Roundtable Discussion
Medical Tourism

Ronald C. Merrell, M.D.,1 David Boucher, M.P.H., FACHE,2 Laura Carabello,3 Devon M. Herrick, Ph.D.,4 Victor Lazzaro,5 Linda Ludwick,6 Ruben Toral,7 Joseph Woodman,8 Charles R. Doarn, M.B.A.9

1 Virginia Commonwealth University, Richmond, Virginia
2 BlueCross Blue Shield of South Carolina, Columbia, South Carolina
3 Publisher, Medical Travel Today, and, CPR Strategic Marketing Communications, Elmwood Park, New Jersey
4 National Center for Policy Analysis, Dallas, Texas
5 Tivis Capital and BridgeHealth International, Greenwood Village, Colorado
6 Health Care Compliance Association, Tucson, Arizona
7 MedNet Asia, Bangkok, Thailand
8 World-Class Medical Tourism Chapel Hill, North Carolina
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last year some 500,000 Americans went abroad for health-care. The motive was simple: Complex surgical and dental procedures routinely cost half the price abroad compared to the United States (U.S.). The U.S. has been the recipient of medical tourists for most of the last 50 years as wealthy people fled the inadequacies of their domestic medical facilities for the heavily regulated, licensed, fully accredited, well-staffed, technology rich and safe facilities in the U.S.

In recent years, standards have been rising in other parts of the world even faster than prices have surged in the U.S. Many physicians abroad trained in the U.S. and the Joint Commission International (JCI) applies strict standards to accreditation of offshore facilities. Those facilities use the same implants, supplies, and drugs as their U.S. counterparts. However, a heart bypass in Thailand costs $11,000 compared to as much as $130,000 in the U.S. Spinal fusion surgery in India at $5,500 compares to over $60,000 in the U.S.

This roundtable brought together a diverse group of experts (Table 1) to address several key issues on medical tourism; including the part that telemedicine plays in this burgeoning field. This roundtable was organized by Ms. Laura Carabello and moderated by Dr. Ronald C. Merrell.

Table 1. Roundtable Participants

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<tr>
<th>Participant</th>
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<tr>
<td>Ronald C. Merrell, M.D., Moderator: Editor-in-Chief, Telemedicine and e-Health, Virginia Commonwealth University, Richmond, Virginia.</td>
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<td>Laura Carabello, Roundtable Organizer: Publisher, Medical Travel Today, and Chief Creative Officer, CPR/Strategic Marketing Communications, Elmwood Park, New Jersey. Ms. Carabello is publisher and managing editor of the on-line journal, Medical Travel Today and a leader in the reporting of medical tourism and its evolution.</td>
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<tr>
<td>David Boucher, M.P.H.: Assistant Vice President of Health Care Services, Blue Cross Blue Shield of South Carolina, Columbia, South Carolina. Mr. Boucher is widely respected as an insurance authority and official who explored and translated medical tourism stemming from his personal research and official travel.</td>
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<td>Devon Herrick, Ph.D.: Senior Fellow, National Center for Policy Analysis (NCPA), Dallas, Texas. Dr. Herrick authored the NCPA white paper on medical tourism.</td>
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<td>Victor Lazzaro: Managing Director, Tivis Capital and CEO, Bridge Health International, Greenwood Village, Colorado. Mr. Lazzaro is an expert on surgical and other medical services in China, based upon personal management experience in that country.</td>
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<td>Ruben Toral: CEO, MedNet Asia and Chairman, Healthcare Globalization Summit (May 2008). Mr. Toral was a major force in the success of the Bumrumgrad Hospital in Bangkok, Thailand.</td>
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<td>Joe Woodman: Author, Patients Beyond Borders: Everybody’s Guide to Affordable, World-Class Medical Tourism. His exhaustive research and highly readable guide define the state of medical tourism today.</td>
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RONALD C. MERRELL (Moderator): I have three questions that I would like to address serially concerning medical tourism. First, why is there such a thing as medical tourism, whereby U.S. patients are going to other places for their healthcare? What is the clinical driver?

