

2008

“Incredible [Accreditable] India”: Trends in Hospital Accreditation Coexistent with the Growth of Medical Tourism in India

Elizabeth Gluck
elizabethgluck@gmail.com

Follow this and additional works at: <https://scholarship.law.slu.edu/jhlp>



Part of the [Health Law and Policy Commons](#)

Recommended Citation

Elizabeth Gluck, *“Incredible [Accreditable] India”: Trends in Hospital Accreditation Coexistent with the Growth of Medical Tourism in India*, 1 St. Louis U. J. Health L. & Pol’y (2008).

Available at: <https://scholarship.law.slu.edu/jhlp/vol1/iss2/8>

This Student Comment is brought to you for free and open access by Scholarship Commons. It has been accepted for inclusion in Saint Louis University Journal of Health Law & Policy by an authorized editor of Scholarship Commons. For more information, please contact [Susie Lee](#).

“INCREDIBLE [ACCREDITABLE] INDIA”:¹ TRENDS IN HOSPITAL ACCREDITATION COEXISTENT WITH THE GROWTH OF MEDICAL TOURISM IN INDIA

I. INTRODUCTION

Over the past decade, an increasing number of patients are traveling to India for medical treatment as part of a growing “medical tourism” trend in that country.² Some choose to explore India’s sights and sounds before or after their medical procedures.³ Most, if not all, choose India for the highly discounted price of medical treatment. And like any good sale, word about the deals found in India has spread quickly.⁴ A collaborative study⁵

1. *Incredible India* is the title of India’s Medical Tourism Brochure and marketing campaign. DEPARTMENT OF TOURISM AND MINISTRY OF HEALTH & FAMILY WELFARE, GOVERNMENT OF INDIA, INCREDIBLE INDIA: THE GLOBAL HEALTHCARE DESTINATION (n.d.), available at www.incredibleindia.org/PDF/medicaltourismbroacher.pdf (last visited Aug. 13, 2008) [hereinafter INCREDIBLE INDIA: THE GLOBAL HEALTHCARE DESTINATION].

2. See generally Nicolas P. Terry, *Under-Regulated Health Care Phenomena in a Flat World: Medical Tourism and Outsourcing*, 29 W. NEW ENG. L. REV. 421, 423 (2007) (discussing how patients travel from industrialized countries to less-developed countries for medical care); Atul D. Garud, *Medical Tourism and Its Impact on Our Healthcare*, 18 NAT’L MED. J. INDIA 318, 318-19 (2005) (noting that India has a vast pool of trained medical personnel); see also CONFEDERATION OF INDIAN INDUSTRY AND MCKINSEY & CO., HEALTHCARE IN INDIA: THE ROAD AHEAD app. C at 246 (2002) [hereinafter CII-MCKINSEY STUDY] (stating that India’s medical tourism market grew from +15% in 1995 to +30% in 2000); DEVON M. HERRICK, NAT’L CTR. FOR POLICY ANALYSIS, MEDICAL TOURISM: GLOBAL COMPETITION IN HEALTH CARE (2007) (“In 2006, the medical tourism industry grossed about \$60 billion worldwide. McKinsey & Company estimates this total will rise to \$100 billion by 2012.”); J. CHRISTOPHER HOLLOWAY & NEIL TAYLOR, THE BUSINESS OF TOURISM (Financial Times/Prentice Hall 2006) (stating that medical tourism is not a new concept).

3. See, e.g., Paul B. Brown, *Have Surgery. Go Sightseeing.*, N.Y. TIMES, Mar. 24, 2007, at C5 (explaining that medical tourism often involves recuperation at a resort or tourist destination).

4. See, e.g., Gouri Agtey Athale, *More Hospitals Offer Medical Tourism*, ECON. TIMES (India), Jan. 5, 2007 (stating that medical tourism is quickly catching on); Julie Davidow, *Thousands of ‘Medical Tourists’ Are Traveling Abroad to Save Money—And at Their Own Risk*, SEATTLE POST-INTELLIGENCER, July 24, 2006, at A1 (explaining that medical tourism “has become wildly popular”); Brad A. Greenberg, *Healing Journeys: More Americans Going Abroad to Save Money on Surgery*, DAILY NEWS (L.A., Cal.), Aug. 7, 2006, at U4 (noting that many are sharing the news about foreign healthcare with their friends).

5. CII-MCKINSEY STUDY, *supra* note 2.

conducted by the Confederation of Indian Industry (CII), a business lobby,⁶ and international management consultants, McKinsey & Company,⁷ projects that India's medical tourism industry will be a \$1.1 to 2.2 billion industry by the year 2012,⁸ second only to information technology and business outsourcing.⁹ Today, the medical tourism market in India is worth approximately \$700 million.¹⁰

Although no organization currently tracks the actual number of Americans who travel to India as medical tourists,¹¹ the National Coalition on Health Care estimated that 500,000 Americans traveled abroad for medical procedures in 2005.¹² Another account is that three quarters of the over 1.5 million international patients who had visited India as of January 2007 came from the United States and the United Kingdom.¹³ Anil Maini, president of the India-based Apollo Hospitals Group, the largest corporate healthcare group in Asia,¹⁴ estimates that ten Americans per month undergo surgery in Apollo Hospitals and an additional forty to fifty schedule eye exams, dental work, and computed axial tomography (CAT) scans, among other procedures.¹⁵ Apollo Hospitals also fields approximately 100 treatment inquiries per day, the majority of which come from the United States.¹⁶

6. *Get Well Away: Medical Tourism to India*, ECONOMIST (London), Oct. 9, 2004, at 76; see also Confederation of Indian Industry (CII), <http://cii.in> (last visited Aug. 24, 2008).

