Malaysia) on these factors. The study finds the following factors critical:

- a. Quality of medical care – This is the most important criterion, and patients set a threshold level for quality (a non-compensatory level).
- b. Cost savings – Beyond the threshold level of quality of care, patients begin to balance additional quality attributes versus cost savings. This is particularly true for price sensitive medical tourists.
- c. Environmental hygiene and safety/security – These are additional two factors that come into play once patients have settled on the first two criteria.

2. It appears from Jotikasthira’s model that touristic/hospitality-industry attributes matter less to the individual patient than medical quality, cost savings, environmental hygiene, and safety/security of the destination.

Chapter III. Philippine Medical Tourism: Demand Aspects

A. Originating Countries of Medical Tourists

The top country-origins of medical tourists in the Philippines are East Asia (China, Japan, Korea, Taiwan), Australia, Americas, Europe/United Kingdom, Gulf States, other Asian countries such as Sri Lanka, and the Pacific Islands (Guam, Palau, Marshall Islands, and Micronesia). These are based on the data provided by three local hospitals in the study by BOI TWG (2012),

The sources of demand for medical tourists in the Philippines include:

- a. Filipino *balikbayans* – residents in the U.S., Canada, Europe, Australia, and other advanced countries who come home as returning Filipinos. The Department of Foreign Affairs estimates that permanent Filipino migrants numbered 4.86 million in 2011. Balikbayans as tourists numbered 197,824 in 2011, up 100.2 percent from 98,831 in 2001.
- b. Overseas Filipino workers (OFWs) – The Commission on Filipinos Overseas estimated 10.44 million OFWs in 2011¹⁹.
- c. Foreign medical tourists looking for less expensive medical care for elective procedures and wellness services – There are no reliable data on foreign medical tourists. However, foreign nationals arriving as tourists in the Philippines numbered 3,998,109 in 2010, up 135.5 percent from 1,698,062 in 2001²⁰.

Estimates of medical tourist arrivals vary widely. Youngman (2012) estimated that in 2010, 80,000 medical tourists came to the Philippines, but this number includes both *balikbayans* and foreigners. Renub Research (2012) claims a much higher figure of 100,000 medical tourists in the Philippines. Medical Tourism (2013) provides a very high approximate of 250,000 non-resident patients in 2006, but cites 100,000 arrivals for the succeeding years, with little explanation for the decline. Local media have variously estimated annual medical tourist arrivals between 60,000 (2007) to 100,000 (2008, 2009), although it is not clear where these estimates come from.

Citing a 2005 DOT visitor sample survey, DTI (2007) cited 0.4 percent as the proportion of tourists who visited the Philippines for health reasons. This proportion certainly looks low; it may be due to the way the question was asked, because many medical tourists combine health with other reasons, e.g., homecoming (OFWs), return (*balikbayans*), or holiday (most tourists). In addition, it is possible that non-*balikbayan* medical tourists will not admit medical tourism as a reason for traveling to the Philippines for fear that immigration authorities may not approve their entry for health reasons.

Using Youngman's (2012) estimate of medical tourists (80,000) and dividing this by the total number of visitors (foreigners and *balikbayans*) of 4,195,933 in 2010 yields a proportion of 1.9 percent,

¹⁹ It is debatable whether OFWs should be included as medical tourists since some analysts regard them as returning residents of their country of birth and, therefore, not tourists.

²⁰ President Aquino has raised the tourist arrivals target (foreigners + *balikbayans*) for the period up to 2016 to 56.1 million, up from the original target of 35.5 million.

which is very close to the 2 percent assumed by HealthCORE (2011) in forecasting the demand for medical tourism in the Philippines.

What is the proportion of medical tourists from total tourist arrivals? Data used by the German-Philippine Chamber of Commerce (2010) show that out of the 3.1 million tourists who arrived in 2008, the 100,000 medical tourists translated to 3.2 percent, lower than the proportion recorded in India, Thailand, and Singapore (Table 7). The Philippine proportion would even go lower to 2.6 percent if one uses 80,000 medical tourists.

Table 7. Proportion of Medical Tourists Out of Total Tourists in Selected Asian Countries, Late 2000s

Country	Total Tourists (Millions)	Medical Tourists (Millions)	% of Medical Tourists to Total Tourists ²¹
Thailand (2007)	14.46	1.20	8.3%
Singapore (2007, 2008)	10.12	0.41	4.0%
Malaysia (2008)	22.05	0.34	1.5%
India (2005, 2007)	3.90	0.45	11.6%
Philippines (2006, 2008)	3.10	0.10 ²²	3.2%

Source of basic data: German-Philippine Chamber of Commerce (2010)

Medical tourist receipts are also a matter of conjecture in the Philippines:

- a. For 2006, Porter et al. (2008) cited US\$350 million in receipts (or 14 percent of the Asian market), based on estimated medical tourists of 250,000. This reflects an average spending of US\$1,400 per medical tourist. (High assumed volume but low assumed per tourist spending, as it turns out.)
- b. For 2007, then-undersecretary of the DOH Jade del Mundo²³ cited PHP1.056 billion in revenues, from a count of 28,143 medical tourists obtained from a survey of 17 hospitals. This implies an average expense per medical tourist of PHP37,523, or about US\$833 (at the then prevailing exchange rate of US\$1=PHP45). He also reported revenues of PHP1.854 billion from drug rehabilitation services. If these two amounts are added, then total revenues for that year would be PHP2.91 billion, or an average spending of PHP103,400 (equivalent to US\$2,300 per medical tourist).
- c. For 2008, DOT estimated that a medical tourist spent an average of US\$2,000.
- d. For 2009, Pinoylifestyle.com reported that each tourist spent an average of US\$3,500 during his/her stay in the country. No source was provided for the figure.
- e. In 2007, DTI forecasted the medical-tourism receipts in Central Luzon (DTI, 2007) assuming 10 days' stay of PHP1,000 spending per day, which seems low for medical tourism.

²¹ Data on this column was calculated by the author and was not in the original presentation.

²² This figure is higher than the 80,000 medical tourists in the Philippines reported by Youngman (2012) for 2010. If Youngman's figure is used, the proportion of medical tourists to total tourists would go down to 2.6 percent.

²³ DOH Undersecretary, based on consolidated data of 17 Metro Manila hospitals, as reported by ABS-CBN News (2008).

- f. HealthCORE’s (2011) estimate of the per capita medical tourist spending ranged from US\$3,213.28 in 2000 to US\$1,780.46 in 2010, a consistent decline, which was not explained.

The wide variation in these figures (US\$1,400 to US\$3,500) shows either a real change in the types of tourists or procedures availed of by medical tourists through the years, or just sheer guessing. To resolve this problem, a thorough study should be done on departing medical tourists. The use of an average figure is also ill-advised as the range of services offered in the Philippines is very wide, and their attendant costs also exhibit wide variance.

B. Price Competitiveness

Naïve Price Comparisons – Tables 8 and 9 show the price comparison²⁴ of selected surgical procedures between the Philippines, the U.S. and competing destination-countries. In both tables, the Philippine data were sourced from two top-rated hospitals involved in medical tourism (BOI TWG, 2011), and were compared to the Deloitte data and the KPMG data. Clearly, the lower-priced hospital in the Philippines is the lowest-priced in the region in all the four surgical procedures considered (Table 9). For hip replacement, the two Philippine hospitals had the lowest cost (US\$5,000), lower than India’s (US\$5,800), about half that of Singapore’s (US\$9,200), and 60 percent cheaper than Thailand’s. The price of knee replacement procedure is also cheaper in the Philippines. Thus, excluding airfare costs, Philippine hospitals involved in medical tourism are price-competitive with their Asian counterparts.

Table 8. Price Comparison of Selected Medical and Surgical Procedures by Country Using Deloitte’s Study as Basis, in US\$

Procedures	U.S.	India	Thailand	Singapore	Philippines, 2012
Heart bypass	80,000 – 130,000	6,700 – 9,300	11,000	16,500	5,000 – 22,200
Angioplasty	57,000	5,000 – 7,000	13,000	11,200	3,200 – 21,000
Hip replacement	43,000	5,800 – 7,100	12,000	9,200	5,000
Knee replacement	40,000	6,200 – 8,500	10,000	11,100	5,000 – 7,400

Sources: Philippine data were computed on the basis of BOI TWG (2012) using information from two hospitals and using an exchange rate of US\$1=PHP40.5. The data for the rest of the table were lifted from Deloitte (n.d.)(a), citing original data from Medical Tourism Magazine, Issue 2.

Table 9. Price Comparison of Selected Medical and Surgical Procedures by Country Using KPMG’s Study as Basis, US\$

Procedures	U.S. ²⁵	India	Thailand	Singapore	South Korea	Taiwan	Philippines, 2012
Heart bypass	70,000 – 133,000	7,000	22,000	12,900	31,750	27,500	5,000 – 22,200
Hip replacement	33,000 – 57,000	10,200	12,700	15,000	10,600	8,000	5,000
Knee replacement	30,000 – 53,000	9,200	11,500	13,000	11,800	10,000	5,000 – 7,400

²⁴ Most of the medical tourism literature refers to it as “cost comparison” but it is actually “price comparison,” or more specifically, “fee comparison” as the figures quoted are fees charged by physicians and hospitals, not their actual costs.

²⁵ U.S. hospital prices for patients without insurance coverage.

Sources: Philippine data were computed on the basis of BOI TWG (2012) using information from two hospitals and using an exchange rate of US\$1=PHP40.5. The data for the rest of the table were lifted from KPMG (2011).

A third illustration of the country's price competitiveness is shown in Table 10 using data collected by HealthCORE (2011). Again, the Philippines out-prices its North American and Asian competitors in spa services and nose lift, has the second lowest price in Lasik eye surgery and dental bridge after Thailand, and comes close to beating India in heart bypass.

Table 10. Average Prices for Selected Health and Wellness Services, in US\$, in the Philippines, the U.S., and Competing Countries, 2011

Countries	Spa Services	Nose Lift	Heart Bypass	Lasik Eye Surgery	Dental Bridge
Philippines	11 – 100	400 – 1,000	11,000 – 25,000	1,000 – 1,500	360 - 600
U.S.	100 – 200	4,000 – 12,000	90,000 – 144,300	3,000	5,500
India	150 – 200	1,700 – 2,000	8,500 – 10,500	1,900 – 2,500	100 - 600
Thailand	45 - 100	600 – 2,500	23,000 – 25,000	650 – 900	290 - 430
Mexico	100 - 300	3,900 – 4,000	30,000 – 33,000	650 – 900	235 - 440

Source: HealthCORE (2011).

Caveats in Price Comparisons – Price comparisons across countries involved in medical tourism are not standardized, and do not take full account of the total financial costs shouldered by the medical tourist in obtaining care abroad. Three factors must be taken into account in this regard:

- a. Other patient-incurred costs – Youngman (2012) notes that the price quotations in destination countries rarely include all hospital extras, travel and accommodation for the patient and his companion, and other sundry expenses that may double or triple the actual direct cost of the procedure. The non-medical and airfare costs of medical tourism are important considerations that should be taken into account.
- b. Type of financing – Prices vary by type of financing (out-of-pocket, social health insurance, private health insurance, employer-based self-insurance) and the expected level of copayment from the patient who is insured; these factors are not clearly spelled out in the price comparison tables, and the implicit assumption is that the patient will pay out of pocket at the point of service.
- c. Negotiated versus non-negotiated price – An implicit assumption of the cost comparisons is that the procedures would be paid out-of-pocket at the point of service, without prior negotiation from the provider. (This is equivalent to the rack rate in the hotel industry.) However, if the care is purchased under a third-party health insurance or by an employer under a self-insured program, the purchaser usually pays only a fraction of the provider's list price or usual, reasonable and customary fee of the physician. The replacement of out-of-pocket financing with health insurance payment will profoundly affect the level of prices, because the health insurance fund has a stronger negotiating position compared to individual patients.

Even assuming a country's cost advantage, policymakers and program managers should not overly obsess with lower costs. According to a 2008 McKinsey and Co. report, medical tourists seek other things aside from lower costs. Some 40 percent of them seek advanced technology, 32 percent

seek better health care, 15 percent seek faster medical services, and only 9 percent seek lower costs (Yu, 2010).

Experts also warn that the focus on lower costs in marketing can give consumers the perception of lower quality (Wendt, 2011). Medical tourists appear to have a base level of care that they expect, so the focus on cost may send a wrong message. Moreover, affluent customers have less concern for cost, and for these types of patients, some other aspect may need to be highlighted. In any case, the marketing message should be that one gets good quality care equivalent to those obtaining in the U.S. or Europe, but at a lower cost.

Chapter IV. Philippine Medical Tourism: Supply Aspects

A. Hospitals

The medical tourism industry gravitates around the 21²⁶ hospitals under the Philippine Medical Tourism Program (PMTP), although there are other facilities accepting tourists aside from these hospitals. Of the PMTP hospitals, 11 have international accreditations: six from JCI, two from Accreditation Canada, one from Trent, and three from ISO 9001.

- a. Joint Commission International (JCI) – JCI accreditation is deemed the gold standard for service quality and patient safety. JCI is the international affiliate of the Joint Commission of Healthcare Organizations (JCAHO) which is charged with accrediting U.S. hospitals.
- b. Accreditation Canada (AC) – AC is a nonprofit independent organization accredited by ISQua to provide national and international accreditation for health care organizations with an external peer review process to assess and improve services provided to patients. It has over 1,000 clients all over the world.
- c. International Standards Organization (ISO) – ISO 9001 certification is an international management quality framework applied to hospitals as a whole or to their component service units or institutions.

PhilHealth has accredited 14 of the 21 PMTP hospitals as centers of excellence (COE). In addition to the PMTP hospitals, PhilHealth has accredited 43 other hospitals as COE, which are the next rung of hospitals that medical tourists are likely to go to. Table 11 shows the number of PTMP hospitals and their number of beds, which cater to both domestic and tourist-patients. It is not known what percentage of these beds is being used by tourists.

Table 11. Hospitals Under the Philippine Medical Tourism Program, by Location, Ownership, Number of Beds, and Accreditation Status

Hospital	Location	Ownership	Year Est.	Beds	Int'l Accred.	PHIC Accred
East Avenue	Quezon City	G	1978	650	-	-
Lung Center	Quezon City	G	1981	210	-	-
National Kidney and Transplant Institute	Quezon City	G	1983	247	ISO	COE
Philippine Children's	Quezon City	G	1979	200	-	COE
Philippine Heart Center	Quezon City	G	1975	800	AC	COE
Capitol Medical Center	Quezon City	P	1974	300	-	-
St. Luke's	Quezon City	P	1903	650	JCI; TEMOS	COE
The Medical City	Pasig City	P	1967	500	JCI	COE

²⁶ The PMTP lists 20 hospitals, but St. Luke's has two campuses (QC and Taguig City), so the actual number of hospitals is 21.