JOE WOODMAN: From a consumer standpoint, contemporary medical tourism is driven by cost considerations, which may not be strictly a clinical driver. But the typical U.S. patient is traveling because the U.S. healthcare system has priced itself out of the market for the uninsured or the underinsured patient.

For other international travelers crossing borders—travelers outside of the U.S.—drivers may be the fact treatment is simply not available. For example, in Cambodia, Vietnam, or mainland China, there just may not be the kind of treatment sought, so those folks might head to Singapore or Thailand for their care.

LAURA CARABELLO: We’re getting a lot of interest and seeing a lot of concern about traveling outside of the U.S. for medical procedures versus simply taking a little jaunt or a tour of another country, although people do find that still very intriguing.

VICTOR LAZZARO: There are two aspects that come into play. One is services that are not offered in the U.S.—for example, stem cell replacement surgery and also certain bariatric treatments that may or may not be covered, and hip resurfacing. Some of those are just starting to come into approval and usage in the U.S.

The other is what we call the “incidental traveler,” or “tourist.” This could be somebody, for example, who is visiting Beijing or Costa Rica and says, “Well, it doesn’t justify the trip here, but I’m going to get what would be a $5,000 medical exam in the U.S. for a fraction of that cost abroad,” or “I’m going to get some dental work done—again, that wouldn’t have been worth the trip in and of itself. But I’m here anyway, and I’ll take a day out of my time.”

RONALD C. MERRELL: So the drivers are certainly access and price. If you’re driving anything, I hope you always have a brake and a steering wheel. Along those lines, what are the barriers? What are the restraints? What are the clinical concerns with regard to medical tourism?

DEVON HERRICK: Our economy is going global. We’re aware of services that are far from home. Granted, you’ve got to get on a plane in many cases and fly abroad, but yet, we know about the quality. We can look up information about quality, whether it’s Joint Commission International credentials or ISO. We can see with confidence what services that are not offered in the U.S.—for example, stem cell replacement surgery and also certain bariatric treatments that may or may not be covered, and hip resurfacing. Some of those are just starting to come into approval and usage in the U.S.

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JOE WOODMAN: A couple of barriers are, of course, the long flight times and some of the increased risks there, especially if the patient is not as well as he or she might be. Continuity of care is an ongoing barrier, and that’s certainly an issue that falls squarely into the telemedicine orbit going forward.

RONALD C. MERRELL: Let me come back to something that Victor said about services not offered here. An early version of medical tourism involved alternative therapies not available or perhaps not even sanctioned in the U.S. Does alternative medicine still play a role in medical tourism?

VICTOR LAZZARO: At BridgeHealth International, we have a number of hospitals that actually feature that and have had patients specifically requesting that. Routinely, we find that a patient looking for a combination of both Western and so-called “alternative medicines.”

CHARLES R. DOARN: One of the issues—even with some of our telemedicine work in the early 1990s—was the legal issue of licensing with the patients in one place and the doctor in another country and therefore another jurisdiction. Any comments on licensing and legal matters as barriers?

JOE WOODMAN: Well, there are legal issues which some of the carriers and providers have largely worked through, and they’re not as onerous as they might seem on the surface, particularly if you’re looking at the leading hospitals, the JCI-accredited hospitals with a large number of surgeries and very, very high success rates comparable to those in the U.S. So the legal and liability issue is not as great. But again, the continuity of care in terms of the doctor-patient relationship across borders is something that needs to be bridged and is a definite barrier.

VICTOR LAZZARO: I’d support those comments, and there are a couple of aspects that are not necessarily publicized but that are important here: recognition that the medical tourist to the international hospital is very high profile and profitable for them. They are making sure that their best and brightest, if you will, are working on that patient and overseeing the procedure. So it gets a little closer scrutiny than the routine.

Secondly, medical records now can be transferred back and forth, and in many cases the pre- and post-care can be provided by the company that’s making the arrangements. At least we can do that.