7. See McKinsey & Company – Home Page, www.mckinsey.com/ (last visited Aug. 11, 2008).

8. CII-MCKINSEY STUDY, *supra* note 2, app. C at 247; *infra* note 33; *Get Well Away: Medical Tourism to India*, *supra* note 6.

9. *Medical Tourism Is Here to Stay*, TIMES INDIA, Feb. 28, 2007.

10. Darlington Jose Hector, *'Treated in India' Catching on in West*, TIMES INDIA, Jan. 27, 2007; see also CONFEDERATION OF INDIAN INDUS., HEALTHCARE: POTENTIAL, at http://cii.in/menu_content.php?menu_id=238 (last visited Aug. 17, 2008) ("In India . . . [h]ealthcare has emerged as one of the largest service sectors with [an] estimated revenue of around \$30 billion constituting 5% of GDP [Gross Domestic Product] and offering employment to around 4 million people.").

11. Joyce Howard Price, *Under the Knife Overseas: With Medical Tourism, Cost is Deepest Cut*, WASH. TIMES (D.C.), Dec. 3, 2006, at A1.

12. Editorial, *Hospitals Must Be Competitive: Medical Tourism Will Be a Reality Regardless of West Virginia Law*, CHARLESTON DAILY MAIL (W. Va.), Feb. 19, 2007, at 4A.

13. Hector, *supra* note 10.

14. The Apollo Hospitals Group owns and manages forty-one medical facilities in and around India, making it the largest healthcare provider in Asia. Apollo Hospitals Group, About Us: Overview, www.apollohospitals.com/overview.asp?PgEuld=1066 (last visited Aug. 17, 2008); Apollo Hospitals Group, www.apollohospitals.com (last visited Aug. 17, 2008).

15. Kathleen Kerr, *Tourism & Treatment*, NEWSDAY (N.Y.), Sept. 26, 2006, at B6.

16. *Id.* (according to Apollo's President, Anil Maini).

The first wave of American medical tourists traveled to India in search of discounted elective procedures predominantly aesthetic in nature.¹⁷ Over the past five years, however, American patients have been seeking increasingly complex forms of medical treatment in Indian hospitals.¹⁸ Vishal Bali, the Chief Executive Officer of Wockhardt Hospitals, another corporate health system in India, observes that “[w]hat started as a low-cost, low-value medical care destination is today turning into a superspeciality zone.”¹⁹ Hip, knee, and spinal disc replacements and a variety of cardiac surgeries are among the many medical procedures offered in Indian hospitals.²⁰

American medical tourists generally fall into one of three categories: the uninsured, insured patients with coverage gaps, and patients sent to India by health insurance companies or employers eager to reduce healthcare expenditures.²¹ It appears, however, that only a small number of patients

17. See generally JEFF SCHULT, *BEAUTY FROM AFAR: A MEDICAL TOURIST’S GUIDE TO AFFORDABLE AND QUALITY COSMETIC CARE OUTSIDE THE U.S.* (2006) (discussing the medical tourism industry and focusing on the costs and benefits of traveling abroad for cosmetic care, other elective surgeries, and the author’s personal experience with medical tourism); JOSEF WOODMAN, *PATIENTS BEYOND BORDERS: EVERYBODY’S GUIDE TO AFFORDABLE, WORLD-CLASS MEDICAL TOURISM* (2007) (a consumer guidebook that evaluates hospitals and treatment centers in twenty-two worldwide destinations).

18. For accounts of medical tourist experiences see, for example, INCREDIBLE INDIA: THE GLOBAL HEALTHCARE DESTINATION, *supra* note 1, at 1, 9 (discussing uninsured Howard Staab’s heart surgery); *id.* at 23 (discussing Henry McInnes’ root canal surgery); *id.* at 25 (discussing Charles Keiser’s surgery for cervical spondylosis of the neck and lumbar spondylosis of the back); AARP, AARP BULLETIN TODAY, ONLINE EXTRA: MEDICAL TOURISM (showing a slideshow of Patricia Hansen’s experience of receiving medical care in New Delhi, India); Medical Tourism-Healthbase-Patient Stories, Resources, www.healthbase.com/resources/patient-stories/testimonials (last visited Aug. 12, 2008) (providing testimonials of patients who have gone overseas for treatment).

19. Hector, *supra* note 10; see also Radhika Pandeya, *Healthcare Goes Five-Star*, INDIA ABROAD (N.Y.), Dec. 1, 2006, at 33 (discussing that people from low and high income groups, under one roof, are receiving the same services).

20. See generally NEAL CONAN, *MEDICAL TOURISM, AND THE COSTS OF TRAVELING FOR CARE* (NAT’L PUB. RADIO Mar. 8, 2007) (discussing the most sought after procedures).

21. See generally Davidow, *supra* note 4 (noting that many uninsured Americans and those with some form of coverage gaps, seek medical care overseas). U.S. health insurers and employers are exploring the idea of outsourcing healthcare procedures. Karen Pallarito, *Insurers Investigate Medical Tourism to Save Money on Care: Questions Remain About Quality of Care in Overseas Facilities*, BUS. INS., Dec. 11, 2006, at 17 (Employers have pursued creative alternatives to combat the rising cost of healthcare. For example, state legislation has been proposed, though none has been approved to date, which “would pay for state employees to have medical procedures in hospitals outside the United States.” Kris Wise, *Bill Would Cover Surgeries Outside U.S., Travel, Medical Costs Would Be Paid If Care Was Significantly Less Expensive in Another Nation*, CHARLESTON DAILY MAIL (W. Va.), Feb. 3, 2006, at 7A.

from the United States who seek highly discounted medical treatment in India are actually influenced by a hospital's accredited status when making the initial decision to obtain treatment in India versus the United States. Accreditation is valuable for Indian hospitals competing for patients who have already decided to travel abroad, but accreditation status probably does not influence a person's initial choice to leave the United States. For that decision, the price of medical treatment controls.