Cardinal Santos	San Juan City	P	1974	235	-	COE
Manila Doctors	Ermita, Manila	P	1956	300	AC; ISO	COE
UST Hospital	Espana, Manila	P	1945	800	-	-
Makati Medical	Makati City	P	1969	570	JCI, ISO ²⁷	COE
St. Luke's Global City	Taguig City	p	1903 ²⁸	600 ²⁹	JCI ³⁰	COE
Asian Hospital	Muntinlupa City	P	2002	217 ³¹	JCI	COE
Las Pinas Doctors	Las Pinas City	P	1982	100	-	-
Paranaque Doctors	Paranaque City	P	2007	99	-	-
St. Frances Cabrini	Sto. Tomas, Batangas	P	1998	220	-	COE
Cebu Doctors	Cebu City	P	1974	300	Trent	COE
Chong Hua	Cebu City	P	1957	660	JCI	COE
Perpetual Succour	Cebu City	P	1950	250	Trent	COE
Davao Doctors	Davao City	P	1969	250	ISO	-
Grand Total	-	-	-	6,051	11	14

Sources: PMTP; HealthCORE (2011) profiles; Websites of NKTi, St. Luke's Global City, St. Frances Cabrini, Perpetual Succor, etc.

Other hospitals and clinics are also involved in medical tourism aside from the 21 formally identified in the PMTP and these are shown in Table 12. However, it appears from cursory search in the Internet that the government (DOT/DOH) accreditation process has moved very slowly relative to the number of clinics advertising themselves as potential tourist destinations. Many of the original 21 hospitals targeted for medical tourism have not received DOT accreditation; only The Medical City and St. Frances Cabrini Hospital have done so.

Indeed, it is possible that the DOT medical tourism accreditation is seen by providers as just another bureaucratic bottleneck as there are already existing accreditation systems for health care in the Philippines (PhilHealth, PCAHO, ongoing ISQua/HealthCORE), including international ones that carry more weight (JCI, Accreditation Canada, ISO, Trent). What the government should be doing more usefully is to assist local hospitals and clinics get international accreditation, rather than impose yet another set of local accreditation that is just merely duplicative. In any case, the signaling mechanism that the DOT/DOH accreditation system is supposed to provide does not seem to work anyway as it is extremely difficult to get the list of these accredited facilities, and it does not convey enough information to the potential medical tourist.

²⁷ Specific departments

²⁸ Year of establishment of mother hospital, St. Luke's Quezon City

²⁹ Its profile in Medical Tourism cites 650 beds.

³⁰ Same accreditation as St. Luke's Quezon City.

³¹ Its profile in Medical Tourism cites 230 beds.

Table 12. Other Hospitals and Clinics³² Catering to Medical Tourists, by Location, Ownership, Number of Beds, and Accreditation Status

Hospital	Location	Ownership	Year Est.	Beds	DOT Accred.
Cinta Derma Clinic and Spa	Angeles City, Pampanga	P	2009	n.a.	Yes
Dagupan Doctors Villaflor Memorial Hospital	Dagupan City, Pangasinan	P	1980s	100	Yes
Ivision Cataract and Lasik Center	Metro Manila	P	n.a.	n.a.	Yes
Lorma Medical Center	San Fernando City, La Union	P	1934	136	Yes
Mary Mediatrix Medical Center, Inc.	Lipa City, Batangas	P	1994	100	Yes
Metropolitan Medical Center (*)	Sta. Cruz, Manila	P	1962	n.a.	-
Sacred Heart Dental Center	Coloocan City	P	n.a.	n.a.	Yes
San Juan de Dios Educational Foundation (*)	Pasay City	P	1578 ³³	n.a.	-
World Citi Med ³⁴ (*)	Quezon City	P	n.a.	276	-

Sources: DOT list of accredited hospitals and clinics; (*) In Health-Tourism.com website;

B. Stem Cell Therapy

Stem cell therapy treats diseases by introducing new adult stem cells into the damaged tissue of a patient. “The ability of stem cells to self-renew and give rise to subsequent generations with variable degrees of differentiation capacities offers significant potential for generation of tissues that can potentially replace diseased and damaged areas in the body, with minimal risk of rejection and side effects” (Wikipedia, 2013). Most stem cell therapies are experimental³⁵ and costly, but the adoption of these technologies in emerging economies dramatically reduces their costs, and their potential wide application across a range of disease interventions dramatically increases their benefits, hence, their importance as a niche service in medical tourism.

Hospital-based – Five hospitals in the Philippines have departments dedicated to stem cell therapy: NKTi in collaboration with the Lung Center of the Philippines, the Makati Medical Center, St. Luke’s Medical Center, and The Medical City³⁶. Table 13 provides a profile of each of these centers or laboratories. According to the article ‘Unlocking the Powers of Cell Therapy from Aesthetics to Cancer Cure’(2013), “stem cell facilities of these five Philippine hospitals use stem cells from the safest known

³² Excludes spas except where a spa is connected to a hospital or clinic.

³³ The oldest hospital in the Philippines, and possibly in Southeast Asia.

³⁴ The first and only medical hotel in the Philippines (www.health-tourism.com).

³⁵ ALS (2010) lists the questionable and notorious stem cell facilities and clinics around the world. None are from the Philippines.

³⁶ Two other local hospitals – Asian Hospital in Muntinglupa, and Metropolitan medical Center in Santa Cruz, Manila – are listed by www.medical-tourism.com as providing stem cell therapy.

sources, bone marrow and peripheral blood from the patient himself or herself, or from human umbilical cord blood. In cases where the patient cannot use his/her own stem cells (the patient is too young or too old), donor stem cells are harvested usually from siblings, parents, and other close relatives.”

Table 13. Philippine Hospitals Involved in Stem Cell Therapy, by Stem Cell Application, Source of Cells, Origin of Technology, and Duration of Treatment

Hospitals	Stem Cell Applications	Source of Cells	Origin of Technology	Duration of Treatment
The Medical City (Dr. Samuel Bernal, et al.) ³⁷	<ul style="list-style-type: none"> • Dendritic cell therapy • Autologous and allogeneic stem cells transplantation • Stromal cell collection, processing, expansion • Umbilical cord blood stem cell treatments • Aesthetic and dermatology, disease prevention, wellness 	Bone marrow stem cells	U.S., Europe, Globe Tek Pro International ³⁸	Typically 6 months and long-term followup
		Peripheral blood hematopoietic stem cells		
		Brain, nerve and muscle stem cells		
		Skin and fat stem cells ³⁹ for cosmetic uses		
		Umbilical cord blood and stem cells from Wharton’s jelly, umbilical arteries and veins, and placenta		
		Amniotic cells		
NKTi Cellular and Molecular Therapeutics Laboratory (Dr. Dante Dator, et al.) ⁴⁰ in collaboration with LCP ⁴¹	<ul style="list-style-type: none"> • Blood and bone marrow transplantation • Dendritic cell vaccine therapy • Clinical trial on autologous dendritic cell vaccine for cancer • Clinical trial on tissue-engineered urinary bladder 	Patient’s bone marrow	U.S., Canada, Japan and Wake Forest Institute of Regenerative Medicine	Months to years depending on patient’s sickness as well as stage of the disease
		Bloodstream		

³⁷ The Medical City specialists are Drs. Alfredo Bengzon, Samuel Bernal, Rolando Berbumias, Mercedes Cancio-Cruz, Menina Chua-Tan, Denise Laviles, Catherine Rosales, John Jerusalem Tiongson, and Michelle de Vera.

³⁸ Globe Tek Pro (Global Technology Professionals) International is a Filipino multinational company leading the way on stem cell therapy in the Philippines and worldwide (Bernal, 2009).

³⁹ Also known as adipose stem cells.

⁴⁰ The NKTi specialists are Drs. Dante Dator, Honorata Baylon, Florecita Padua, Gloria Cristal Luna, Beatrice tiangco, and Sigrid Agcaoili.

⁴¹ The Lung Center of the Philippines specialists are Drs. Teresita Barzaga and Nelia Tan-Liu.

	substitute			
Makati Med, Cellular Therapeutics Laboratory ⁴²	<ul style="list-style-type: none"> • Dendritic cell vaccination for cancer • Neurological diseases, diabetes type 1, cardiovascular diseases, joints 	Primarily autologous, i.e., donor receives own cells (autograft)	U.S.	Varies from 3 to 6 months
St. Luke's (Dr. Francis Lopez, et al.) ⁴³	<ul style="list-style-type: none"> • Ocular surface reconstruction • Clinical trials on amyotrophic lateral sclerosis • Clinical trial on repair of spinal injury • Bone marrow transplantation for leukemia and lymphoma • Clinical trial for the treatment of arthritis, Alzheimer's disease, and others 	Patient's uninjured eye	Singapore Eye Research Institute	Transplantation performed only once; months to recuperate
		Allogenic, matched bone marrow	StemCord, Singapore	Depends on severity of condition
		Patient's bone marrow	TICEBA, Germany	Depends on severity of condition

Source: Anonymous (2013), "Unlocking the Powers of Cell Therapy from Aesthetics to Cancer Cure"

Adult stem cells have many facets pertaining to their origin and application. This field is extremely complex; to simplify matters, the following definitions were taken from the report, "A Patient's Path Through the Maze of Stem Cell Transplantation" which received the 2010 advocacy award from the World Stem Cell Summit and the grassroots advocacy award by the Genetics Policy Institute (ALS, 2010):

- a. **Autologous** refers to the stem cells found in most adult tissues such as bone, skin, and blood and which are also present in placentas and umbilical cords. Autologous stem cells are called "somatic," meaning "of the body." This means that stem cells found in the bone marrow of an adult have the potential to become other kinds of cells that pose no risk of rejection if they are utilized in another place in the donor's body (ALS, 2010).
- b. **Allogeneic** stem cells are those derived from healthy donor and transplanted into the patient recipient. In contrast to using autologous cells, the genetic match between donor and recipient is critical so that the risk of rejection of the stem cells is minimized. The best matches are often

⁴² The Makati Medical Center specialists are Drs. Eric Flores and Francis Chung.

⁴³ The St. Luke's specialists are Drs. Francis Lopez, Jessica Abano, Jacqueline Dominguez, and Joven Quanang.

found between siblings, but even then, rejection is not always avoided. Extensive testing is always performed to ensure that the risk of rejection is minimized (ALS, 2010).

- c. **Hematopoietic** stem cells are adult cells obtained from a patient’s own blood, are frequently used to treat life-threatening conditions such as leukemia, lymphoma, cancer, and are now being clinically tested for the treatment of ALS. These are cells that can be isolated from the blood or bone marrow, renewed, and differentiated into a variety of specialized cells (ALS, 2010).
- d. **Mesenchymal** stem cells are of particular interest because they have the capacity to differentiate into a variety of tissues. These adult stem cells are found in the bone marrow and are able to develop into a variety of cells, including fat, cartilage, bone, tendon, ligaments, muscle, skin, and nerve cells (ALS, 2010).

Embryonic stem cells come from embryos that are 4 to 5 days old. At this stage these cells can divide in more stem cells or they can specialize and develop into any type of body cell (ALS, 2010). Variants include:

- a. Amniotic fluid which produce multipoint stem cells that are extremely active and not tumorigenic (tumor-causing). Therefore, these stem cells can differentiate into many different types of cells including liver, skin, neurons, bone, muscle, and more (ALS, 2010). According to ALS (2010), the Vatican has pronounced amniotic stem cells “the future of medicine.”
- b. Umbilical cord blood is obtained when a mother donates her infant’s umbilical cord and placenta after birth. Cord blood has a higher concentration of hematopoietic stem cells than is normally found in adult blood (ALS, 2010).

Stand-alone Clinics – Table 14 shows stand-alone clinics and labs involved in stem cell therapy. The listing is based on reports from media and Internet sites. Given the sensitivity of this industry and the DOH administrative order on stem cell therapy, the listing is not to be taken as an endorsement of these clinics and labs but merely as an assessment of the likely size of the industry and its key players. Note that most of the clinics and labs are involved in cosmetic and wellness procedures, but a few deal with other conditions as well. Also, while most of the clinics are currently in the Makati, Ortigas/Pasig, and Taguig corridor, new clinics have sprung outside Metro Manila in Cebu City, Davao City, and soon in Iloilo City.

Table 14. Stand-alone Clinics and Laboratories Involved (or About to be Involved) in Stem Cell Therapy, 2013

Clinic	Location and Key Person	Stem Cell Source and/or Application	Origin of Technology
Acosta clinic	Medical Arts Bldg., San Pedro Hospital, Davao City (Dr. Luz Acosta)	Autologous stem cells for various conditions	Equipment from Australia and U.S.A.

Asian Regenerative Center for Cellular Therapies (ARCCT) ⁴⁴	N.A.	Cosmetic and wellness; orthopedic and reconstructive conditions; anti-aging	Partnership with U.S.-based Keller Medical Institute
Asian Plastic Surgery Center	MATI Bldg., Ortigas Ave., Pasig City (Dr. Florencio Q. Lucero)	Autologous stem cells from fat, for cosmetic and other conditions	Collaboration with Dr. Bill Paspaliaris, chief executive of StemTech Ltd., of Hong Kong
Asian Stem Cell Institute (ASCI)	Pasig City (Dr. Cristina Puyat)	Autologous, tissue-derived cells, i.e., use patient's own adipose stroma (fat), bone marrow, and/or blood for a variety of conditions	N.A.
Asian Stem Cell Regeneration Institute ⁴⁵	Pasig City	Cosmetic and wellness	N.A.
Beverly Hills Medical Group (BHMG) ⁴⁶	Makati City	Cosmetic and wellness within a multispecialty practice	U.S.
Dermclinic ⁴⁷	Makati City (Dr. Vinsons Pineda)	Cosmetic and wellness	N.A.
Euro-Med	N.A.	Cosmetic and wellness	Australia
Health & Leisure ⁴⁸	Makati City	Cosmetic and wellness	N.A.
La Estetica ⁴⁹	Pasig City	Cosmetic and wellness	N.A.
MEDICard Lifestyle Center ⁵⁰	Paseo de Roxas corner Sen. Gil Puyat Ave., Makati City (Dr. Florencio Q. Lucero)	Autologous human stem cells from fat, for cosmetic and other conditions	Collaboration with Dr. Bill Paspaliaris, chief executive of StemTech Ltd., of Hong Kong
n-RICHLIS ⁵¹ Stem Cell Center, Cebu City	Adventist Hospital, San Nicolas, Cebu City (Dr. Jeimyko de Castro)	Autologous human stem cells from the blood, bone marrow, or fat	Harvard USA's SmartPREP2
(To be named) Memorandum of Understanding with hospital being worked out	St. Paul's Hospital, Iloilo City (Proponents: Dr. Helen Caro Pastolero and PSSCM)	Adult autologous stem cells	N.A.
Wellness and Health Services Asia, Inc.	N.A. (Dr. Florencio Q. Lucero)	Cosmetic and wellness	N.A.

⁴⁴ Announced in the media to open September 2012.

⁴⁵ Listed in www.StemCellList.com and Online Medical Tourism.

⁴⁶ BHMG is a multispecialty group owned by an American corporation that also has clinics in Beverly Hills and Pasadena, California, U.S.A. It is a JCI-certified ambulatory surgery center.

⁴⁷ Listed in www.Novasans.com.

⁴⁸ Listed in www.Novasans.com.

⁴⁹ Listed in www.Novasans.com.

⁵⁰ Reported to have been performing stem cell therapy since 2006 (Alano, 2012).

⁵¹ Network Regenerative Interventional Cellular Health and Lifestyle Integration Specialists

Zen Institute (medical spa)	Bonifacio Global City, Taguig City (Dr. Mary Jane Torres)	Non-invasive procedure involving platelet rich plasma for cosmetic purpose	N.A.

Source: This study using news items and websites of the individual clinics and laboratories.