RONALD C. MERRELL: It seems to me, as I read on the topic, that the mainstream of medical tourism involves units that have jumped over that barrier of international credentialing. I sit on one of the
advisory panels for JCI, the one on patient safety, and it would seem to me that the mainstream of medical tourism is fully accredited, credentialed units. This credentialing process doesn’t involve an emerging periphery, but, in fact, is the mainstream of what’s going on in medical tourism now. Is that fair?

JOE WOODMAN: It lends a great deal of comfort, particularly, to a U.S. or European patient. Ten years ago, before JCI, there were accreditation agencies. There were other countries that had great healthcare and local accreditation, but it might be in a different language. It might not have been posted on the Web. The combination of JCI and the growth of the Internet and distributive technologies have given a great deal of comfort not only to the consumer, but to the practitioners as well.

LINDA LUDWICK: From the aspect of the self-insured world, that’s going to be a critical issue. Our clients are going to want to know that this is going to move from an individual service to something that clients and employers are going to pick up as a potential benefit. So having these quality measures in place, and the people who are making the bridge between the care here and internationally, is going to be strategically important to implementing medical tourism for employer groups.

RONALD C. MERRELL: I can see that employers are always interested in the rapid recovery of their employees. They want to get people back. They want to have good outcomes and not pay an arm and a leg. Can you see a role of medical tourism in workers’ compensation injury?

LINDA LUDWICK: I could, if it was a long-term issue. Many workers’ comp issues are emergent, so that would take out the medical tourism aspect. However, if it was a long-range issue, I could see us involving workmen comp issues into that, or problems.

VICTOR LAZZARO: I would support that. I don’t know the incidence, for example, of some of the orthopedic procedures that are non-emergent, such as knee or hip replacement, which would fall under workmen’s comp. But theoretically, a case could be made for that. I would not see that being a leading offering.

RONALD C. MERRELL: I was thinking about it in terms of the chronic back injury and the repetitive action injuries and hernia that are in the workers’ compensation area. An acute injury on the job would probably not be at issue but a work-associated problem with a potentially surgical solution might be a matter for medical tourism.

VICTOR LAZZARO: From our perspective, when we look at which procedures fit best from an international standpoint, we categorize them two ways. I mentioned the incidental tourist item where the trip does not have to be justified in the cost savings. But so many procedures now can be done on an outpatient basis, in and out, and some of the costs have dropped such that from a transportation standpoint, the savings become smaller unless we’re going to a nearby Central American country.

RONALD C. MERRELL: With regard to the clinical issues, we’ve covered a lot of ground. We know that we can go to a place that has similar credentialing. We can know about it, we can understand it. We know why there are clinical issues. A lot of it has to do with cost, but some of it has to do with services not offered here. We understand that we have some brakes with regard to quality issues, but we are dealing with the matter of natural growth into a global economy. We covered workers’ compensation a bit, issues of confidence and licensure, and the very important observation that legal seems to be less of an issue than anyone would have ever thought.

LAURA CARABELLO: We’re seeing a lot of partnerships emerging between U.S. providers and foreign providers. This is where we’re going to find a lot of traction in the U.S. for larger hospitals, or even community hospitals with excess capacity that partner with foreign institutions in assuring cost-effective, highest-quality care, and back the U.S. providing follow-up treatment.

RONALD C. MERRELL: Thank you for bringing that up. It could be important to find a clinical and financial partnership between a U.S.’s base and an international arm.

VICTOR LAZZARO: Yes. I think there’s a corollary to that: the domestic hospital, again, partnering with an international hospital on clinical studies.

RONALD C. MERRELL: Ah, the research part.

VICTOR LAZZARO: I can’t say that we’re participating in any of that, but it has been mentioned in discussions, and we have basically said, “Well, not today, but let’s look at it tomorrow.”

RONALD C. MERRELL: Our next category is financial drivers. I propose we first ask why is it so much less expensive to have certain medical procedures done in countries other than the U.S.?