After a brief introduction to India's medical tourism industry in Part II, Part III of this Article focuses on a notable trend that has emerged in India concurrent with the growth of the medical tourism industry: the increase in public and private efforts to accredit medical facilities on international, national, and even local levels and India's use of accredited status as a means of promoting the legitimacy of its medical facilities to foreign consumers. This trend, and the emergence of a "one-stop shopping" approach to medical tourism combining Western medicine and India's traditional healing arts,²² appears to be driven by India's efforts to develop a distinctive brand of medical tourism in the face of stiff regional competition.²³

II. MEDICAL TOURISM IN INDIA

A. Background

During the 1990s, the Indian healthcare industry grew at a compound annual rate of 16%.²⁴ By 2012, India's healthcare market is projected to expand from \$22.2 billion, or 5.2% of gross domestic product (GDP), to between \$50 and \$69 billion, 6.2% and 8.5% of GDP, respectively.²⁵ International demand for medical treatment in India has spurred "rapid expansion at big stockmarket-listed hospital operators such as . . . India's Apollo Hospitals," Wockhardt Hospitals, and Fortis Healthcare Hospitals.²⁶

22. See discussion *infra* Part II.

23. Competitor destinations include Malaysia, Singapore, and Thailand. See, e.g., Vishakha Talreja, *Yoga & Ayurveda: New Mantras of Tourism*, *ECON. TIMES* (India), Sept. 17, 2006 ("By focusing on niche tourism we want to differentiate India as a tourist destination, from the others," said Amitabh Kant, [J]oint [S]ecretary, [M]inistry of [T]ourism.").

24. *Windows of Opportunities Open Up for Health Sector*, *HINDU* (India), Nov. 15, 2007, at 18.

25. Rupa Chinai & Rahul Goswami, *Medical Visas Mark Growth of Indian Medical Tourism*, 85 *BULL. WORLD HEALTH ORG.* 164, 164 (2007) (All figures are in U.S. dollars; healthcare industry includes health insurance.).

26. *Medical Tourism: Sun, Sand and Scalpels*, *ECONOMIST* (London), Mar. 10, 2007, at 79; see also Pandeya, *supra* note 19 ("The last five years have witnessed the evolution of very large corporate hospitals that don't stop at just a single unit. So you have Max Healthcare setting up six hospitals in Delhi alone, Wockhardt setting up 10 across the country, Apollo

B. CII-McKinsey Study

In 2002, the CII's National Committee on Healthcare "set out to define an achievable way forward for [Indian] healthcare and commissioned McKinsey & Company to define 'The Road Ahead.'"²⁷ The Committee's research was guided by three objectives.²⁸ First, the Committee chose to focus on the future of Indian healthcare rather than dwell on past failures.²⁹ Second, the Committee studied "the Indian healthcare landscape in parallel with that of developing and developed countries" and sought to "cull out lessons, if any, for India."³⁰ Third, the Committee aimed to make its "recommendations actionable and realistic."³¹ Medical tourism was one area that the Committee identified as an emerging opportunity for India's healthcare industry.³²

The CII-McKinsey Study projects that by the year 2012, the size of the total medical tourism market will be 195 thousand crore, or almost 2 trillion U.S. dollars.³³ According to the Study's estimates, the medical tourism market would represent 3% to 5% of the total healthcare delivery market in India by 2012.³⁴ The CII-McKinsey Study recommends that India's healthcare industry undertake several key actions in order to realize medical tourism's potential: (1) "[p]romote independent accreditation to identify hospitals that meet international standards";³⁵ (2) "[a]pproach large payors from developed markets . . .³⁶ and negotiate as a group of providers to enhance credibility";³⁷ and (3) "[i]nvite government to collaborate."³⁸ The

Hospitals going international and Fortis Healthcare running 12 hospitals in north India, with more in the pipeline. Indian healthcare owes its facelift to changing consumer expectations.").

27. CII-MCKINSEY STUDY, *supra* note 2, at Forward.

28. *Id.* at Introduction.

29. *Id.*

30. *Id.*

31. *Id.*

32. CII-MCKINSEY STUDY, *supra* note 2, app. C at 245 ("Medical tourism has great potential in India due to a strong value proposition on cost, quality and service").

33. *Id.* at 247; see also Kshitij Consultancy Services, Lakhs And Crores to Millions and Billions, at www.kshitij.com/utilities/LnCtoMnB.shtml (last visited Apr. 20, 2008) ("To convert a Rupee amount (given in Crores), into its corresponding Dollar amount in Millions, divide the [R]upee [a]mount by 4.87. Thus, Rs 4.87 Cr = Rs 4,87,00,000/- = USD 1 million[.] Similarly, Rs 16 Cr = USD 3.29 million." Therefore, 1 crore = 10 million and 195,000 crore = approximately 1,950,000,000,000 U.S. Dollars. This conversion rate was as of April 20, 2008.).