Cord Blood and Tissue Banking – Although the banking of cord blood is not oriented to medical tourists as such, it is a critical part of stem cell therapy. Cord blood and tissue banking has been engendered by scientific evidence showing that the use of induced umbilical cord blood stem has successfully treated 12,000 patients involving 75 diseases (Bernal, 2009). As a result, countries are now putting up storage centers for umbilical cord, or cord blood banks. In the Philippines, this has taken three routes: a private one, a public one, and a hybrid system.

Private cord blood banking involves affluent families who keep their newborn babies’ umbilical cord in a bank for a fee for future use by the person or by his/her close relatives. “It has long been acknowledged that a perfect matching in the use of cord blood stem cells... can be more likely between close relatives” (Bernal, 2009). Private cord blood banks only allow use of such cords among immediate family members or other close relatives. Private banking is best represented by Cordlife which “provides a suite of full cord blood and tissue banking services to expectant parents for the collection, processing, and cryopreservation of cord blood stem cells and umbilical cord tissue” (www.cordlife.com).

A public cord blood bank obtains donations from the public at large, and allows the use of a cord blood unit in any good match, whether relatives or not. According to Bernal (2009), the Philippines is one of the countries planning to have its own public cord bank system, with the University of the Philippines looking at the possibility of doing so.

The Medical City cord blood bank is a hybrid system “which involves a directed donation whose use is only for a certain family, and a nondirected donation where a donor signs that his family members are eligible for one use, but the cells can be used for others, too” (Bernal, 2009).

Policy and Regulatory Issues – On March 20, the DOH (2013) issued the Administrative Order containing the “Rules and Regulations Governing the Accreditation of Health Facilities Engaging in Human Stem Cell and Cell-based or Cellular Therapies in the Philippines.” The AO prescribes minimum quality of service and staff qualification of health facilities involved in human stem cell preparations and cell-based therapies, and classifies which stem cell preparations and therapies will be registered and allowed with certain restrictions. Allowed preparations include those with adult human stem cells, human umbilical cord stem cells, and human organ-specific cells. The AO restricts the use of genetically altered stem cells and tissues of human adults and the umbilical cord, fat-derived human stem cells, and live animal stem cells. It also prohibits the creation of human embryos⁵² and their derivatives, the use of aborted human fetal stem cells and their derivatives, and plant parts labeled as stem cells.

Health facilities utilizing stem cell preparations and cell-based or cellular therapies are mandated to comply with the guidelines set by the Bioethics Advisory Board composed of representatives of relevant government and nongovernment offices as well as local and international

⁵² In contrast, Thailand allows this practice. In 2012, Chulalongkorn University announced that it was the first in the country to produce human embryonic stem cells (Maslog, 2012).

experts. An Institutional Review Board will review and approve the stem cell therapies based on the guidelines set by the Bioethics Advisory Board. The Philippine Food and Drug Administration (FDA) has also issued guidelines regulating stem cell therapy.

The Philippine Society for Stem Cell Medicine (PSSCM) was organized in 2012 and had its first annual meeting in January 2013. The society's active involvement in promoting and certifying legitimate clinics, labs, and practitioners is expected to further expand the industry. In January 2013, PSSCM issued a joint statement with the PMA that warned against the dangers of receiving stem cell transplants that come from a source other than the patient's body (non-autologous). The society warned that complications arising from this type of stem cell transplantation include graft-versus-host disease, stem cell failure, organ injury, infections, cataracts, infertility, new cancers, and even death.

Stem cell therapy is novel and controversial. It is deemed alternative and experimental medicine in many parts of the world, even in advanced countries. In the Philippines, the following seems to be the key issues:

- Lack of knowledge on the capacity of legitimate health facilities to undertake stem cell therapy – TMC, Makati Medical Center, St. Luke's, NKTl, and the Lung Center are at the forefront of research and application, but the Filipino public (and the outside world) knows very little of what they do and have done. For instance, a known political figure claimed in a public forum that the Philippines can only handle two areas of stem cell therapy – hematology and ophthalmology (Torres, 2012); the fact is that these facilities can deal with other conditions.
- Confusion over the ethical issues – Some critics of stem cell therapy oppose it on ethical grounds. However, critics should note the differences among the stem cells. What the Catholic church opposes is the use of fetal stem cells⁵³ (de la Cruz, 2012). None of the five hospitals currently involved in stem cell therapy use fetal stem cells, as shown in the table above on the origin of stem cells. Also, the DOH AO regulating stem cell therapy in the Philippines specifically prohibits the creation of human embryo, an issue that is often lumped with stem cell therapy in general.
- Lack of publicly available outcomes research – Despite much literature being published on the benefits of stem cell therapy, very little research on outcomes of this therapy is being made available to the public.
- Unscrupulous 'hyping' and mislabeling – The phrases "stem cell" and "stem cell therapy" and the words "placenta" and "cellular" have become catchy and lure many unsuspecting people, especially in the Internet where mislabeled products (e.g., stem cell capsules, vegetable stem cells) and opportunistic advertising abound. As many as 351 Philippine clinics and doctors (85 percent of them in Metro Manila) advertise their services as "stem cell therapy" in the website www.whereismydoctor.com.
- Inadequate regulation – The Philippine College of Physicians, the umbrella organization of Filipino doctors in internal medicine, has noted that the DOH/FDA guidelines are inadequate to

⁵³ Fetal stem cells are primitive cells types in the organs of 6-week to 2-month old fetuses. When transplanted into an adult, their immature developmental stage frequently causes them to fail as replacements for the cells that are damaged (ALS, 2010). None of the five Philippine hospitals involved in stem cell therapy use fetal stem cells.

control the dangers of poorly regulated stem cell therapy in the country. Its President has expressed the view that “the recent guidelines released by the FDA will not stop the proliferation of stem cell therapy for ailments that were not subjected to scientific study or clinical trials” (Tubeza, 2013).

C. Cosmetic Surgery and Beauty Clinics

The Philippine Association of Plastic Reconstructive and Aesthetic Surgeons (PAPRAS) is the only organization that accepts fellowship training in its field. Fellows then undergo certification by the Philippine Board of Plastic Surgery. The top hospitals have available state of the art technology in plastic and cosmetic surgery. The major hospitals, notably Makati Medical Center, The Medical City, and St. Luke’s Medical Center, offer top-of-the-line cosmetic surgeries.

There is no available inventory of stand-alone cosmetic and dermatological clinics involved in medical tourism. Specialist clinics in cosmetic surgery and care include Belo Medical Clinic, Beverly Hills Medical Group, Calayan Surgicenter, Dermclinics, Euro-clinic, Home Health Care, Dr. Carlos I. Lasa clinic, Medicard Lifestyle Center, Dr. Jorge B. Neri clinic, and A.T. Reyes Dermatology Center. Wikipilipinas (2013) lists 17 top Philippine beauty doctors⁵⁴ who have gained prominence in the country as well as abroad. Many of the cosmetic and dermatological clinics are located in malls and heavy-traffic urban areas and are patronized mostly by upper- and middle-class households as well as medical tourists.

D. Dental Clinics

The Philippines is known in the dental field because of Filipino dentists abroad as well as its 17 dental schools that attract a sizeable number of foreign students, especially from the Middle East. Contemporary technologies are well integrated in local dental practice including dental implants, dental cosmetics, orthodontics – braces and dentures – and teeth whitening. The Philippine Dental Association has a dental tourism committee that has actively created its market. Many dental practices (e.g., Sacred Heart, Dental World, Manila Dental Services) have vibrant websites advertising dentistry and tourism. Most of the dental clinics have ISO 9001:2000 certification which is proof of a high standard of dental services and strict sterilization procedures.

Dental tourism is getting more geographically diffuse compared to the other segments of medical tourism. Although most of the dental tourism providers are still concentrated in Metro Manila (270 of the 310 dentists listed in www.wheremydoctor.com are in the National Capital Region), dentists from major cities (Cebu, Davao, Bacolod) have also emerged. Many of the local dentists are endorsed by Treatment Abroad, an influential U.K. tourism website, U.K. being the source origin of many dental tourists. The industry appears focused on procedures that can be done quickly (five days or shorter); some target to “fly in, fly out” clients. The most common procedures appear to be dental inlays, onlays, crowns, veneers, Laser surgery, and Laser tooth whitening (www.cosmeticdentistryguide.co.uk.)

⁵⁴ Cherie Abaya-Blas, Aser Acosta, Vicky Belo, Manny Calayan, Pie Calayan, Angel Cumagun, Gio Dimayuga, Elsie Floreza, Marlon O. Lajo, Vinson Pineda, Sylvia Huang, Jasmin Jamora, Rino Lorenzo, Atoy Manalo, Filomena Montinola, Isabel Nazal, and Margaret Plaza-Corcoran.

E. Eye Clinics

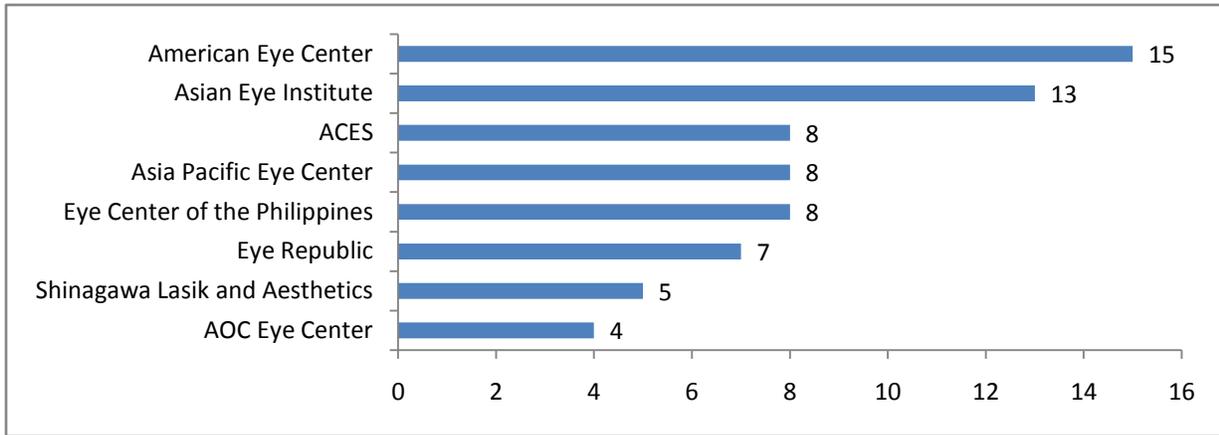
Medical doctors wanting to pursue ophthalmology in the Philippines have to take residency training in hospitals and clinics regulated by the Philippine Academy of Ophthalmology (PAO). Licensing (board certification) is done by the Philippine Board of Ophthalmology. Many Filipino eye doctors are also accredited by international bodies including the International Society of Refractive Surgery, the American Society of Cataract and Refractive Surgery, and the American Academy of Ophthalmology. There is no available count of the number of eye care specialists in the country. In December 2012 when PAO had its annual meeting, it expected “to attract 1,400 participants” but this number probably includes non-ophthalmologists.

Philippine eye clinics cater to multiple refractive errors and their correction (nearsightedness or myopia, farsightedness or hyperopia), regular and irregular astigmatism, and presbyopia. Filipino doctors have gained reputation in Lasik (Laser-assisted in situ keratomileusis), a bloodless surgical procedure that corrects hyperopia, myopia, and astigmatism. Top-notch clinics also render high-quality clinical procedures such as cataract removal; corneal transplant; PRK surgery; conductive keratoplasty; refractive lensectomy; oculoplastic, orbital, lachrymal and reconstructive surgery; and low-vision rehabilitation. The Philippine Academy of Ophthalmologists confers board certification through the Philippine board of ophthalmology. Top-notch eye doctors are also accredited by the International Society of Refractive Surgery, the American Society of Cataract and Refractive Surgery, and the American Academy of Ophthalmology.

Prominent ophthalmology centers that cater to tourists include hospital-based and stand-alone clinics. (a) Among the hospital-based eye clinics are those at Asian Hospital, Capitol, St. Luke’s (QC), the Medical City, and Makati Medical Center. (b) The notable stand-alone eye clinics are: the American Eye Center in Shangri-La Mandaluyong, the Asian Eye Institute (JCI-accredited; Rockwell, Makati City), Beverly Hills (a multispecialty group in Makati), Eye Republic (with clinics in the top medical tourism hospitals), Intermed Group (a multispecialty center in PhilAm, Quezon City), Makati Eye Laser Center, and QC Eye Center.

From individual practices, eye care has evolved into group practices or corporate setups, as shown by the number of eye doctors per clinic among the more prominent clinics (Figure 1). It also seems that a clustering of eye-care practitioners has occurred, with a handful of ophthalmology clinics emerging in the Angeles City/San Fernando area (6 of the 18 ophthalmologists listed in www.whereismydoctor.com are from this area), perhaps as a response to the sizeable number of retired American veterans there.

Figure 1. Number of Doctors Per Eye Clinic, 2013



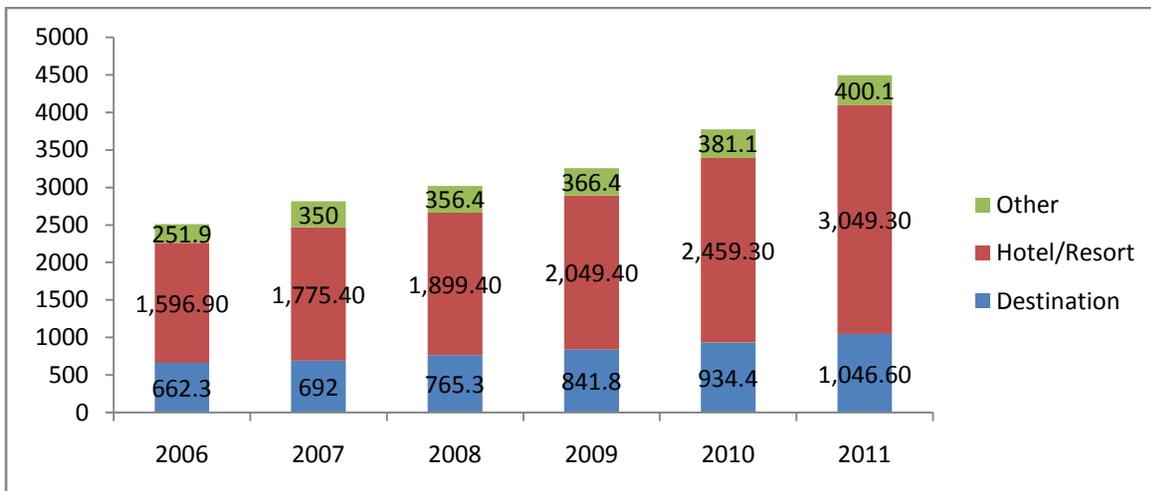
Source: This study, based on data on eye clinic websites.

F. Spas

SAPI, the spa industry organization, counts 39 members able to provide a variety of wellness treatments (HealthCORE, 2011). The number of acclaimed spas is growing and now include The Farm in San Benito, Lipa, Batangas; The Sanctuary Spa at Maya-Maya, Nasugbu, Batangas; Nurture Tropical Spa in Tagaytay; Plantation Bay Resort and Spa in Mactan; Cebu Paradise Health and Beauty Spa in Mactan; and Mandala Spa in Boracay. High-end metropolitan-based spas include Club One Health and Fitness Center (Glorietta 4, Ayala Mall, Makati), SM Kenko (Pasay City), The Ritz Spa (Adriatico St., Malate, Manila).