JOE WOODMAN: Well, first the spread between the retail and the wholesale price in the U.S. has become untenable for an uninsured or an underinsured healthcare consumer, a patient. Many of these expensive procedures, especially cardiovascular, orthopedic, and oncological, price themselves out of the market at the retail level.

On the other hand, you have a collapsing or telescoping of the bureaucracy across the water, less malpractice and lower surgeons’ salaries—anywhere from a third to a fifth what a surgeon in the U.S. would command. Most of international market is for surgical procedures. And that combination creates kind of a perfect storm, at least for now, where a 30 to 80 percent savings can be realized.

VICTOR LAZZARO: There is a much higher availability and a lower cost with nurses, also.
In addition, medical supplies, often from People coming here to the U.S., from say, for travel at all. And we might even advise them that they are fine for determining whether that patient is a good candidate to sit on an airplane. And we might even advise them that they are fine for

American companies, are sold at a lower price abroad because of the lower cost of living. Pharmaceuticals are also lower-priced, and at least in our agreements, we require a certain amount of the pharmaceuticals that the patient can carry back with them until they can get a prescription filled in the U.S.

So I have a fairly keen sense of why it is so much cheaper. First and foremost, the model of delivery of medical services is very different. Generally speaking, at big, major international hospitals, you’ve got an integrated care model where someone comes in and all of the practitioners and multiple specialties are all under one roof. That’s number one.

Number two, most of these hospitals work on a cash basis, not on an insurance basis. So right there, you’re taking about 20 cents on the dollar in administration costs right out of the equation. Because these are cash-based businesses, they have no accounts receivable. You ask for and get medical services. You pay for those medical services.

The third thing, of course, as Joe had mentioned, is that you definitely have lower wages. Wages are about 20 percent of the cost structure of an international hospital versus around 50 or 60 percent in the U.S. hospital. And then, of course, you’ve got lower costs being paid on things like malpractice and liability.

You put all of those together, and that starts to make sense of why these practitioners and hospitals overseas are charging a lot less, because they have got essentially what Toyota built in their auto manufacturing system. They’ve just got a leaner, meaner model in healthcare delivery.

In the U.S., it is possible to offer a remarkably low price or a package for international patients, because anyone who can get this far by definition is a lower-risk patient than the one who might come in through the emergency room with excellent insurance. Does that apply in medical tourism?

I believe it is. We do a risk assessment prior to determining whether that patient is a good candidate to sit on an airplane. And we might even advise them that they are fine for a short flight, but not for a long flight, or they are not a candidate for travel at all.

People coming here to the U.S., from say, Jordan or Saudi Arabia, for instance, may go to the Mayo Clinic. How important is branding, such as a Cleveland Clinic or a Massachusetts General Hospital, and how much does that influence choice?

Branding is a massive influence on decision making. Patients from Arabic countries, for example, are very, very name conscious with regard to medical facilities. When I was trying in early 2000 to get the Dubai Department of Health or the National Health Authority in Qatar to send their patients to Thailand, they were saying, “Yes, but we send our patients to Harley Street clinics in London, the Mayo Clinic, M.D. Anderson.” These are top-rated facilities. Only when Bumrungrad started to establish a brand name in that market did we start to see a massive shift of patients over to us.

More and more in healthcare brand becomes really the magnet. Because many times when people are traveling overseas, they don’t really know the doctors. They know the brand or the hospital.

I’m going to challenge a finance matter. Someone reading this may say, “Well, wait a minute. Then the U.S. hospital is not a disadvantage, and I believe we can fix that.” For example, the way we price the services in hospitals is curious. No one pays retail unless they lack insurance. Insurance companies negotiate with health units for a discount from retail. Therefore, the published retail price of U.S. health services bears little resemblance to what anyone actually pays.