34. CII-MCKINSEY STUDY, *supra* note 2, app. C at 246.

35. *Id.*

36. For example, the CII-McKinsey Study identified private insurance companies as a large payor from a developed market. *Id.*

37. *Id.*

38. For example, the Committee suggested that "Indian missions abroad should be able to deliver visas promptly." *Id.*

Committee suggested that individual hospitals, specifically: (1) get accredited (2) “[i]ncrease awareness about low price and high quality through websites targeting individual patients,” and (3) “[b]uild specific capabilities to improve service to foreign patients,” such as call centers, travel agencies, and welcoming staff.³⁹

C. *“Incredible India:” Marketing India’s Brand of Medical Tourism Abroad*

The 2002 release of the CII-McKinsey Study and the launch of the “Incredible India” advertising campaign marked the beginning of India’s concerted effort to promote medical tourism abroad.⁴⁰ India now has tourism offices in thirteen countries: Australia, Canada, China, France, Germany, Italy, Japan, the Netherlands, Singapore, South Africa, the United Arab Emirates, the United Kingdom, and the United States.⁴¹ There are two offices in the United States, one in New York City and one in Los Angeles.⁴²

Through its more specific “Wellness” campaign, designed and implemented through the collaborative efforts of India’s Ministries of Health, Tourism, External Affairs, and Aviation, India brands itself to foreign consumers as “The Global Healthcare Destination.”⁴³ In 2003, then finance minister Jaswant Singh called for widespread infrastructural improvements to accommodate medical tourists.⁴⁴ Since his call to action, many changes have been effected, ranging from the basic, such as improved roads, to the more complex, such as building new airports.⁴⁵

39. CII-MCKINSEY STUDY, *supra* note 2, app. C at 246.

40. Chinai & Goswami, *supra* note 25, at 164; see also Incredible India: The Official Tourism Website of Ministry of Tourism, Government of India, www.incredibleindia.org (last visited Aug. 17, 2008) (discussing the Incredible India campaign); INCREDIBLE INDIA: THE GLOBAL HEALTHCARE DESTINATION, *supra* note 1.

41. Incredible India: The Official Tourism Website of Ministry of Tourism, *supra* note 40, at Helpdesk: India Tourism offices – Abroad, www.incredibleindia.org/newsite/cms_page.asp?pageid=1109 (last visited Aug. 17, 2008).

42. *Id.*

43. *Id.* at Wellness, www.incredibleindia.org/newsite/cms_page.asp?pageid=492 (last visited Aug. 17, 2008); INCREDIBLE INDIA: THE GLOBAL HEALTHCARE DESTINATION, *supra* note 1.

44. Chinai & Goswami, *supra* note 25, at 164; see, also MIRA KAMDAR, PLANET INDIA: HOW THE FASTEST-GROWING DEMOCRACY IS TRANSFORMING AMERICA AND THE WORLD 194 (2007) (“Decades of neglect and explosive population growth have left India’s urban infrastructure in tatters.”). The CII-McKinsey Study also called for infrastructural improvements in order to accommodate the increasing demand for healthcare services. See CII-MCKINSEY STUDY, *supra* note 2, at 4 (“To meet the demand for healthcare in 2012 and improve the availability of hospital beds and doctors, the infrastructure will need to improve significantly. Around 750,000 additional beds will need to be added to the existing base of 1.5 million beds . . . [c]reating this infrastructure will require investments in hospitals (secondary and tertiary), medical colleges, nursing schools and hospital management schools.”).

45. For example, India’s two largest airports at Delhi and Bombay are being redeveloped and modernized “through a private-public partnership in which the Airports Authority of India

"However, as has historically been the case in India, this effort, like other badly needed infrastructure upgrades, has been a reactive response to a crisis."⁴⁶

The increased prevalence and expansion of corporate hospital systems in India after the release of the CII-McKinsey Study (for example, Max Healthcare,⁴⁷ Wockhardt Hospitals,⁴⁸ Apollo Hospitals,⁴⁹ and Fortis Healthcare⁵⁰) has helped India earn a reputation abroad as a destination for cutting-edge private medical facilities and high-quality medical care.⁵¹ And these corporate hospitals have spared no expense in their efforts to attract medical tourists, "[b]e it introducing healing coaches for patients, incorporating aerobics centres, health spas or swimming pools or even building a separate 500-bed hospital exclusively for foreign patients."⁵²

[a government entity] holds a 26 percent share." KAMDAR, *supra* note 44, at 123. New airports are also planned for the cities of Bangalore and Hyderabad. *Id.*

46. *Id.* This reactive tendency raises questions about India's ability to support future medical tourism growth.

47. Max Healthcare was the first hospital in North India to earn accreditation from India's National Accreditation Board for Hospitals & Healthcare Providers (NABH) (discussed *infra* Part III). See generally Max Healthcare, www.maxhealthcare.in/corporate/index.html (last visited Aug. 12, 2008) (noting that Max Healthcare hospitals became the first hospitals in North India to receive NABH accreditation, awarded for the highest quality of care).

48. Wockhardt Hospitals is an associate hospital of Harvard Medical International. See generally Wockhardt Hospitals, www.wockhardthospitals.net/ (last visited Aug. 17, 2008) (stating they have "state of the art facilities, world class infrastructure and excellent patient care"); Harvard Medical International, HMI Partners: Wockhardt Hospitals, www.hmi.hms.harvard.edu/hmi_partners/partners/wockhardt.php (last visited Aug. 17, 2008) (noting "the development of high-quality facilities and clinical programs").

49. The largest of the corporate hospital system catering to medical tourists in India is the Apollo Hospital Group. See generally Apollo Hospitals Group, *supra* note 14 (noting that Apollo Hospitals has over 8,000 beds in more than forty-one hospitals).

Apollo Hospitals initially contracted with Britain's National Health Service to conduct medical tests for patients at much cheaper prices. Apollo's business grew significantly with the deregulation of the Indian economy, and the company imported modern medical equipment. Over time, patients from Europe, the Middle East and Canada began to arrive for treatment. Apollo now has more than 37 hospitals in India, and additional sister hospitals in Kuwait, Sri Lanka and Nigeria. Apollo has been so successful that it has offered its services and free beds to India's indigent populations.