The local spa industry has steadily grown in revenues since 2006, according to data released by www.hotelsandspaessentials.com (2013), as shown in Figure 2. Revenues grew from PHP2.5 billion in 2006 to PHP4.5 billion in 2011 and are expected to soar to PHP13.2 billion in 2016.

Figure 2. Growth of Revenues (PHP Million) of the Spa Industry in the Philippines, by Type of Spa, 2006 to 2012



Source: www.hotelsandspaessentials.com

G. Size of the Health and Wellness Industry⁵⁵

According to the National Statistical Coordination Board (NSCB), health and wellness tourism “refers to the activities of persons traveling to and staying in places outside their usual environment for not more than one consecutive year for health and wellness purposes not related to the exercise of an activity remunerated from within the place visited” (Virola and Polistico, 2007). On the basis of this definition, the Virola and Polistico (2007) calculated the key indicators of the entities involved in medical tourism for the years 1999, 2001, 2003, and 2005. This study updated the same data for 2006 and 2009.

Readers are warned that the data presented here covers domestic and tourist-oriented services in the health and wellness industry. It was not possible to disaggregate data pertaining only to medical tourism as it would require special runs of the establishment survey of the National Statistics Office. Despite this shortcoming, the gross data still provide indicative figures of the industry.

Table 15 shows the revenue data of the industry. Except for the dip in 2006, it has grown apace, becoming a PHP 80 billion industry in 2009, twice its size a decade ago. The industry is dominated by the medical sector (hospitals and medical and dental practices), accounting for 84 percent of total revenues in 2009.

Table 15. Revenue Data of Selected Health and Wellness Activities in the Philippines, in PHP Billion, 1999 to 2009

Year	Hospital Activities and Medical and Dental Practices	Social Work Activities	Other Service Activities	All Activities	Percent Growth Rate (over the previous period)
1999	29.97	0.55	9.73	40.24	-
2001	33.46	0.52	9.85	43.83	8.9
2003	39.36	0.42	10.55	50.34	14.8
2005	53.83	1.11	13.58	68.51	36.1
2006	45.25	1.14	3.89	50.28	(36.3)
2009	67.01	3.03	9.92	79.96	37.1

Sources: 1999-2005 data are from Virola and Polistico (2007); 2006 and 2009 data were calculated in this study.

The cost data (Table 16) show a similar pattern to that of revenues. Revenues have consistently been above costs, indicating the health of the industry (Table 17).

Table 16. Cost Data of Selected Health and Wellness Activities in the Philippines, in PHP Billion, 1999 to 2009

Year	Hospital Activities and	Social Work Activities	Other Service Activities	All Activities	Percent Growth
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⁵⁵ The data presented in this section is inclusive of domestic and tourist-oriented services. The two cannot be disaggregated during the tight deadline of this study as it would require special runs of the establishment surveys, from the 3-digit PSIC to the more disaggregated 5-digit PSIC data.

	Medical and Dental Practices				Rate (over the previous period)
1999	16.17	0.31	5.13	21.60	-
2001	19.57	0.32	5.65	25.55	18.3
2003	24.37	0.26	5.86	30.49	19.4
2005	34.42	0.59	7.88	42.88	40.6
2006	28.48	0.60	2.56	31.64	(35.5)
2009	44.03	1.79	6.62	52.45	39.7

Sources: 1999-2005 data are from Virola and Polistico (2007); 2006 and 2009 data were calculated in this study.

Table 17. Revenue to Cost Ratio of Selected Health and Wellness Activities in the Philippines, 1999 to 2009

Year	Hospital Activities and Medical and Dental Practices	Social Work Activities	Other Service Activities	All Activities	Percent Growth Rate (over the previous period)
1999	1.85	1.78	1.90	1.86	-
2001	1.71	1.62	1.74	1.72	(7.9)
2003	1.61	1.61	1.80	1.65	(3.8)
2005	1.56	1.88	1.72	1.60	(3.2)
2006	1.59	1.90	1.52	1.59	(0.6)
2009	1.52	1.69	1.50	1.52	(4.6)

Sources: 1999-2005 data are from Virola and Polistico (2007); 2006 and 2009 data were calculated in this study.

Chapter V. Benchmarking Exercise

“Sustainable Medical Tourism – The delivery of high quality healthcare services to local, regional and international patients through an organized, long term strategic approach, which relies on service development, niche marketing, and continuous message delivery to achieve steady growth, endure market fluctuation and exhibit endurance in the face of increased competition in targeted markets.”

Renee-Marie Stephano
Medical Tourism Association

A. Rationale

Benchmarking is the process of comparing one’s business processes and performance metrics to industry best practices or to other industries’ or countries’ practices. In benchmarking, the best firms, industries, or countries where similar processes exist are chosen, and the results are then compared to one’s own firm, industry, or country results and processes (Wikipedia, 2013). There are various types of benchmarking including process benchmarking, product benchmarking, functional benchmarking, and financial benchmarking.

Leading countries in the global medical tourism industry have begun to demonstrate practices that can be adopted in other countries. Using these good practices as benchmarks for the Philippines permits the identification of gaps in the domestic industry, which can then be used to address lingering shortcomings. The Philippines can learn from these practices so that it can expand its market share and provide better services to its international clientele. It is therefore useful to benchmark Philippine practices against these benchmarks. While there is yet no globally accepted set of standards, Todd (n.d.) has summarized the most important items in her article, “30 Key Findings from Medical Tourism Research.” This study uses Todd’s list as benchmarks. Her list has been used in the case of Egypt (Helmy, 2011).

The benchmarking exercise done in this study has several shortcomings. First, the industry – at the global and even more so at the domestic level – suffers from paucity of data. While some leading countries generate their own data, these are often not comparable with those in other countries. The definitional differences in some key data have not been addressed. Second, there is no well-accepted set of industry standards. Medical tourism, after all, is a very young industry, and many good practices have not been documented in peer-reviewed journals. Moreover, the industry is rapidly evolving, and what may be good practice today may no longer be so tomorrow. Third, many accounts of good practices come from sponsors, consultants, or practitioners in the industry, with the obvious risk of their having a personal stake in their being publicized (e.g., as blogs). Fourth, a few of the so-called good practices are contentious, the most obvious example being the concept of medical “cluster” and/or free trade zone for health.

The benchmarking exercise did not benefit from focus group discussions with local players because of the tight deadline. The exercise relied only on published literature from the Internet. Thus, the results need to be validated with a thorough focus group discussion with key stakeholders. Finally, given the dynamic nature of the industry, the benchmarks will evolve as better medical practices, health technologies, and business processes emerge and as new providers and patients enter the global market. For this reason, a separate paper on emerging practices should also be written. Despite these obvious shortcomings, the exercise is still a useful way of taking stock of the industry.

B. Strategic Benchmarks

Benchmark #1: Development of a clear industry vision and strategic objective – This requires the specification of goals to be achieved within a specific timeframe, and the formulation of relevant strategies, plans and programs to reach the objectives. All leading countries involved in medical tourism had achieved this benchmark.

The strategic objective of the medical tourism industry in the country is expressed in the Philippine Medical Tourism Program (PTMP), a public-private partnership initiative under the DOT that was initiated in 2006. It has four domains: full hospital care and treatment, specialty clinics (e.g., eye, dental, and cosmetic services), wellness and spa centers, and retirement and long-term care for the elderly. It involves 21 of the country's top-echelon hospitals, 17 of which are in the National Capital Region (Luzon), three in Cebu City (the Visayas), and one in Davao City (Mindanao).

Several years later, observers note that the local medical tourism industry “obviously failed to sustain and effectively capitalize on the momentum of the PTMP” (HealthCORE, 2011). Its lackluster performance “has resulted in huge loss of opportunities in billions of dollars in potential revenues not to mention thousands of needed jobs for the wellness, health, and tourism sectors” (HealthCORE, 2011).

A major cause of PMTP's lackluster performance appears to be its weak marketing campaign, characterized as being very general, basic, and outdated – of the type: “Come to us as we are cheap/ good doctors/ friendly people/ nice beaches...” (IMTJ, 2013). Indeed, the lack of aggressive marketing campaign is being pointed as the main culprit, even by mainstream media (Philstar, 2011).

Benchmark #2: Coordination among relevant authorities and stakeholders – PMTP lists a whopping number of 48 organizations and agencies as partners in the program (DOH, 2013), aside from providers. This number of stakeholders requires an infrastructure and coordinating mechanism. However, there is no medical tourism council or board in the Philippines, unlike its competitor countries with active industry bodies (e.g., Malaysia). In the absence of such a board, local government authorities have set up their own, notably the Cebu Health and Wellness Council, a public-private coalition consisting of hospitals, doctors, dentists, spas, hotels, and travel agents (IMTJ, 2009). Bacolod City is also interested in setting up its own, and the city council has amended the ordinance on special economic zones to include medical tourism and retirement villages (IMTJ, 2010).

In addition to the 48 PMTP organizations, several private sector groupings and public/private sector initiatives have sprung, including (a) the Philippine Association of Health Organizations in Medical Tourism (PhilAsHOMe = “feel as home”), a private, nonprofit organization comprising of the top hospitals in Metro Manila; (b) the Health and Wellness Alliance of the Philippines (HEAL Philippines), which was established in 2010 as a partnership between the government and the private sector to lobby

for the required infrastructure and other preparations needed to elevate the country's status in medical tourism; and (c) the Spa Association of the Philippines (SAPI).

An industry insider noted that "It is well-known that the hospital industry is a little bit closed... We sort of operate like a village association. We interact among ourselves and even that isn't something that we do as a matter of routine" (www.abs-cbnnews.com). This statement tells a lot about the need to strengthen the steering and coordination of the industry along more professional lines.

Benchmark #3: Provision of tax and other incentives – The Philippine Investment Priorities Plan (IPP) has classified the medical tourism industry as a priority area (RA 7916, as amended). The health and wellness services included in the 2005 IPP are hospital/medical services, ambulatory surgical services, dental services, other human health and wellness services such as rehabilitative and recuperative services, retirement villages and other related services, and development of medical zones (Adarlo, 2010). Incentives under the IPP include a 4-year tax holiday and tax and duty-free importation of medical equipment⁵⁶ including spare parts and supplies, and non-fiscal incentives including employment of foreign nationals and granting of special investor's resident visa. Medical and spa tourism facilities also enjoy reduced import tariff on selected equipment (Nelle, n.d.).

The IPP promotes the following: (a) Medical tourism economic zone⁵⁷ – a selected area that is highly developed or which has the potential to be developed into a medical tourism park/center. The location is fixed/delimited and declared by Presidential proclamation. (b) Medical tourism park – an area which has been developed into a complex capable of providing medical infrastructure and other support facilities in compliance with DOH and DOT requirements. (c) Medical tourism center – either a medical hospital or a stand-alone building attached to a hospital that hosts specialized medical clinics and other specialized medical related activities in compliance with DOH requirements. (d) Medical tourism enterprise – a corporation or other form of business entity which has been endorsed by the DOH and registered with PEZA to engage in the practice of medical health services with foreign patients as primary clientele.

Between 2003 and 2011, Board of Investments (BOI) data show that commitments to the health and social work industry reached PHP 20,500 million (BOI, 2011). However, this figure only represents 1.1 percent of total commitments. There are no readily available data by year, so it is difficult to assess whether investments in the sector are increasing or not.

Some of the projects that have been approved are:

- a. the Medical Tourism Park in Santo Tomas, Batangas⁵⁸;
- b. the Medical Tourism Center in Bonifacio Global City⁵⁹, Taguig City;
- c. the PEZA-approved integrated medical tourism zone⁶⁰ in Nasugbu, Batangas of the Global Village Network Corp., slated for completion in November 2012 (IMTJ, 2009);

⁵⁶ St. Luke's and St. Francis Cabrini Medical Center were reported to have applied for duty-free importation of medical equipment (www.abs-cbnnews.com). Cabrini received approval of the application in 2007.

⁵⁷ A complementary topic is "clustering" dealt with below.

⁵⁸ This is the St. Francis Cabrini Hospital.

⁵⁹ This is the St. Luke's Medical Center at Global City, Taguig.

⁶⁰ The GVMNC facilities will occupy a 24-hectare portion of the 52-hectare medical tourism park being developed by a local group, Camp David Investment and Holdings, which PEZA has also approved as a new medical tourism park developer subject to presidential proclamation. Facilities within the medical tourism park will include a 100-bed tertiary hospital, 8-bed intensive

- d. Providence Hospital Inc., in West Triangle, Quezon City, a PHP1.2 billion 500-bed hospital catering to medical tourists and expected to generate 278 jobs.

In addition, foreign investments are also involved in the Asian Hospital in Muntinglupa City which is now partly owned by Bumrungrad Hospital of Thailand. An ongoing large medical tourism project is the Centuria Medical in Makati City, a PHP2.1 billion, 28-story building facility with 553 outpatient clinics to be completed in 2014. Boxer Manny Pacquiao has also been reported as planning to develop medical tourism facilities within the tourism economic zone in General Santos City (MTG, 2010).

C. Marketing Benchmarks

Benchmark #4: Use of a “competitive advantage approach” in optimizing unique points of strength while minimizing weaknesses – The Philippines’ “cover all the bases” approach to medical and wellness tourism needs to be narrowed more strategically, with a clearer message, and hinged on the country’s natural endowments and cost advantage. The approach also has to focus on the quintessentially Filipino experience, rather than products and services that the tourist can obtain more authentically elsewhere (e.g., Thai, Swedish, and shiatsu massages; Balinese architecture and decor). Service providers also appear to have been dulled by the captive market consisting of diaspora Filipinos (OFW, ‘*balikbayans*’) resulting in less attention to other untapped markets.

Benchmark #5: Positioning for excellence in specific treatments or medical products – The Philippines appears to have cast its net as widely as possible. However, more recently, HealthCORE (2011) has recommended the following as market niches: elective surgery, specifically cardiovascular care, joint replacement, and eye care; aesthetic and cosmetic services, covering dermatologic, plastic and reconstructive surgery; dental care; wellness treatments including spas, executive checkups and diagnostic procedures; and alternative therapies such as stem cell or regenerative medicine. In 2011, www.wheremydoctor.com ranked the Philippines in the top ten (#7) destinations, principally for dental and plastic surgery. According to the survey of three hospitals done by BOI TWG (2012), the most common procedures performed are executive checkups, cancer/oncology, cardiology, neuroscience, orthopedics, regenerative medicine including stem cell therapy, and surgery.

(a) Elective surgery – The Philippines appears to have comparative advantage in kidney transplants, hip and other joint replacement, and cardiac bypass surgery. The country also has comparative advantage in eye care (Lasik surgery and others).

(b) Stem cell therapy – Top-notch hospitals in this area include TMC, MakatiMed, St. Luke’s, NKTi, and Lung Center (Bernal, 2009).

(c) Aesthetic and cosmetic/plastic surgery – This area was also identified by the International Medical Tourism Journal (IMTJ, 2013) where the Philippines has notable expertise. Cosmetic surgery practice in the Philippines is advanced, with well-qualified plastic surgeons and world-class facilities (Porter, et al, 2008). However, this segment has not grown in medical-tourist clientele in the same pace that its competitor-countries have done so (say, Thailand and Malaysia). The IMTJ blog (2013) notes that the country “seems unable or unwilling to promote this niche” to medical tourists.

care unit, 8-bed cardiac care units, 10-bed hemodialysis unit, 8-bed day-care surgery, 3 fully functional operating rooms, a cardiac catheterization lab, and a lithotripsy unit. A 5-star hotel will accommodate patients and visiting relatives. The development also includes clustered home facilities for 1,152 elderly people with long-term medical care requirements, mainly targeted at Japanese retirees. Other facilities in the park include wellness and cosmetic surgery and spa, country club complex, pavilion complex, and satellite network hub facility (IMTJ, 2009).