That’s precisely right. The fact that they don’t have as much third-party payment in India goes beyond just saving the overhead to competition. When the consumer or the patient controls the dollar, and when the hospital wants that dollar, and they pay it directly, they have to compete for their business. And that is precisely what you’re talking about when you say the U.S. hospitals have a retail price that no one pays. When the consumer enters that hospital, a third-party insurance company is paying the bill. That is why our healthcare system is so uncompetitive, and that is why a lot of the hospitals abroad are much more efficient.

From the third-party administrator’s standpoint, I know when using the different networks throughout the U.S., most of the time our clients will achieve about a 51 percent discount, utilizing networks. So you have a 51 percent discount off retail.

With regard to the high cost of implants and so forth, why is it that the same U.S. manufacturer can market an implant for half the price in India that it would cost to buy that same implant for a patient treated in the U.S.?

I would sense that again no one in markets like India, Thailand, Malaysia, or the Philippines would pay the prices that manufacturers want to charge in the U.S. for similar products overseas. Again, it’s much more competitive. It’s cash-based. They understand that there is going to be a lower purchasing power in

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these markets. They’ve got to lower their prices if they want to sell the product.

**RONALD C. MERRELL:** That will also apply to drugs so that the same drug made by a U.S. manufacturer may be a fraction of the U.S. cost when purchased abroad.

**VICTOR LAZZARO:** Yes, that’s accurate and addresses some of the other cost problems here in the U.S.

**RONALD C. MERRELL:** The reason I mention these matters is not to be contrarian, but because there are many aspects that make the care of U.S. patients abroad financially desirable that reflect anomalies in the U.S. medical market.

The nurse supply is so large in other parts of the world that the cost for nursing goes down. And an excess supply of physicians in other parts of the world also plays a role in the supply/demand aspect of medical cost.

**LAURA CARABELLO:** In many other countries, the cost of labor and the labor supply is much different than in the U.S., where constraints of minimum wage, unions, and other pressures on our system cannot be avoided. Furthermore, the inherent cost of litigation and the threat of litigation essentially do not exist in other parts of the world.

**RONALD C. MERRELL:** I have one last challenge question, then, Linda. Do you think there will be a backlash or a reaction to sweatshop medicine being performed in other parts of the world, where the laborers lack representation and rights?

**LINDA LUDWICK:** I do believe that there will be a backlash. However, I think the baby boomer issue that’s going to hit the whole health industry—not just medical tourism—predicts that we will have a lot of talented people leaving the medical worker pool with no bodies to fill their places. And the only way that we can make up some of this worker loss is by shifting some services to other countries or bringing their workers here. Medical tourism makes a lot of sense financially from that aspect, as well.

**VICTOR LAZZARO:** With regard to lack of worker representation, that is not necessarily the case. China is an example. Nearly every person there works in a larger organization—for instance, a hospital—and is represented by a union, as required by the central government. Their union fees take a substantial portion of their income and cover a substantial portion of social benefits, just as they might in France and, to some degree, even here, parallel to Social Security. So they do have representation. They do have coverage in many of those countries. It’s just somewhat different than the way it is here.

**JOE WOODMAN:** Just commenting on the sweatshop terminology that was used: in order to have a backlash against a sweatshop scenario, you’ve got to have the sweatshop in the first place. And one of the pillars of medical travel is that it’s quite the opposite of a sweatshop. You’re getting gold standard care and heavy accreditation, and a lot of governmental supervision. So I don’t anticipate a sweatshop mentality, at least not in the next three to five years.

**RONALD C. MERRELL:** We can do a lot of things with technology such that being cared for abroad or in other places is really not altogether different from being cared for in the U.S. I am most interested in what the group here with us today has to say about what telemedicine should be doing to support medical tourism.

**JOE WOODMAN:** That conversation begins with the role that telemedicine is currently playing, because at its most pragmatic and pedestrian level, it is part and parcel of the medical travel experience. The medical travel experience by definition could not exist without telemedicine, without some kind of telecommunications, whether by a consultative e-mail, physician to patient, patient to physician, scheduling an appointment, the digital transfer of medical records and x-rays and images, all the way through to the post-operative, post-procedure consultation that helps to reinforce continuity of care. All of that is going on right now without a real consciousness of the fact that it is telemedicine. Telecommunication is so important to the experience that medical travel would be unthinkable without it.