Diana M. Ernst, *Medical Tourism: Why Americans Take Medical Vacations Abroad*, HEALTH POL'Y PRESCRIPTIONS, Sept. 2006, at 3, available at http://liberty.pacificresearch.org/docLib/20070223_hppv4n9_0906.pdf (last visited Aug. 14, 2008).

50. Fortis Healthcare recently acquired the Escorts Healthcare System. See generally Fortis Healthcare, About Us, at www.fortishealthcare.com/about_fortis/about_us/fortis_group.html (last visited Aug. 17, 2008) (noting its growth strategy entailed the acquisition of the Escorts Healthcare System).

51. See generally Pandeya, *supra* note 19 (noting that patients can get "world class-healthcare at less than half the cost" than in the US and UK).

52. *Medical Tourism Is Here to Stay*, *supra* note 9.

Mumbai, Delhi, Bangalore, and Chennai are India's major medical tourism destinations for standard surgical procedures, and these states comprise approximately 70% of India's total medical tourism revenue.⁵³ Southern India, specifically the state of Kerala, is the most popular destination for "complementary" and alternative medical therapies,⁵⁴ particularly Ayurveda.⁵⁵ This region accounts for the remaining 30% of revenue generated by medical tourism.⁵⁶

Cost drives consumers of medical treatment to seek less expensive alternatives abroad.⁵⁷ Healthcare in India is less expensive than it is in the United States primarily due to the value of the American dollar in undeveloped countries.⁵⁸ This price difference translates to medical procedures in India costing approximately one-fifth to one-tenth of the U.S. price.⁵⁹ The cost of advanced surgeries performed in India is estimated to be ten to fifteen times less than anywhere else in the world.⁶⁰ For example, a heart surgery that would cost \$30,000 in the United States costs approximately \$6,000 in India, and a bone marrow transplant with a price tag of \$250,000 in the United States would be billed at approximately \$26,000 in India.⁶¹ Knee replacement surgery in India costs approximately \$8,500, but, if performed in the United States, the same operation would cost approximately \$40,000.⁶² Despite significant cost savings, some

53. *India's Healing Touch*, HINDUSTAN TIMES (India), Oct. 18, 2006.

54. Complementary medical therapies include, for example, yoga and acupuncture. INCREDIBLE INDIA: THE GLOBAL HEALTHCARE DESTINATION, *supra* note 1, at 7.

55. *India's Healing Touch*, *supra* note 53. Ayurveda is the "the ancient holistic and comprehensive Indian system of therapy that revolves around organism-environment interaction and relies on a rich herbal pharmacopoeia." K.G. Kumar, *Protecting Traditional Knowledge*, HINDU BUS. LINE (India), Dec. 11, 2006, at 15.

56. See *id.* ("[A]lternative therapies like Ayurveda . . . make up the rest of the revenue pie.").

57. See generally THOMAS L. FRIEDMAN, *THE WORLD IS FLAT: A BRIEF HISTORY OF THE TWENTY-FIRST CENTURY* (2006) (discussing outsourcing as a by-product of economic globalization in the twenty-first century). See generally Stuart H. Altman, David Shactman & Efrat Eilat, *Could U.S. Hospitals Go the Way of U.S. Airlines?*, 25 HEALTH AFF. 11, 18-19 (2006) ("The primary reason that Americans travel for medical services is price."); Terry, *supra* note 2 (arguing that medical tourism can be viewed as the complete outsourcing of healthcare).

58. See generally Price, *supra* note 11 ("The American dollar is more valuable in many undeveloped, foreign countries . . ." (quoting Ernst, *supra* note 49, at 1). "Generic drugs produced by Indian pharmaceutical companies" also lower the costs of medical treatment. KAMDAR, *supra* note 44, at 15.

59. See INCREDIBLE INDIA: THE GLOBAL HEALTHCARE DESTINATION, *supra* note 1, at 5 ("The average cost of healthcare in India is about 1/5th to 1/10th that of the West.").

60. *Id.*

61. *Id.*

62. 'Medical Tourism Is Next Big Boom After IT Sector', HINDUSTAN TIMES (India), Feb. 13, 2007. See generally KAMDAR, *supra* note 44, at 255 ("While the care provided at these

medical procedures, for example in vitro fertilization, can be prohibitively expensive due to the length of the treatment that increases the costs of the stay.⁶³

India's lower healthcare labor costs are partially attributable to the country's less active, and relatively non-existent, medical malpractice bar, as compared to the United States.⁶⁴ In the absence of an active malpractice bar, doctors in India pay approximately twenty-five times less than American doctors for malpractice insurance coverage, sometimes as little as \$4,000 a year.⁶⁵ Despite these seemingly favorable working conditions, the realities of life in a third world country prompt many Indian doctors to emigrate. There are over 41,000 physicians and 12,000 medical students, residents, and fellows of Indian origin in the United States.⁶⁶ Additionally, because medical tourism facilities require full payment before services are rendered, India's hospitals are generally not burdened with the expense of unpaid debts like many American hospitals. Those debts, in turn, are not factored into the price of medical procedures.⁶⁷

Cost is not the only reason people choose India for medical procedures. Patients from countries with nationalized healthcare systems, such as Canada and the United Kingdom, are often frustrated by long waiting periods.⁶⁸ For others, medical conditions necessitate immediate care to

facilities is much too costly for most Indians, it is a bargain compared to what equivalent care costs in the United States.”).