(d) Dental care – An influential website catering mostly to U.K. medical tourists promotes Philippine dental tourism (www.treatmentabroad.com, 2013), citing the country’s Western-trained dentists, many of whom have advanced training from the U.S. and Japan. It notes that medical technologies are advanced and clinics have state of the art facilities, citing laminate veneer crown (ceramic), tooth whitening, root canal, dental implants, and other restorative and prosthetic procedures as among the key procedures where the Philippines enjoys a cost advantage. It also notes the low-cost flights going to Manila, Cebu, and Davao where dental clinics are mostly located. The market appears to center on the U.K. and Japan.

(e) Wellness treatments – The medical package (including executive checkup) of the Asian Hospital, St. Luke’s Medical Center, and Chong Hua Hospital illustrate the type of services being offered to medical tourists. In addition to hospital-based wellness care, spa clinics and health resorts also offer a range of services.

Benchmark #6: Holding marketing campaigns, whether national, joint, or corporate – The lack of a sustained Philippine marketing campaign abroad has been pointed as a major shortcoming of medical tourism in the country. In addition, international airports still do not have information booths⁶¹ staffed with knowledgeable guides who can provide assistance in linking tourists to their medical and other providers⁶².

Nevertheless, the Philippines has tried several innovative approaches: (b) Joint marketing – The memorandum of understanding between Eye Republic, a consortium of Filipino eye specialists, and a Korean travel agent, Bingo Tour, provide medical packages for Korean patients desiring eye and cosmetic surgery in the Philippines (Porter, et al., 2008). (b) “Beauty holidays” – These have been arranged by the Belo Medical Group (Porter, et al., 2008). (c) Medical tourism brochure – The DOH has produced a medical tourism guidebook being distributed in originating countries.

Benchmark #7: Using websites to promote medical tourism products – The Philippines does not have a dominant website on medical tourism and its subsectors. The existing websites (e.g., www.rxpinoymedicaltourismphilippines.com, www.philmedtourism.com, www.healthandleisure.net) have varying quality. The DOT website (www.tourism.org.ph) is not updated on the list of accredited hospitals and ambulatory clinics (circa 2011). The spa association website (www.spaassociation.com.ph) is sparse and does not have enough pictures; another (www.sapi.org.ph) highlights foreign-looking pictures (the Dead Sea) which do not subliminally direct the tourist to the Philippines. More time is needed to assess the individual websites of hospitals, clinics, and spas. In mid-2000s, DOH Undersecretary Jade del Mundo was quoted as saying that 80 percent of the medical tourism transactions happen through websites (www.abs-cbnnews.com).

Benchmark #8: International affiliations and partnerships for quality assurance and marketing – Affiliations with medical tourism facilitators started around 2008. Both the Medical City and St. Luke’s Medical Center are now in partnership with Healthbase, a Boston-based company that markets these hospitals to American, Canadian, and other clients (www.healthbase.com). Healthbase is an award-winning company (“Best Website for Accessing International Medical Information for

⁶¹ Experience with medical tourism booths in airports is mixed. Bumrungrad Hospital’s kiosk inside Bangkok’s international airport has produced very limited results since “leisure travelers are not necessarily medicare seekers (Peacock, 2013). The exception to this rule seems to be the combination of low-cost annual company check-up with a round of golf (Peacock, 2013).

⁶² Interestingly, several months back, the Philippine media pilloried Belo Group’s advertisement of cosmetic services at the back of the tourist’s arrival card. Note the overly-sensitive public perception of this and similar business and entrepreneurial ideas.

Patients/Consumers”) with 41 years of experience and has 40 hospital partnerships in 14 countries. Similar partnerships still have to gain ground between local hospitals and medical facilitators.

Benchmark #9: Attendance at international medical tourism events – Filipinos’ attendance in these conferences through Internet searches indicates minor presence. Filipinos are not routinely invited as speakers or presentors in these events. The country staged its first Philippine Medical Tourism Congress in November 2006. The Second Annual Medical Tourism Conference in 2007 was held in Manila and attracted representatives from 16 countries, but it has not been followed by another large event.

E. Organization and Management Benchmarks

Benchmark #10: Adoption of a hospital management business concept that allows formation of more competitive entities that collaborate to brand the country as a medical tourism destination – Because hospital chain and “cluster” concepts are highly capital intensive and involve large investments and financing, the Philippines has lagged behind in adopting these models. However, over the past decade, the Hongkong-based Metro Pacific Investment Corp. led by local businessman Mr. Manuel V. Pangilinan, has acquired several hospitals⁶³, making it the largest private hospital operator in the country (Rimando, 2011). Mr. Pangilinan has been quoted in 2011 as saying that in the next 3-5 years, the company wants to create the first nationwide chain of 15 hospitals with 3,000 beds generating PHP10 billion in revenues. It is not known whether this business strategy takes into consideration the burgeoning trend in global medical tourism.

The Medical City (TMC), one of the pioneers of medical tourism in the country, also appears to be consolidating hospitals. IMTJ (2010) reported that “it has assumed the management and operations of the Great Savior International Hospital and the Global Medical Network in Iloilo... At the same time, TMC has acquired existing sister sites in Luzon, including the Mercedes Medical Center in Pampanga and a network of outpatient clinics in Dagupan, Olongapo and Cavite.” According to IMTJ (2010), “TMC is increasing its presence in Luzon and Visayas as part of a national expansion strategy, aimed at offering its distinct brand of health care to a broader patient base.”

Benchmark #11: Learning the lessons from the medical cluster concept – The medical cluster concept is akin to the idea of industrial clustering or industrial ecology. The most visible examples are Silicon Valley for information technology, and Hollywood for films. In the Philippines, clustering is being demonstrated in the highly successful business process outsourcing (BPO) industry.

BOI’s promotion of medical tourism parks and zones under the IPP recognizes the economic efficiencies that can be generated with industrial clustering. However, there are also risks, notably the obsessive focus on infrastructure-building without the requisite relationship building with doctors and other providers, and the equally important demand-generation. The Philippines itself has had a long experience with white elephants in other sectors, and therefore, a gradualist, risk-minimizing approach is certainly more realistic. Where large investments are called for, a PPP approach should be resorted to, with clear planning, funding, and implementation roles defined for each party.

⁶³ Asian Hospital, Inc., Makati Medical Center (acquired in 2007), Cardinal Santos Medical Center in San Juan, Our lady of Lourdes Hospital in Santa Mesa (Manila), Riverside Medical Center in Bacolod City, and Davao Doctors Hospital, with combined beds of 1,800. In 2012, it also acquired De los Santos General Hospital in Kamuning, Quezon City, the seventh hospital, raising the group’s total bed capacity to 2,000.

Constantinides (2013) observes that starting a free trade zone (FTZ) where a medical “cluster” can be developed “does not necessarily require millions of dollars” as the enterprise tends to be more effort-intensive rather than capital-intensive, i.e., it requires multiple business pitches, discussions with, and approvals from, multiple government departments and private partners. If one has to go by similar efforts in other Philippine sectors in the past, an investor in a medical cluster/FTZ has to have the psychological wherewithal to last over the long haul.

Benchmark #12: Consortium training, either through the government, the private sector, or a PPP arrangement – While the Philippines is one among very few medical tourist destinations able to produce enough health workers and even export them, it needs to face the following issues:

- a. As the medical tourism industry grows exponentially, the labor market for skills will loosen, precipitating “nomadic transfers among staff” (Todd, n.d.) or outright migration as other destinations also require their skills.
- b. Medical tourism requires not only clinical skills but increasingly, cultural skills as well. In this regard, Millar and Munro (2012) recommend inclusion of hospital and clinic staff’s familiarity with cultural and ethnic differences as part of their training and orientation. According to them, “few institutions train or educate their personnel about attitudes toward death, family, humor, marriage, sexuality, pain, justice, or gender differences.”
- c. New business processes (insurance processing, medical transcription, personal assistance, medical facilitation, etc.) underpin the medical tourism market. These are new skills for which local providers may not have prepared for. Todd (n.d.) recommends that providers should crowd-source insights from these new fields, which can only be achieved more cost-effectively through economies of scale under consortium arrangements.

Consortium training is not a major thrust of Philippine players; each health facility seems to be content recruiting and training its own cadre of workers. This is also an indication of the continuing absence of an ecological cluster mindset among the industry stakeholders.

Benchmark #13: Standardized database systems – This is one of the weakest areas in the Philippines. At the macro level, “the Philippine statistical system does not generate the necessary information that can provide a meaningful assessment of the health and wellness industry” (Virola and Polistico, 2007). Because of this, an overall national strategy and business plans for the sector and its subsectors have not been developed. At the micro level, individual hospitals have been late in adjusting their information systems to take account of medical tourism. Moreover, hospitals still do not trust regulatory agencies well enough to freely provide information about their activities. The low rate of response to the BOI survey on medical tourism reflects this distrust.

The following data need to be gathered on a regular basis: (a) number of inbound and outbound medical tourists and their incurred costs; (b) number of institutions and professional providers; (c) outputs and intermediate inputs engaged in the industry; (d) costs of key services and procedures performed; (e) revenues derived from resident and non-resident users of health and wellness services, including foreign exchange earnings; (f) employment and compensation of those working in the industry; and (g) per capita visitors’ consumption expenditures on health and wellness; and (h) gross fixed capital formation.

Benchmark #14: Advancement in technology and research – In the Philippines, top private medical institutions have been investing heavily in expanding services through buildings, purchase of new equipment, and technology (Porter, et al., 2008; IMTJ, 2013). Notable investments have been in the area of stem cell therapy, e.g., Medical City’s Institute for Personalized Molecular Medicine, MakatiMed’s Cellular Therapeutics Laboratory (IMTJ, 2013), and St. Luke’s Hospital in Taguig City. Two government hospitals, NKTl and the Lung Center, are also at the forefront of stem cell therapy and research.

Maslog (2012) assessed the stem cell research capability in Southeast Asia and concluded that Singapore leads the way, followed by Thailand. On the one hand, Singapore has set up Biopolis, a biomedical research center on stem cell science, which is a government subsidized effort. Singapore has also organized a stem-cell consortium with the aim of ensuring a coordinated R&D program on stem cells. On the other hand, Thailand has a free enterprise model with funding coming from various private and public sources. Three Thai institutions are actively involved: Chulalongkorn, Police General Hospital, and Mahidol University’s Siriraj Hospital.

Filipino leaders in stem cell therapy may disagree with Maslog’s assessment, for there are cutting-edge procedures and clinical trials being done in the Philippines. However, it is clear that government support in this area has been lackluster. During the 15th Congress, Senator Manny Villar introduced Resolution 159 urging the Committee on Health and Demography “to conduct a comprehensive report on the feasibility of massive government support to stem cell research, intervention and application with the end objective of making health policies responsive to the citizens’ needs.” So far, this has not been done.

Advancement in other areas of the medical tourism industry is difficult to rate as there are no readily available assessments. NKTl is the leading kidney transplant center in Asia, with over 5,000 kidney transplants performed in its 30 years of existence. NKTl performed the first kidney-pancreas transplant in Asia in 1988 and the first kidney-liver transplant in Asia in 1990. St. Frances Cabrini Hospital has acquired the Image-Guided Radiation Therapy (IGRT) for cancer, only the third in Asia to have this technology. Makati Med has also established the first Tomo Therapy radiation treatment facility. Despite these technological edges, however, the clientele of these hospitals is still largely local, and weak international campaign has constrained more medical tourist inflows.

The Philippines also seems to be lagging behind in research and continuing medical education (CME) on medical tourism. Relative to leading countries in this industry, the Philippines sends few Filipinos to international conferences. There have been a flurry of local learning events, and these are usually counted as CME, e.g., the First Philippine Global Healthcare Forum held at NKTl was accredited with 35 units by the Philippine Medical Association.

Benchmark #15: Well-established ambulance system and traumatology care – Philippine ambulance and rapid response systems are highly variable across cities and towns. Metro Manila and Metro Cebu consist of independent smaller local government units having responsibility for devolved services, and this has precluded the development of a more organized accident response system in metropolitan areas. In Metro Manila, Makati City and Marikina City have well developed ambulance systems with quick response times. The “Pamilya Mo, Lingap Ko” ambulance services for OFWs, staffed by volunteers of the Philippine National Red Cross and Rizal Commercial Banking Corp., was cited in one review (Lion Rock, 2005) as a good model. Ambulance medical priority dispatch services are one area that health authorities and LGUs in the Philippines need to focus on.

F. Service Quality Benchmarks

Benchmark #16: International safety and quality accreditations – The Joint Commission International (JCI) has accredited 5 Philippine hospitals – St. Luke’s Medical Center, Quezon City (accredited in 2003, one of the earliest in Asia⁶⁴), St. Luke’s Global City⁶⁵ (Taguig City), The Medical City⁶⁶ in Quezon City (accredited in 2005), Makati Medical Center⁶⁷, and Chong Hua⁶⁸ in Cebu City. St. Luke’s Medical Center is also TEMOS-accredited⁶⁹. In addition, two other hospitals - the Philippine Heart Center and Manila Doctors Hospital - have received the stamp of approval from Accreditation Canada International. Accreditation Canada has also accredited two clinics (Asian Eye Institute in Rockwell, Makati and Clinica Manila in Mandaluyong City.) Trent has accredited two hospitals: Cebu Doctors University Hospital and Our Lady of Perpetual Succor Hospital. Note that the Philippines equals Thailand in the number of JCI-accredited hospitals, and Malaysia has only 2 hospitals with JCI accreditation (Table 18).

Table 18. Number of JCI-Accredited Hospitals in Countries Involved in Medical Tourism, as of 2012

Countries	JCI Accredited Hospitals	Services Offered by the Respective Countries’ Industry
Thailand	5	All range of services
Singapore	15	All range of services
India	11	Focuses on cardiac care
Malaysia	2	Mainly cosmetic surgery and alternative medicine
Philippines	5 ⁷⁰ + 2 ⁷¹	All range of services
Gulf States	38; 17 in Saudi Arabia	
South Africa	0	Specializes in safari medical tourism focusing on cosmetic surgery
Hungary	0	Mainly dental and cosmetic surgery
Mexico	3	Mainly dental and cosmetic surgery
Brazil	12	Mainly cosmetic surgery
Costa Rica	1	Mainly dental and cosmetic surgery

Source: Figure 5, Medical Tourism and Medical Traveling, Deloitte (n.d.b), updated with newer JCI data obtained from Grail Research (2009).

Benchmark #17: Development of national ISQua accreditation system – The International Society for Quality in Healthcare’s (ISQua) first locus of work was the Philippines (Rana, 2011). Its local affiliate, HealthCORE, has been giving workshops to local hospital administrators on how to meet ISQua standards and assist them in the actual process of ISQua accreditation (Digal, 2013). The Philippine

⁶⁴ First accredited in 2003; reaccredited in 2006, 2009, and 2012.

⁶⁵ First accredited in 2012.