**LAURA CARABELLO:** Telemedicine is going to be a very key component of ensuring that aftercare and follow-up care is streamlined and coordinated.

**JOE WOODMAN:** Yes, I agree. That’s where the “shoulds” come in. U.S. physicians, whether it’s on the domestic front or the international front, are reluctant to use e-mail. I speak, really, from my own personal experience and the personal experience of patients that we have interviewed and the research for *Patients beyond Borders*. Across the water e-mail is used regularly by paying patients. There’s a collapsing of the bureaucracy. There’s much more of a direct relationship between the patient and the physician or the patient and the surgeon. E-mail, the Internet, and other tools are much more widely used on the international front.

Where the “shoulds” come in is in the continuity of care. One would hope that the physician-to-physician relationship which would help to reinforce continuity of care post-procedure would be more readily embraced as practitioners become more comfortable with the medical travel experience and feel more a part of the global health-care experience.

**RONALD C. MERRELL:** It would seem to me continuity has to come back to the managing medical people in the U.S.—primary care or a peer in the same specialty or a rehabilitation specialist. This should be an area where telemedicine could make medical tourism stronger. How strong is it right now in terms of the handover of care from the international facility back to the U.S. for rehabilitation?
DAVID BOUCHER: I certainly do. I am reading an article that just came out a few minutes ago—at www.USCensus.gov. An increasing number of folks are turning 62—365 Americans just turned 62 while we’ve been on this call. Fifty-one percent of those people do not have Medicare and won’t have it for another three years unless they’re drawing early Social Security. And 95 percent of those patients do not have an employer-sponsored medical plan.

RONALD C. MERRELL: In surgery, there has been a global billing tradition that says for 90 days after the procedure the operating surgeon is responsible for that patient no matter what happens to them. How is that handled in medical tourism in terms of maintaining at least a 90-day continuity of care, which is sort of an ethical and business responsibility in the U.S.?

LINDA LUDWICK: I can speak from our angle. We would implement case management with each individual to coordinate care between their primary care in the U.S. and the surgeon that had performed the services overseas.

RONALD C. MERRELL: How about videoconferences with the person who is going to be your operating surgeon in another place? Is that done?

RUBEN TORAL: Yes, it is done in medical tourism outside the U.S. So you’ll find if you go to India, for example, that they have vid-
eoconferencing with patients in Sri Lanka or patients in Bangladesh where they have set up referral offices. I believe the Cleveland Clinic may do the same in Dubai.

RONALD C. MERRELL: Our time is up. And I can’t tell you how grateful I am. We have comments from everybody on all three areas, and we’re going to work on some things. I’m really optimistic that telemedicine has a lot to offer, and what I think is a very exciting, well-grounded, sensible, and inevitable aspect of healthcare—medical tourism. With regard to drivers for medical tourism there is a clear demand created by access and cost issues. Related issues may be remediable in the U.S., but economics and demographics make that unlikely. The drivers are so strong that deterrents are being easily carried along and the industry is being supported by the investment community and not international development or philanthropy. Telemedicine is already a part of this phenomenon in the use of communications and electronic data transfer. However, the role of telemedicine in securing seamless care could bring medical tourism into a continuum from diagnosis to patient information to treatment, consultation, recovery, rehabilitation, and full spectrum longitudinal care and health maintenance. Medical tourism offers a great challenge to the telemedicine community and a challenge we can hardly ignore in the interest of our specialties, our technology, and our patients.

Address correspondence to:
Ronald C. Merrell, M.D.
Professor of Surgery
Clinical Director of VCU Health Systems Telemedicine Program
Virginia Commonwealth University
1101 East Marshall Street
Richmond, VA 23298

E-mail: rmerrell@mcvh-vcu.edu