63. See generally CONAN, *supra* note 20 (explaining that patients have to consider their cost of being overseas for a specific time period); see also Price, *supra* note 11 (“[I]t is not financially wise to go abroad for a procedure that would cost \$6,000 in the United States. Even if the same procedure costs only \$1,500 in a foreign country, ‘you’ll probably only break even,’ when you add in the costs of airfare and hotel accommodations” (quoting Patrick Marsek, Spokesperson for MedRetreat)).

64. Price, *supra* note 11 (“[M]edical malpractice is not nearly so ruthless’ overseas as it is in the United States” (quoting Ernst, *supra* note 49, at 1)).

65. Price, *supra* note 11; Ernst, *supra* note 49, at 2; see also DANIEL P. KESSLER, THE DETERMINANTS OF THE COST OF MEDICAL LIABILITY INSURANCE, available at www.piaa.us/pdf_files/press_releases/Kessler_Malpins_Report.pdf (last visited Aug. 14, 2008); MICHELLE M. MELLO, ROBERT WOOD JOHNSON FOUND., UNDERSTANDING MEDICAL MALPRACTICE INSURANCE: A PRIMER, available at www.rwjf.org/pr/synthesis/reports_and_briefs/pdf/no10_primer.pdf (last visited Aug. 14, 2008).

66. American Association of Physicians of Indian Origin (AAPI), About AAPI, at www.aapiusa.org/about/aboutus.htm (last visited Aug. 17, 2008); see also *infra* Section IV (Looking Forward). See generally Fitzhugh Mullan, *Doctors for the World: Indian Physician Emigration*, 25 HEALTH AFF. 380, 381 (2006) (noting that large numbers of Indian physicians travel to the United States, the United Kingdom, Canada, and Australia to pursue residency training).

67. Patrick Marsek, spokesperson for MedRetreat, explains that “[h]ospitals involved in medical tourism don’t take you unless you pay. When you go overseas for medical tourism, you present your credit card, and that’s that.” Price, *supra* note 11.

68. Hector, *supra* note 10.

avoid death or other serious consequences.⁶⁹ Additionally, some patients go to India to obtain higher quality care than they might receive in their home countries, such as Bangladesh, Kenya, and Vietnam.⁷⁰

Criticisms of outsourcing aside, healthcare economists generally believe that “medical tourism is a reasonable option” for uninsured Americans and those requiring especially expensive procedures.⁷¹ However, according to David Dranove, Director of the Center for Health Industry Market Economics at the Kellogg School of Management at Northwestern University, because of travel costs to India, “[i]t takes a very rare patient for [medical tourism] to make sense.”⁷²

Numerous United States-based medical tourism agencies, including MedRetreat,⁷³ IndUShealth,⁷⁴ PlanetHospital,⁷⁵ and HealthAbroad.net,⁷⁶ have formed to assist Americans considering medical treatment in India. These for-profit businesses offer “information and resources about doctors, hospitals, and medical treatments and ‘medical holiday’ packages in low-cost countries, as well as cost comparisons between procedures in those countries and Western countries.”⁷⁷

Both public and private interests are collaborating to further develop India’s burgeoning medical tourism industry.⁷⁸ The Indian Government, for example, promotes approximately forty-five private hospitals as “‘centres of excellence’” in its tourism brochures.⁷⁹ Public and private entities co-organize medical tourism conferences where topical issues in medical tourism and strategies for development are discussed. At Kerala Health Tourism 2007, for example, Conference Chairman Dr. Philip Augustine indicated that CII’s next target should be to develop standardization and

69. *Id.*

70. *Id.*

71. Greenberg, *supra* note 4.

72. *Id.*

73. MedRetreat, www.medretreat.com (last visited Aug. 14, 2008) (American operated medical tourism service company).

74. IndUShealth – A New World of Care, www.indushealth.com (last visited Aug. 14, 2008).

75. PlanetHospital – A New Way to Care!, <http://planethospital.com> (last visited Aug. 17, 2008) (discussing how PlanetHospital can help individuals, corporations, and insurers save time and money on healthcare through its vast network of treatment options in India).

76. Information and Reviews for Medical Tourists - HealthAbroad.net, <http://healthabroad.net> (last visited Aug. 17, 2008) (provides information on doctors, hospitals, and popular medical treatments in foreign countries).

77. Ernst, *supra* note 49, at 2.

78. See *Adopt Integrated Approach to Promote Medical Tourism*, HINDU (India), Mar. 25, 2007, at 5 (noting that medical tourism “is organised jointly by the Confederation of Indian Industry, Kerala Tourism Department and various stakeholders in the health care sector”).

79. Chinai & Goswami, *supra* note 25, at 164.

accreditation processes for Ayurvedic therapy.⁸⁰ At the India Health Conclave 2007 in Mumbai, Ambika Soni, India's Union Minister of Tourism, highlighted the success that India's Ministry of Tourism has experienced with promoting Kerala as a center for Ayurveda and modern medical therapies.⁸¹

In addition to co-sponsoring health tourism conferences, the Indian Government has taken legislative steps to assist and promote further expansion and development of the medical tourism industry. For example, "India's National Health Policy declares that treatment of foreign patients is legally an 'export' and deemed 'eligible for all fiscal incentives extended to export earnings.'"⁸² Thus, the Indian Government has categorized medical treatment delivered to medical tourists as "'export of service.'"⁸³ Additionally, to facilitate the flow of medical tourists into the country, the Indian Government has created a new category of entry visas for medical tourists. These Medical, or "M Visas," are valid after issuance for the shorter period of one year or the length of treatment.⁸⁴ This initial period may be extended further by state governments upon producing a medical certificate or advice by "reputed/recognized/specialized hospitals in the country" about a particular patient's needs.⁸⁵

After the first extension, any additional visa extensions require the involvement of the Indian Ministry of Home Affairs.⁸⁶ In these situations, extensions can only be granted where state governments have made a recommendation and the appropriate supporting medical documentation has been presented.⁸⁷ If such conditions are satisfied, the patient's M Visa "will be valid for [a] maximum [of] three entries [into India] during one

80. *Adopt Integrated Approach to Promote Medical Tourism*, *supra* note 78.