⁶⁶ First accredited in 2006; reaccredited in 2009 and 2012.

⁶⁷ First accredited in 2011.

⁶⁸ First accredited in 2009.

⁶⁹ TEMOS, introduced in 2010, certifies the quality of the services at hospitals, health clinics, and dental clinics worldwide. It is meant to provide additional certification of quality above the JCI or other accreditation, and provides a consultancy-style service to help providers improve their standard of care (Ratner, 2012).

⁷⁰ Datum on hospitals not in the original Deloitte (n.d.b) study and was added by the author of this study.

⁷¹ Two other ambulatory clinics have also reportedly received JCI accreditation: (a) the Asian Eye Institute, and (b) the Beverly Hills Medical Group, a multispecialty center.

society for Quality in Healthcare already exists. By 2013, NABH International is expected to accredit the Belo Medical Group, the first small healthcare organization and ambulatory network to be granted international accreditation (Guille, 2012).

In addition, PhilHealth has developed Benchbook⁷² hospital accreditation for facilities receiving reimbursement from the social health insurance program. At present, 57 hospitals are accredited as centers of excellence based on the standards of PhilHealth⁷³. This means that these hospitals have complied with at least 90 percent of the requirements for quality in the areas of patient rights, organizational ethics, patient care, safe practice and environment, leadership and management, human resource management, information management, and improving performance.

The Philippine Council for the Accreditation of Health Organizations (PCAHO) also accredits local health facilities but focuses on the special needs of patients, e.g., interpreters and tour packages for medical tourists. The industry organization (HEAL) is also involved in accreditation, having on its list 44 hospitals and designated clinics (www.globalsurance.com). The DOT and DOH have also accredited 44 hospitals and health facilities for medical tourism by the DOH and DOT.

Benchmark #18: International credentials of physicians – Philippine medical education is patterned after the U.S. system, and many doctors in the top hospitals have credentials abroad. Moreover, the Philippines has historically exported physicians, both to emerging economies (mainly Middle East) and even earlier, to advanced countries notably the U.S. Health Tourism (2013) highlights that “60 percent to 80 percent of medical professionals would eventually work or train abroad and get international medical diplomas” and that “Filipinos constitute the second largest foreign students that graduated in the medical field from U.S. institutions.” Although the specific data need to be confirmed, the general impression is that Philippine medical education is outward oriented, and this is an advantage that the Philippines has exploited in medical tourism.

Although international physician credentialing is important, some industry insiders think that the more critical aspect is gaining the trust of foreign patients, and this can be achieved mainly by having publicly available profiles of physicians, including their training and experiences and, hopefully, their track record. This is a well-established practice in advanced economies operating under health insurance, but is yet to take hold in the Philippines.

Benchmark #19: Strong ties with international medical institutions – Top Philippine hospitals have international affiliations, e.g., St. Luke’s with New York Presbyterian Hospital, Cornell University, and Columbia University; MakatiMed with Stanford University. The Manila Adventist Medical Center is affiliated with the Adventist Hospitals Abroad. The Asian Hospital and Medical Center has past affiliation with the Bumrungrad Hospital in Thailand. St. Frances Cabrini is affiliated with Kissito Healthcare, operator of more than 10 long-term/acute care facilities in the U.S. Given the expected increase in medical tourists, however, more Philippine hospitals should seek greater international affiliations.

⁷² This is an accreditation system sponsored by a social health insurance fund. However, the plan is to contract out the accreditation to a third-party (Guille, 2012).

⁷³ PhilHealth started implementing the Benchbook accreditation standards in 2010. In that year, 40 hospitals were granted the center of excellence (COE) accreditation. Another batch of 14 hospitals made it to the COE list by July 2011. COE is the highest of the three awards of accreditation that a hospital can obtain in PHIC.

G. Care Benchmarks

Benchmark #20: Good quality of nursing staff – The Philippines is the world’s largest producer and exporter of nurses. They are known the world over for their caring and nurturing attitude. While the quality of nursing staff varies by work setting, those in the top-rated health facilities involved in medical tourism are able to pay nurses a higher rate than their counterparts in other settings, thus incentivizing provision of quality of care. The queue of nursing trainees at these facilities is also long, providing a stable cadre of workers. The threat in these positive aspects is the outmigration of nurses, either on a permanent or temporary basis.

Benchmark #21: Good base of skilled therapists in spas and health resorts – In general, English proficiency is not a problem in the Philippines. The large labor pool of the Philippines and the trainability of its workforce are assets that can be tapped. TESDA (Technical Education and Skills Development Authority) is already doing some of the training, in partnership with private entities. More sophisticated procedures and techniques should be added to the training programs in medical and wellness tourism.

Benchmark #22: Use of local natural approaches to health and healing – In 2007, the report “Spa Industry Profile Philippines 2003-2007” (Intelligent Spas, 2006) identified 87 spas in the country, 54 percent of which responded to the survey. Some 76 percent of the spas were stand-alone day spas and 20 percent were located in hotels and resorts. The spas contained 10.9 treatment rooms on average, making them the largest across the Asia Pacific Region. Some 70 percent of the spas provided a relaxation room. Baths with water and/or air jets were offered by 54 percent of the respondents.

The DOT is promoting the development of seven areas with natural endowments (e.g., hot springs, waterfalls) as spa resort destinations. These are: Bay, Laguna; Tiwi, Albay; Sta. Lourdes, Puerto Princesa, Palawan; Coron Island, Palawan; Mambucal, Murcia, Negros Occidental; Malabuyoc, Cebu; and Camiguin Island.

Given the established use of local and natural approaches to health and healing in leading countries in the spa industry, the key challenge in this subsector is the search for a “Pinoy spa” concept (Nelle, n.d.). Towards this end, the following should be underscored:

- a. Indigenous/local practices such as “*hilot*,” a deep-tissue therapeutic body massage known all over the country and “*dagdagay*,” a traditional foot massage first popularized in the Mountain Province – In HealthCORE’s (2011) profile of 39 members of SAPI, 24 (or 62 percent) offer “*hilot*” massage.
- b. The use of indigenous plants for the local spa industry (Lopingco, 2008) – Extraction and sale of indigenous oils and essences should be promoted for body pampering, health, and beauty treatments.
- c. The use of organic plants as ingredients in spa preparations and food.

H. Travel and Accommodation Benchmarks

Benchmark #23: Specialized visa for medical tourism – The Philippines announced that it will introduce the medical tourist visa in 2011 which allows foreigners six months' stay without having to reapply for re-extension. On June 14, 2013, the government approved the Long Stay Visitor Visa Extension (LSVVE), which allows extensions up to 36 months. The LSVVE, however, is a non-residency visa and is not meant to replace the Retirement Visa. The remaining issues are (a) the rather stringent qualification requirement and the higher visa fees compared to those obtaining in Thailand (Lachica, 2013). In this regard, Retirement and Healthcare Coalition has written the Bureau of Immigration to request amendment in the implementation of the LSVVE (Lachica, 2013).

Benchmark #24: Airlines providing models of best medical tourism practices – Philippine carriers have been slow to take up this challenge. An Internet search yielded no similar arrangements being implemented by either the Philippines Airlines or Cebu Pacific, but PAL appears to be starting medical tourism packages. Moreover, SEAir, in partnership with PMTI, has a local package for medical tourists wanting to holiday. SEAir has 28 daily flights to Boracay Island, the country's top tourist draw. It is also the first airline to introduce the paradise-to-paradise island-hopping routes that underscore the archipelagic appeal of the country

Benchmark #25: Specialized medical services and facilities in airports – Philippine international airports are not of the same level as those of the leading competitors (Singapore, Bangkok, Kuala Lumpur), although the main gateway (Ninoy Aquino International Airport) has been planned for renovation. To support medical tourism, the planned NAIA renovation should take account of the medical service benchmarks in the competitor countries. To deal with airport transport inadequacies, Euro-Clinic which is involved in cosmetic surgery, offers airport-to-hospital limousine service, among others that the medical tourist needs (MTA, 2013).

Benchmark #26: Specialized travel agencies with medical tourism logistics – DOT has accredited 350 travel agencies, though it is not known how many of them have requisite systems and staff dealing with medical tourism. The Philippine Medical Tourism Inc. (PMTI) provides an example of medical facilitation using local knowledge and expertise to offer comprehensive medical packages for international patients in association with hospitals, clinics, hotels and resorts in the country. It appears some of these tasks are being done by the larger hospitals themselves.

Benchmark #27: Providers' good ability to respond to the special needs of patients – The top Philippine hospitals' accessibility to hotels and other urban amenities (St. Luke's Taguig/Bonifacio Global City; MakatiMed/Makati City; The Medical City/Ortigas; St. Luke's QC/Cubao) works well in their favor. These hospitals have adopted the Western model of incorporating non-medical services that patients need, and hence have begun to look like malls. In the future, the creation of the central business district in Quezon City should also bring the Philippine Heart Center, NKTi, and the Lung Center much closer to transient living quarters of potential foreign patients.

HealthCORE's survey of hospitals under the PMTP yielded information on the non-medical services they provide to patients. Out of the 20 PMP hospitals, 16 provided information on this aspect of care, and the results are summarized in Table 19. In general, the rates can be further improved: only a quarter of the hospitals that responded provide airport transfers to medical tourists. However, a surprisingly significant proportion of them (43.8 percent) already have an international patient center, language translation, and even home care services.

Table 19. PMTP Hospitals Providing Non-medical Services to Patients, by Type of Service, 2011

Services (N=16 hospitals with responses)	No.	%
Airport transfers	4	25.0
Tour and travel services	9	56.3
Currency exchange	10	56.2
Restaurants	7	43.8
Halal food	6	37.5
Internet	11	63.2
International patient center	7	43.8
Language translation services	7	43.8
Homecare	7	43.8

Source of basic data: Constructed from the profiles of 19 hospitals as collected by HealthCORE (2011), of which 16 had responses. The three government hospitals did not provide responses which cannot be determined whether these meant no service.

H. Financing Benchmarks

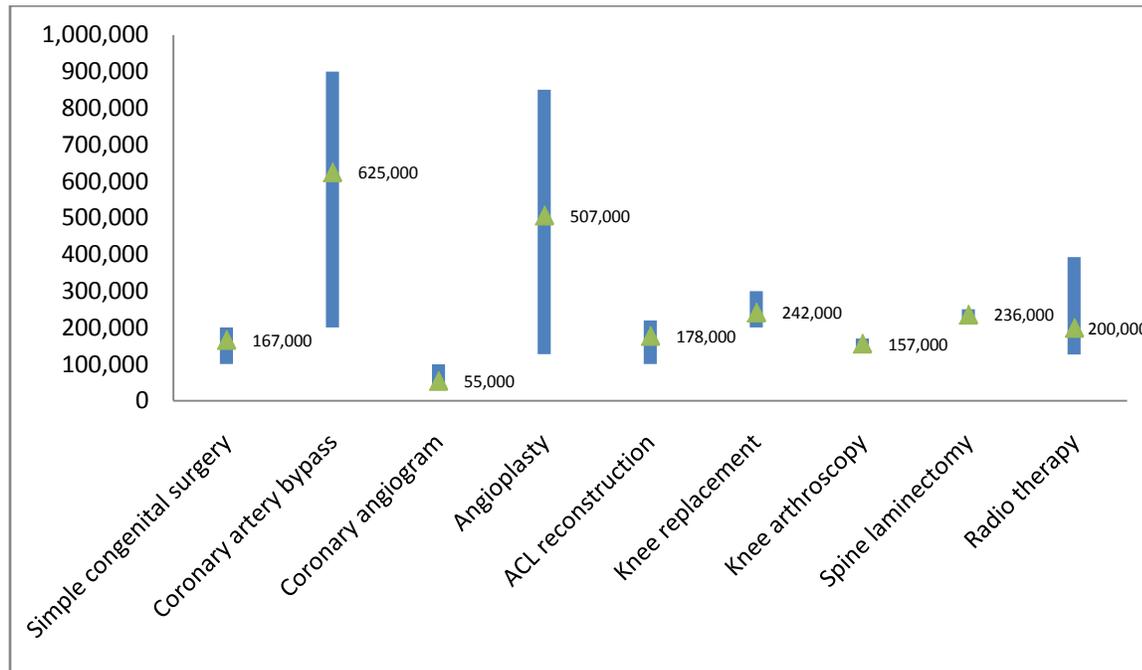
Benchmark #28: Transparent and responsive pricing of services – In contrast to the global leaders, the Philippines has not adopted transparent fee schedules among its providers. The law that created PhilHealth provides that medical prices be disclosed beforehand, but it is not commonly enforced among local patients especially for those paying out-of-pocket. Neither is it clear whether this holds for procedures on medical tourists. During the 15th Congress, a Price Disclosure Bill was filed in Congress by Rep. Roman Romulo, but has not been enacted into law. In addition to non-transparency, local prices of some procedures also tend to vary by a wide margin. Using data from three hospitals that were gathered by BOI TWG (2012), Figure 3 shows high variance in prices for coronary artery bypass, angioplasty, and radio therapy, although prices for hip replacement, knee arthroscopy, and spine laminectomy tend to converge⁷⁴.

Benchmark #29: Moving from individual medical tourists to corporate tieups with employers – Philippine hospitals and clinics initially focused on individual patients financed through out-of-pocket (including credit card⁷⁵) payments. While this model will continue (especially for procedures that will not be funded by employers of health insurance plans any time soon, e.g., cosmetic surgery, spa and relaxation therapy) and should be exploited to the hilt, the bigger source of revenues in the future are likely to come from institutional payors (employers, insurance companies) which require a different marketing strategy, price negotiation, and business process for payment. Table 20 lays out in broad strokes the key differences between the two types of payors.

⁷⁴ HealthCORE's (2012) data support the finding about the wide variation in cardiac care services. (a) Coronary arterial bypass graft surgery varies from PHP495,000 to PHP800,000. (b) Mitral and aortic valve replacement surgery varies from PHP558,000 to PHP800,000. (c) Pacemaker insertion varies from PHP127,000 to PHP800,000. These variances may be due to real differences in medical or surgical practice and resource use; they may also be due to the inability of patients to do price-shopping arising from the severity and urgency of illness – all the more arguing for greater price transparency.

⁷⁵ The safety of credit card payments is a key issue in this respect. Recent news reports showing the increasing frequency of credit-card scams do not bode well for the promotion of medical tourism.

Figure 3. Price Variation Among Selected Medical Procedures for Medical Tourists in Three Philippine Hospitals, in PHP, 2012



Source: Based on the data of BOI TWG (2012) obtained in three hospitals.

Table 20. Individual vs. Institutional Payor in Medical Tourism Industry, 2013

Aspect	Individual	Institutional
Payment	Cash or credit card	Reimbursement
Marketing	Direct selling; oriented at potential patient	Corporate selling; oriented at managers of employee benefits or insurance plan benefits
Care sought	Usually those excluded in insurance plan	Those included in the employee or insurance benefit package
Price negotiation	Individualized; there may be no prior negotiation about the price, especially for walk-in patients (e.g., cosmetic procedures)	Prior negotiation needed
Intermediary organization	May or may not be used	Will increasingly be used to facilitate transactions, e.g., marketing and business development specialists

Source: This study.

Benchmark #30: Strong ties with international health insurance companies – Few data exist to assess this benchmark in the Philippines. The HealthCORE survey (2011) indicates that the 20 PMTP hospitals now have arrangements with at least 20 local health maintenance organizations (HMOs) and preferred provider organizations (PPOs) and as many as 32 international HMOs/PPOs and other health insurance companies, including such big names as Aetna, Allianz, Blue Cross, Blue Shield, IMG, Kaiser, and Vanbreda. A survey (BOI TWG, 2012) of the three major local hospitals involved in medical tourism

shows their relationships with related services including insurance (Table 21). It does seem that the Philippine players in medical tourism are responding to the changes in payment by establishing tieups with insurance companies and third-party administrators.

Table 21. Hospital Tieups with Related Services, 2012

Tieups	Hospital A	Hospital B	Hospital C
With airline companies	No	No	Yes
With insurance companies	Yes	Yes	Yes
With hotels	Yes	Yes	Yes
With travel agencies	Yes	No	Yes
With third-party administrators	Yes	Yes but inactive	N.A.

Source: BOI TWG (2012)

Chapter VI. S.W.O.T. Analysis

“Developing the market for medical tourism provides many benefits to residents, businesses, and governments of the destination, which include: the reduction of seasonality and cyclicity, diversification of the tourism consumer base, the potential to attract other high-revenue support industries, and the reversal of ‘brain drain.’ “

Krista Wendt, 2012

“You have to sell the individual hospitals, but first and foremost, you have to sell the country.”

Alma Rita D.R. Jimenez,
President
St. Francis Cabrini Hospital and PhilAsHome

A. Strengths

Good quality care – Top-notch hospitals and clinics have institutionalized internally-driven quality improvement programs. The Medical Tourism Magazine (2013) notes that these facilities routinely conduct peer audits, monitor sentinel events, track hospital quality indicators, and have launched quality circles, with visible impact on quality. A sampling of Philippine hospitals shows that the infection rates are in the lower range levels per the standards of the International Nosocomial Infection Control Consortium (INICC), thus proving “the undoubtedly excellent indicators of patient care and safety.”

- a. In the monitor for Foley catheter infection, sample Philippine hospitals scored a low of 1.9 (compared to the INICC range of 1.7 to 12.8);
- b. In blood stream infection, sample Philippine hospitals scored a low 8.9 (compared to the INICC range of 7.8 to 18.5); and
- c. In ventilator-associated infection, sample Philippine hospitals scored 13.2 (compared to the INICC range of 10.0 to 52.7).

Clear cost advantage in certain medical and surgical procedures – The Philippines is able to offer lower prices for a wide range of services to medical tourists: stem cell therapy, elective surgery such as hip and other joint replacements, dental care, and cosmetic surgery. Lower cost of living, lower labor costs, and other factors contribute to the cost advantage. This is a solid base that needs to be exploited fully by the industry⁷⁶. As the number of tourists increase, the industry is expected to reach a better scale of operations, perhaps even integrate services and functions, which can contribute significantly to maintaining the cost advantage.

⁷⁶ According to Health Tourism in Asia (2013) (www.healthtourisminasia.com), a big disadvantage for the Philippines is the high cost of medicines locally.

The low cost of accommodation in a wide range of hotels is also an advantage. However, the trend seems to be towards condotel living for the patient's family.

Large pool of qualified, English-speaking, and caring health and tourism professionals – The Philippines is known globally as a major source of medical, nursing, and allied health professionals. The country is also known abroad for its caring and nurturing workers (nurses, care-givers). Local employment in the health professions remains loose, with some opting to work abroad, even in competing countries (notably the Middle East). There is also a large cadre of English-speaking workers who can be trained as therapists. As a revenue stream, the medical tourism industry can help ease the problem of brain drain in the medical and nursing professions.

Captive market consisting of the Filipino diaspora – *Balibayans* in the US/Canada, Europe and to a lesser extent Australia/NZ and other industrial countries, and OFWs in emerging economies (the Middle East, Singapore, Hong Kong) have provided a ready market for medical tourism services and procedures. While this market is expected to continue its patronage, limiting the industry to this natural niche market could reduce its competitiveness in other segments.

Proximity to the Pacific and Micronesia – Medical tourists in the Philippines mostly originate from Pacific Rim countries and Micronesia. The nearness of these countries confers a travel-cost advantage to the country, if the policy issues are resolved (see section on Weaknesses). However, the market has not been fully exploited (the U.S. and Australian non-*balikbayan* market), and there are potential originating countries that have not been explored at all despite the proximity (Vladivostok, Russia).

Tropical climate/environment and cultural openness – The southward movement of aging populations in the northern hemisphere is a market potential that should be tapped. Note also that the salubrious months in the Philippines (November to March) matches the winter season in the northern hemisphere.

B. Weaknesses

Lack of data to determine the parameters of the industry – Basic data on this industry do not exist or are not readily available. As a result, the government is unable to set industry targets. Although possible data sources have been identified (Virola and Polistico, 2007), they have not been acted upon. These data sources include: (a) arrival/departure cards processed by the DOT which provide information on the purpose of travel, including health/medical reason as a separate category; (b) visitors' sample surveys which should be a monthly survey that generates information on visitor characteristics and preferences; those reporting under the category of health/medical reason should be asked questions on actual expenditures incurred; (c) establishment surveys of the National Statistical Office (NSO), including questions on revenues, hours worked, compensation, cost, and capital formation; and (d) administrative and regulatory forms of the DOH.

Lukewarm cooperation of some of the major industry stakeholders – Key players are hesitant to participate in data-gathering activities and in sharing experiences and lessons learned. Most stakeholders and relevant institutions merely provide basic services such as yellow book registration; there is no perceptible collective effort to make the industry more competitive (Porter, et al., 2008). Among some players, a zero-sum mentality rather than positive-sum mentality persists. One industry

insider noted, “You cannot play in this industry if you deliver fragmented services. We need to come up with a more unified product development, with the principle that hospitals need to unite and sell the Philippines as a whole” (ABS-CBNNews, 2013).

Lack of strong brand recognition abroad – Although top-rated hospitals are well-regarded and have international accreditation and affiliation, and although cosmetic surgery clinics are well-known among overseas Filipinos, they do not have wider brand recognition (Porter, et al., 2008). Many foreigners have a mistaken notion about the security situation in the country (IMTJ, 2013) while others do not know how to get here. Local players also tend to have an obsessive focus on the captive Filipino diaspora market. Distinctive Filipino practices in health services and care-giving (respect for elders, caring qualities of Filipino nurses known in overseas work) have not been incorporated into image-building and branding.

Long and costly international travel to Manila, and airport infrastructure deficits – Medical Tourism (2013) points out that “flight times from the U.S., Canada, and Europe are long and may not be conducive to patients with certain medical conditions.” Add to this the fact that the three major international airports (Manila, Cebu, Clark) all face huge air traffic. NAIA Terminal 1 is old compared to spanking airports in the Asian region, and has been cited much-too-often as one of the worst airports in the world. NAIA Terminals 2 and 3 remain mired in legal tussles, and have not been fully utilized. The few direct flights to the Philippines are a major hindrance to medical tourism as “ill people cannot be expected to make two to three flight changes” (IMTJ, 2010). Finally, the cost of air travel to the Philippines is high⁷⁷, relative to those in competing countries. Government needs to push more vigorously for “open-skies” agreements with North American and European countries. Finally, ground transport, especially in large cities, still leaves much to be desired (e.g., the monumental traffic in EDSA, Metro Manila’s major thoroughfare), as is the state of hygiene, a key aspect among medical travelers.

Lack of portability of insurance plans among OECD medical tourists – Most insurance plans in developed countries do not cover treatments received overseas because of concerns about the quality of providers, the cost of monitoring providers, and other legal and institutional barriers (Matoo and Rathindran, 2005). Specifically, many larger health insurance plans in the U.S. have not yet embraced medical tourism because they are worried about potential lawsuits linked to bad outcomes (Deloitte, n.d.) (b). Adjusting insurance plans to allow patients to be treated in accredited facilities overseas could result in significant savings for both the insurer and the insured, even after travel costs are taken into account (Porter, et al., 2008). Fortunately, the health insurance landscape is changing in this regard. A few health insurance plans in the U.S. now carry a medical tourism option, although many consumers and providers are not aware of it (Wendt, 2012).

Downside of a strengthening peso – From the point of view of the medical tourists, a weaker dollar/euro and stronger peso will reduce their purchasing power and increase their costs⁷⁸. The peso has appreciated from PHP55.0 to US\$1 in the early 2000s to PHP40.5 in March-April 2013, and 43.00 in September 2013. Forecasts indicate further peso strengthening as both the US dollar and the euro will

⁷⁷ To reduce airfare costs further, President Aquino signed R.A. 10374 in early March 2013 which removed the common carriers tax and gross Philippine billings imposed on foreign airlines. This should encourage more airlines to fly to the country.

⁷⁸ The PMTI website (www.philmedtourism.com) erroneously states that the currency appreciation “increases the value of most foreign currencies and thus makes the Philippines an attractive destination of medical travel.” On the contrary!

continue to be relatively weak⁷⁹. Paradoxically, the more tourists who arrive, the stronger will the peso be.

Administrative barriers to entry in LGUs and CHDs – Some LGUs and some regional health offices (CHDs) still have an anti-profit mentality when it comes to health service provision, even for paying patients. Casual conversations with government officials reveal a mentality pervaded with socialist thinking in social service provision. Private investors are often looked down. As a result, obtaining the required legal or administrative documents (license to operate, business permits) is often onerous and needlessly delayed and time-consuming. In global rankings, the Philippines often gets a low rating on the ease of doing business, and nowhere is this more visible than at CHDs and LGUs. A national roadshow by the leaders of three departments may be necessary to loosen these difficulties.

Weak synergy between medical and travel-service providers – Prospective medical tourists, especially non-diaspora clients, need a one-stop service that answers both medical and tourism needs and queries. Ideally, health facilities for medical tourism should be located at or near tourist areas (Subic Bay⁸⁰/Olongapo City, Clark/Angeles City, Mactan/Cebu City, Samal/Davao City, Boracay); new sites could also be marketed. If this is not possible, joint efforts should be made between hospitals and travel service providers to package or integrate their services together, or at least to have joint marketing. A tourist unfamiliar with the archipelagic nature of the Philippines would find the task of putting together a medical-cum-tourism package daunting.

C. Opportunities

Improving global perception of the Philippine economy and tourism – The Philippine economy has been growing steadily over the past decade, and had a sterling performance last year, a refreshing change from its usual laggard image. Tourism is also glowing; the World Economic Forum's Travel and Tourism Competitiveness Report 2013 identifies the Philippines as one of the "rising stars in emerging market economies" in travel and tourism. Moreover, medical tourism is performing better than the rest of the tourism segments in the Philippines (Pinoylifestyle, 2009).

Continued aging of the population in originating countries – In the US alone, Deloitte (2008) estimated the number of American medical tourists to reach around 15 million by 2017. The demographic profile favors continued growth of medical tourism in destination countries. The changing age/income profile and insurance-coverage of patients is also a positive factor: medical tourism can be offered to patients and services not covered with health insurance (dental and cosmetic surgeries). Finally, as the American and European populations age, severe winters become more unbearable to larger segments of their population. Winters exact their toll on aging patients with arthritis and other ailments; medical and recuperative options can be marketed to these population segments, in addition to elective surgeries.

⁷⁹ Note, however, that the Thai baht has also been strengthening.

⁸⁰ The building of the Bay Pointe Hospital in Subic Bay was announced in 2007. It will initially be a 100-bed facility, with an eventual upgrade of 300. It is targeted to 62,000 workers in Subic Bay and to medical tourists. It will provide modern health care services, and will offer touristic attractions like nearness to the beach, sports, eco-tourism, and the historical charm of a former U.S. naval base.

Continued high-cost care in advanced countries that engenders medical outsourcing – Despite reforms in health care financing and delivery in the U.S., observers believe medical costs are not going to come down any time soon. If anything, skeptics believe Obamacare will lead to greater regulation of the health system, which can increase costs even further. Cost containment remains a challenge in OECD health systems as well, even among countries with a public system (U.K., Canada). It is believed that higher costs in industrial countries – in combination with population aging and greater consumer say in medical decisions – will fuel more outsourcing of care to emerging economies.

Possible exploitation of many segments of care – Given the wide range of available providers, the country can engage in a choice of segments: high tech – organ transplants, e.g., kidney; stem cell therapy; standard hospitalization – hip and other joint replacements; eye and dental care; fringe services – medical spa, drug rehabilitation; beauty procedures – dermatology and cosmetic surgery; care-giving – recuperative services, retirement havens; and relaxation – spa and massage. Indeed, as more hospitals, clinics, and spas get into the medical tourism industry, new products can be introduced and the range of available products and services is expected to widen.

Government commitment to PPP to develop sectors including health and tourism – The Aquino administration has embraced public/private partnership (PPP) as an approach to health and tourism investments. The DOH has lined up 23 of its largest retained hospitals for refurbishment using PPP arrangements; some of these facilities may well be involved in medical tourism, providing them with a revenue stream not otherwise available. (This, of course, engenders its own set of revenue sharing and equity issues – e.g., crowding out of poorer patients – that cannot be dealt fully in this paper.) PPP, which already has a legal and policy framework, can also be used in promoting and crafting new investments in health and tourism.

D. Threats

Intense competition from established market leaders and rapidly emerging new destinations – Aggressive capital investments in leaders India and Singapore and followers Taiwan and South Korea are likely to make these countries more attractive. Higher-cost countries like Singapore and South Korea (in cities like Daegu and enclaves like Gangnam) are moving apace in their vision to create industrial clusters for medical tourism; the economies of scale, scope, and agglomeration that industrial ecology brings can reduce costs and is expected to make them more competitive to their lower-cost rivals.

Lack of price transparency and wide variation in local prices – Price transparency is not yet the norm in the Philippines. Some providers impose hidden charges that it has become a badge of pride for some dedicated websites to say upfront that they don't have such charges that others continue to impose, e.g., dental exams. Although the Philippine Health Insurance Law requires transparency in pricing, this has not been enforced strongly. Wide variation in prices in some procedures also characterizes the local medical market, and more so if the patient are medical tourists. While some procedures exhibit price convergence (e.g., hip replacement, knee arthroscopy, and spine laminectomy), others do not, notably coronary artery bypass, angioplasty, and radio therapy.

Slow prosecution of medical malpractice cases and lack of malpractice framework for cutting-edge procedures – Medical Tourism (2013) opines that “there are adequate provisions in the Revised Penal Code for medical malpractice that would protect patients against medical negligence and

incompetence from erring physicians.” It also notes that significant awards have been given “to victims of confirmed medical malpractice cases as well as fines meted out by DOH on erring physicians.”

Still, the prospect of lengthy medical litigation may dissuade potential medical tourists. The incidence of medical malpractice in the Philippines is negligible: 0.00003 percent of patients, according to the Philippine Medical Association (PMA) in its Medical Malpractice Workshop in 2005 (Medical Tourism, 2013). However, the low figure is a reflection not so much of the occurrence of physician error or misjudgement but of low incidence of complaints from patients who cannot afford the financial and time costs of a protracted litigation. Several bills have been filed in Congress on medical malpractice, but these are opposed by the medical community as being detrimental to the growth of the sector.

As more providers enter the medical-tourism scene, quality will be more difficult to assure. Thus, there is a need to balance industry growth and risk. Rather than waiting for destination countries to get their act together on medical malpractice, the U.S. insurance industry is beginning to address the issue of medical legal liability by offering insurance products that provide patient protection in case of malpractice under medical tourism (Wendt, 2011). These are insurance add-ons which the provider should ask from patients, or remind them about before their travel.