81. *Tourism Ministry Promotes M Visas*, FIN. EXPRESS (India), Feb. 16, 2007.

82. *Medical Tourism: Need Surgery, Will Travel*, CBC NEWS, June 18, 2004, at www.cbc.ca/news/background/healthcare/medicaltourism.html (last visited Aug. 17, 2008).

83. *'Medical Tourism Is Next Big Boom After IT Sector,' supra* note 62 (quoting Dr. Nitin Boraskar).

84. *See generally Tourism Ministry Promotes M Visas*, *supra* note 81 (noting that the Ministry of Tourism is promoting the M visa specifically for medical tourists to India for up to one year).

85. INCREDIBLE INDIA: THE GLOBAL HEALTHCARE DESTINATION, *supra* note 1, at 27. The requirement that a hospital be reputable, recognizable, or specialized may be yet another reason why medical facilities in India seek external labels of quality. If medical tourists are aware that they would need to secure advice from a facility that is "reputed/recognized/specialized" to apply for a visa extension, they might be encouraged to choose facilities that are designated as such through accreditation, standardization, or credentialing programs. *See infra* Section III (Trends in Accreditation Coexistent with the Rise of Medical Tourism in India).

86. INCREDIBLE INDIA: THE GLOBAL HEALTHCARE DESTINATION, *supra* note 1, at 27.

87. *See id.*

year.”⁸⁸ Additionally, the patients’ attendants or family members are eligible to receive an “MX Visa,” a miscellaneous visa that is granted along with the patient’s M Visa.⁸⁹ The number of attendants receiving visas under the MX scheme is limited to two.⁹⁰

Although the purpose of the M Visa is to facilitate the movement of medical tourists into India, a registration requirement associated with the visa may actually reduce the number of people who apply for them. According to CII Spokesperson Aditya Bahadur, “patients prefer to come on ordinary tourist visas to avoid the M-visa’s requirement that they register with the regional authorities within two weeks of arrival.”⁹¹

The Indian Government even has allowed officials in India’s Ministry of External Affairs, the body that issues India’s entry visas, to outsource visa procedures during “peak season” to prevent delays.⁹² The Ministry of External Affairs has also confirmed with its missions in eighteen countries that the visa procedure for tourists should take no more than forty-eight hours to complete.⁹³

Recently, India launched a concerted effort to differentiate itself from competing medical tourism destinations by marketing a special brand of medical tourism: one that combines modern medical treatments with traditional healing methods, particularly Ayurveda, “the ancient holistic and comprehensive Indian system of therapy that revolves around organism-environment interaction and relies on a rich herbal pharmacopoeia.”⁹⁴

In Ayurvedic teaching, three vital forces—or dosha—govern the body, and combine to create an individual’s physiological make-up: vata, linked to the wind, governs movement and relates to the nervous system; pitta, the force of the sun, rules digestion and metabolism; and kapha, likened to the moon, governs the body’s organs. A healthy body has the three forces in balance. When they’re not, illness occurs.⁹⁵

88. *Id.*

89. *Id.*

90. *Id.*

91. Chinai & Goswami, *supra* note 25, at 164.

92. *Tourism Ministry Promotes M Visas*, *supra* note 81.

93. *Id.*

94. Kumar, *Protecting Traditional Knowledge*, *supra* note 55. See generally SCOTT GERSON, *AYURVEDA: THE ANCIENT INDIAN HEALING ART* (NIAM Press, 2d ed. 2001) (noting that the object of Ayurveda is to alleviate suffering, preserve the healthy, and heal the diseased); SUNIL V. JOSHI, *AYURVEDA AND PANCHAKARMA: THE SCIENCE OF HEALING AND REJUVENATION* (1997) (discussing how Ayurveda has captured the attention and imagination of the West); DEP’T OF AYURVEDA, YOGA & NATUROPATHY, UNANI, SIDDHA AND HOMOEOPATHY, FREQUENTLY ASKED QUESTIONS, at <http://indianmedicine.nic.in/html/ayurveda/afmain.htm> (last visited Aug. 17, 2008) (discussing the origin and structure of Ayurveda).

95. INCREDIBLE INDIA: THE GLOBAL HEALTHCARE DESTINATION, *supra* note 1, at 21.

According to India's Ministry of Tourism, Ayurveda differs from the "Western approach to medicine" because "Ayurveda works to remove the cause of illness, not just treat the disease, by suggesting lifestyle and nutritional guidelines to reduce the excessive dosha."⁹⁶ It is not uncommon for Indian citizens to combine allopathic medicine and Ayurveda, going to an "English" doctor for more serious illnesses and to an Ayurvedic practitioner for chronic conditions.⁹⁷ The lack of standardization of Ayurvedic treatments is a major reason why Ayurvedic doctors cannot practice medicine in the United States.⁹⁸ Thus, patients have the unique opportunity to pursue this combination therapy in India, where such limitations on the practice of medicine by Ayurvedic doctors do not exist.