Patients traveling for treatments that are illegal or unethical in their home countries pose jurisdictional legal issues⁸¹. Originating countries’ courts have the right to decide as criminal the activities of their citizens abroad (Cohen, 2011). If a patient’s home country chooses to enforce such limitations, this can dramatically reduce the market base of medical providers engaged in those procedures. Ethical and quality-concern issues also bedevil cutting-edge technologies. If the Philippines promotes cancer and stem cell tourism, this can backfire as the Philippines uses procedures not (yet) accepted in the U.S. (IMTJ, 2013). Legal and ethical issues in organ marketing in the Philippines also need to be resolved⁸². Recently, the DOH issued the administrative order dealing with stem cell therapy (DOH, 2013), a set of rules that the medical community has been waiting for sometime, but this administrative order and the subsequent FDA guideline, is being criticized by some local medical groups (the Philippine College of Physicians).

Pre- and post-operative risks of combining health + holiday, and possible discontinuity of care

– On the surface, medical tourism looks like a win-win package for the customer, but certain procedures actually require real recuperation after patients undergo them, and travel should be avoided. In certain cosmetic surgeries, for instance, the patients are asked to avoid sun exposure, walking tours, bus tours, alcohol intake, smoking or exposure to second-hand smoke, exercise, and water leisure activities (Lasa, 2013). Pre-operative and post-operative rest and recuperation is also advised for major surgeries. In these cases, patients should be advised properly on what they can and cannot do.

Medical tourism also poses problems of possible discontinuity of care: elective procedures require follow-up care for a period of weeks. (See Figure 4.) The patient may face the prospect of not having access to clinical support system once s/he is back in the country of origin. Even more seriously, most hospitals will not cover the cost of medical complications; nor is there a common definition of

⁸¹ Cohen (2010) distinguishes three kinds of medical tourism from the ethical point of view: (a) medical tourism for services that are illegal in both the patient’s home and destination countries; (b) medical tourism for services that are illegal in the patient’s home country but legal in the destination country; and (c) medical tourism for services legal in both the home and destination countries. Both (a) and (b) poses difficult ethical and regulatory challenges that destination countries are just beginning to wrestle with.

⁸² Add to this the social and anthropological aspects; see, for instance, Albuero (2007).

“medical complication” (Medical Tourism, 2013). Needless to say, these issues arise not only in the Philippines but in other destinations as well.

Figure 4. Classification of Patients by Requirement for Follow-up Care Versus Complexity of Treatment

Increasing need for follow-up care	Quadrant 3: Less invasive surgery, e.g., laparoscopic procedures	Quadrant 4: More invasive and complex, e.g., heart bypass; organ transplants, cancer treatment
	Quadrant 1: Elective, cosmetic procedures, e.g., Lasik eye surgery, dermatological/cosmetic	Quadrant 2: More invasive surgery, e.g., hip/knee replacements
	Increasing complexity	

Source: Deloitte (n.d.), “Medical Tourism: The Asian Chapter”

Potential crowding out of domestic poor patients and other adverse equity effects – Unlike some facilities in other countries (e.g., Thailand) which serve only medical tourists, Philippine hospitals serve a mixed clientele. Thus, the fear exists that medical tourists may crowd out local patients in hospitals, especially the lower middle class and the poor. Medical tourism may also entrench the two-tiered system of care, even within the same facilities. This may not necessarily be true as the market is well-segmented, or if medical tourism can be limited to private hospitals and clinics.

If care is segmented, medical tourism may still bring adverse effects by diverting physicians and nurses from ill-paying jobs catering to local patients to better-paying jobs catering to foreigners and *balikbayans*, a phenomenon known as ‘internal brain drain.’ In Thailand, by one estimate, an extra 100,000 medical tourists leads to an internal brain drain of between 240 and 700 medical doctors (Arunanondchai and Fink, 2006). In the Philippines as in Thailand, this problem is particularly difficult to resolve as a significant amount of tertiary medical and nursing education is provided by state-owned colleges and universities with subsidized tuition.

Finally, whatever subsidy the national and local governments will provide to the medical tourism industry (fiscal incentives or direct provision of benefits) may only benefit a few.

Potential domestic medical inflation – Price inflation from the practice of medical tourism may flow into the domestic practice of medicine. Specifically, a demand-pull inflation can ensue from the increase in external demand for local services. Although tourists’ demand for higher quality services has a good effect in increasing overall quality of care, it may unduly increase costs that local patients cannot afford. As Arunanondchai and Fink (2006) point out, “Any economic activity that experiences rapid growth due to export expansion will become dearer in the domestic economy. Even if economies as a whole gain, export expansion in the health sector may have important distributive consequences for domestic patients.” These fears are empirical issues that need to be confirmed.

Who will keep the savings? – The anticipated large-scale entry of third-party payors (health insurance, employers), administrators, or intermediaries in the medical tourism market would dramatically change its dynamics, and who would recoup the large savings from the outsourcing of care. As the HMO/managed care experience in the U.S. showed, the reform created huge savings from economic efficiencies, but this did not necessarily accrue to the patients, or even the providers. Much of the savings eventually ended up with the intermediaries. This is an important policy question that countries (including patient groups, providers, and regulators) in both source and destination countries should look out for.

Chapter VII. Conclusions and Next Steps

“All that is lacking is more aggressive marketing of the expert and affordable medical services available in the Philippines.”

Editorial, Philippine Star
November 12, 2011

***“Iba talaga mag-alaga ang Pinoy. Di tayo nagtatapon ng tao.
Filipinos never forget they’re dealing with people.”***

Sec. Ramon Jimenez, DOT
Quoted by Geronimo (2012)

Despite efforts stretching as far back as the 1970s, medical tourism in the Philippines has been slow to evolve relative to its neighboring countries. The efforts of the Arroyo administration in 2004-2006 have not resulted in dramatic uptake of medical tourists, and promotion has been described as lacking steam (Philstar, 2011). As a result, the Philippines is a perennial 4th runner-up in the annual rankings of medical tourist destinations in Asia, after India, Thailand, Singapore, and Malaysia.

By all indications, the burgeoning global market for medical tourism is expected to continue well into the future. Most tangible elements seem to be in place for the Philippines to get its rightful share in the increasing trade pie (e.g., professionals and other workers, geographic and climatic advantages, a culture of caring, facilities and equipment that growth can start from, and good global perception). But the country needs to work some more on the intangible elements of sector leadership, coordination, cooperation, creativity, and zeal.

The improving fiscal space of the National Government provides a unique opportunity for a more aggressive industrial policy in selected sectors for which comparative advantage can be demonstrated. On the basis of cost comparison of selected procedures alone, the Philippines does have significant advantage in medical tourism vis-à-vis its Asian competitors. More extensive market and cost studies need to be undertaken to establish the market niches for which the Philippines enjoys large advantage.

More importantly, studies also need to determine the types of support services for which government assistance is warranted. A basic principle would be for government to focus on those services that have large (hopefully, industry-wide) externalities, such as advertising promotion and marketing campaigns; research, data generation, and monitoring and evaluation; strategic planning; sharing of experiences, lessons learned, and best practices; and selected training to upgrade the skills of key staff in the industry.

Good practices abound, both here and abroad, that have not been integrated in medical tourism practice in the Philippines. There are many potential partnerships, linkages, and networks that should be established. But bad beliefs and practices also persist, such as entrenched anti-private sector

ideologies, bureaucratic delays, zero-sum mentality, preference for visible investments rather than more useful “software,” and wholesale importation of ideas without careful adaptation.

To invigorate the industry, the following are the suggested next steps:

- a. Commission an international consulting firm, with local counterparts, to conduct a comprehensive study on the medical tourism industry covering its global competitive advantage and market niches, the binding constraints, its future prospects, and needed policy thrusts.
- b. Undertake follow-on information gathering and analytical work that can be included for funding under any of the three departments’ (DTI, DOT, DOH) research programs, including a standard set of data that needs to be produced on a regular basis.
- c. Based on the results of the study, prepare a sector-wide business strategy and plan.
- d. Mount a media campaign abroad to promote medical tourism in the country.

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Annex 1: Draft Scope of Work for Consultancy to Formulate the Roadmap of Expanding Medical Tourism in the Philippines

A. Introduction

Medical tourism became a global phenomenon in the past decade as hundreds of thousands of travelers crossed borders to seek care in less expensive countries, often in combination with holiday or homecoming (for those with ethnic roots in destination countries). Most global analyses indicate the growing demand well into the future for medical travel owing to a combination of demographic, economic, technological, communication, and transport factors.

Despite the Philippines' visible comparative advantage in the provision of medical tourism services, its share of the market continues to be small. Recent global data indicate its fifth ranking – after Asian leaders Thailand, India, Singapore and Malaysia. A benchmarking exercise revealed the key weaknesses of the domestic medical tourism industry, including:

- g. Strategic aspects – There is no formal coordinating body (council or board) as in competitor countries, and industry coordination is weak.
- h. Marketing aspects – The industry suffers from weak market niching. There is no sustained promotion campaign abroad. The websites of some local providers are less attractive relative to the competition.
- i. Organizational and management aspects – Industry clustering is weak. Uptake of the incentives offered by government is low. Critical industry data are not readily available readily.
- j. Service quality and care aspects – The number of internationally accredited health facilities is low relative to India and Singapore, although the number is increasing.
- k. Travel and accommodation – There are no airline packages from local carriers (Philippine Airlines, Cebu Pacific).
- l. Financing – Pricing transparency still leaves much to be desired.

B. Objective of the Consultancy

The objective of the consultancy is to provide technical assistance to the government of the Philippines and its private-sector partners that will formulate the roadmap to expand and strengthen medical tourism in the country.

C. Tasks of the Consulting Team

The specific tasks of the consulting team are:

1. To identify the market niches that the Philippines should focus on based on a thorough and comprehensive scanning of the global competitive environment and the country's own comparative advantage. The market niching exercise should consider current and future trajectories of demand, health and wellness technologies and practices, constraints for expansion (infrastructural, behavioral, legal, ethical), preferences of medical tourists, and other relevant factors. The market niching exercise should estimate the likely size of demand (in terms of expected medical tourist arrivals and average spending) that can be used as targets for the local industry and its subsectors.
2. To identify activities where government support is needed and how this support should be managed and utilized. This should be based on a thorough and comprehensive knowledge of what the leading and emerging competitor countries have done or are doing, what works and

what have failed, and the means to mitigate failures. The consulting team should define clearly the range of options that the government can provide, assess the costs and benefits of each specific option, and identify the respective opportunities and risks.

3. To identify key data and information that need to be generated on a regular basis to steer the industry, to measure performance, and to benchmark local efforts against leading competitors. The consulting team should identify macro-level data as well as institution-level data and the manner in which the latter can be aggregated. The consulting team should identify the specific roles of the government (as promoter, steward, and regulator) and the private sector (as providers, financiers, and intermediaries) in data production and aggregation.
4. To identify major policy and operations research areas that the industry should focus on, and which can be farmed out to local and external research and consultancy institutions and individuals. The research should focus on concrete (rather than abstract) topics the findings of which can be acted on to improve competition, or used to feed the policy process in this area. The research areas should encompass efficiency concerns (costing and resource use, comparative pricing, industry benchmarking, identification of innovative approaches) as well as equity considerations (crowding out of patients, discrepant behavior of providers providing service to both domestic clientele and medical tourists, residual claimants to efficiency savings, and related issues).
5. Based on the results of the above tasks, to develop a roadmap that will guide government and private-sector stakeholders in leading and coordinating the industry so that it becomes more competitive and garner a larger share of the global market. The roadmap should lead to a business strategy and plan. To this end, the consulting team is expected to be cognizant of the following aspects:
 - a. Marketing requirements;
 - b. Infrastructure requirements;
 - c. Legal, policy, licensing, regulatory, and accreditation requirements;
 - d. Strategic and operational planning and implementation coordination; and
 - e. Monitoring and evaluation.

To undertake the above tasks, the consulting team is expected:

1. To review relevant local and global literature, including research findings, market and other surveys, conference proceedings and presentations, records of focus group discussions, industry position papers, and blogs and opinions;
2. To review relevant laws and regulations, including Republic Acts; executive and administrative orders; circulars and board resolutions; city, municipal, or provincial ordinances; and industry plans;
3. To gather, organize, analyze, and interpret relevant statistical and other data including demographic, economic, industry, and other forecasts;
4. To interview relevant stakeholders, researchers, opinion makers, etc.;
5. To document good practices, innovations, and lessons learned; and
6. To make briefings and presentations.

D. Qualifications of the Consulting Team

The consulting team is expected to possess a mix of relevant skills obtained from local and international experience and education dealing with medical tourism or related areas. These skills include, but are not limited to, the following:

1. Market research in medical tourism or related field;
2. Trade, industrial, and investment promotion;
3. Health facility planning and management and public health;
4. Information technology and systems, especially with respect to health and wellness;
5. Public policy in tourism, trade, and/or health services;
6. Health care financing, economics, and research;
7. Industrial clustering or industrial ecology;
8. Health, medical, and wellness regulation and legal aspects of medical tourism;
9. Industry leadership, administration, and governance in medical tourism; and
10. Management of medical tourism enterprises.

No one consultant is expected to possess all or most of the above skills. However, the consulting team is expected to show that its proposed members have the best blend of skills, and that it has access to specialized skills, if necessary.

The consulting team is expected to have 3-5 members, to be led by a chief of party. The consulting team will ideally come from one consulting firm, or a consortium of partners with a clearly designated prime contractor and subcontractors.

E. Reporting Requirements

The three government departments responsible for medical tourism (DOT, DTI, DOH) will set up a steering committee that will provide oversight to the work of the consulting team.

F. Deliverables

The consulting team is responsible for producing required reports, designs, presentation slides and briefing kits, and other consultancy materials needed for this kind of assignment. The consulting team is required to make top-level briefings and presentations to officials of the three departments and related government agencies (such as the National Economic and Development Authority), private-sector stakeholders and investors, civil society groups, professional societies, and other interested parties.

G. Level of Effort

To be determined.

H. Timeline

To be determined.

Annex 3: Comments on the Draft Senate Bill on Medical Tourism

1. A Senate bill on medical tourism has been filed by Senator Lito Lapid (SB No. 959) but it has not been enacted. The key provisions are:

- a. Establishment of national accreditation procedures for hospitals, medical centers, and health service providers;
- b. Creation of a national task force on medical tourism;
- c. Creation of a secretariat for the task force;
- d. Creation of a national website for medical tourism
- e. Marketing of medical tourism;
- f. Issuance of visa for foreign medical tourists;
- g. Creation of a medical modernization credit facility;
- h. Holding of annual conferences in medical tourism;
- i. Monitoring the state of medical tourism in the country;
- j. Mandating the DTI to assist in the international accreditation of hospitals and health services;
- k. Establishing rules and regulations on medical malpractice and litigation.

2. Many of the provisions of this draft bill can be done by existing departments (DOH, DTI, DOT) under their mandates (b to f, h, and i). The provision to create a medical modernization credit facility is interesting, but the Development Bank of the Philippines already has a Health and Wellness Access Loan program providing loans to priority projects. The provision to establish rules on medical malpractice is right in line with the need for a quick and effective recourse system for aggrieved customers, and this should be followed up.