The Indian Government has thrown its weight behind this one-stop shopping approach to medical tourism. Specifically, the second phase of the government-sponsored Incredible India marketing campaign is focused on expanding areas of niche tourism, including spiritual, yoga, and Ayurveda tourism.⁹⁹ As the *Incredible India: The Global Healthcare Destination* brochure touts, the country has no rivals "when it comes to a blending of healthcare with spiritual well-being."¹⁰⁰ In January of 2007, Ambika Soni, India's Union Tourism and Culture Minister, stated that "[i]t is not just medical tourism that we want to focus on. I want India to gain popularity as a centre for well-being tourism. I want this message to be spread across the world that doctors in India offer patients a holistic treatment and give medicine with spirituality."¹⁰¹

India advertises its holistic healing approach as an integration of modern medicine with traditional medical systems that combine to address "the physio, psycho, socio, nutritional, ecological, environmental and spiritual needs of each individual."¹⁰² These traditional medical systems include not only Ayurveda and homeopathy, but also yoga and acupuncture.¹⁰³ Although Ayurvedic therapy is available throughout India, Kerala is billed as the "heart" of Ayurveda.¹⁰⁴ Government officials hope that Kerala's focus on Ayurveda will help the state become one of India's

96. *Id.*

97. Patricia Leigh Brown, *In the Land of Four-Star Asceticism*, N.Y. TIMES, Aug. 13, 2006, at 5-1.

98. *Id.*

99. Talreja, *supra* note 23.

100. INCREDIBLE INDIA: THE GLOBAL HEALTHCARE DESTINATION, *supra* note 1.

101. Parul Sharma, 'Well-Being Tourism Needed', HINDU (India), Jan. 14, 2007, at 4.

102. INCREDIBLE INDIA: THE GLOBAL HEALTHCARE DESTINATION, *supra* note 1, at 7.

103. *Id.*

104. *Id.* at 21; see also Keralatourism.org, Ayurveda, www.keralatourism.org/ayurveda/index.php (last visited Aug. 17, 2008) (noting that Kerala's climate is best suited for Ayurvedic therapy).

top five medical tourism destinations by the year 2011 and achieve its goal of earning 20% of India's medical tourism revenues by the year 2016.¹⁰⁵

Medical tourism companies have realized the value of promoting Kerala's holistic approach to healthcare, and several specialize in that niche market.¹⁰⁶ Beyond medical treatment, Kerala is a popular destination for medical tourists because the region also offers tropical cuisine, a "history of progressive politics," the state's "[ninety-one] percent literacy rate and, not the least, the sensuousness of a culture where even trucks are works of art."¹⁰⁷ Some Ayurveda "purists," however, are skeptical about the effectiveness of Ayurveda-focused medical tourism.¹⁰⁸ They believe that practitioners who cater to medical tourists are providing treatments that may be safe, but not necessarily of medicinal value.¹⁰⁹ To address both quality and safety concerns, India's government officials have developed accreditation standards for Ayurveda centers.¹¹⁰

III. TRENDS IN ACCREDITATION COEXISTENT WITH THE RISE OF MEDICAL TOURISM IN INDIA

In June of 2006, Dr. Bruce Cunningham, President of the American Society of Plastic Surgeons (ASPS), testified before the Senate's Special Committee on Aging about the globalization of healthcare.¹¹¹ In particular, Dr. Cunningham voiced his concerns over the quality of healthcare available through medical tourism.¹¹² Dr. Cunningham testified that

105. See *Kerala to Focus on 'Responsible Tourism,'* HINDU BUS. LINE (India), July 26, 2006, at 23; see, e.g., Kerala Institute of Medical Sciences – International Patient Services – Health Tourism, KIMS- Ayurveda, www.kimskerala.com/ayurveda.html (last visited Aug. 14, 2008) (discussing Ayurveda's impact in Kerala).

106. See *generally BestMed Begins Operations,* HINDU BUS. LINE (India), Jan. 23, 2007, at 23 ("BestMed Tourism will focus on promoting the medical tourism potential of Kerala and India in overseas markets, especially the West."); Kerala & South India Tourism, www.kerala-tourism.net (last visited Aug. 17, 2008) (information about major attractions in Kerala, including Ayurveda); Keralatourism.com, Plan Your Tour, www.keralatourism.com/put_kl.htm (last visited Aug. 17, 2008) (tour packages designed for Ayurvedic resorts in Kerala).

107. Brown, *supra* note 97.

108. *Id.*

109. See *id.*

110. See *infra* Part III. Increased interest in traditional Indian healing therapies coexistent with medical tourism has also led to the development of the "Traditional Knowledge Digital Library-Kerala (TKDL-K)." Kumar, *supra* note 55. This project, undertaken by the Directorate of Ayurveda Medical Education in 2006, aims to protect the intellectual property rights of traditional healers by establishing a digital library of Ayurvedic concepts and medicinal formulations. *Id.*

111. *The Globalization of Health Care: Can Medical Tourism Reduce Health Care Costs?: Hearing Before the S. Spec. Comm. on Aging*, 109th Cong. 47 (2006) (statement of Bruce Cunningham, President, American Society of Plastic Surgeons).

112. *Id.*

[w]e are all aware of cases, which are reported in the media and which confront some of my colleagues and other physicians, of patients returning to this country with disfigurement and nearly fatal infections associated with unaccredited hospitals and unlicensed providers. Patients simply cannot make informed decisions about medical care, or establish a proper physician patient relationship from travel brochures.

. . . .

For some developing or third world countries, there is no credible process for verifying physician training, education, and experience

. . . .

. . . In the US, there are rigorous rules and regulations regarding the availability of emergency equipment and appropriately trained staff. Standards overseas are highly variable and patients may take unnecessary risks when they unknowingly do not have adequate information.¹¹³

Dr. Cunningham's testimony highlights an important question for American patients, employers, and health insurance companies considering medical treatment in India: Is the quality of care available in India through medical tourism equivalent to the level of care that they could receive at home in the United States?¹¹⁴ And to what extent do accreditation trends actually influence the quality of Indian healthcare?

The CII-McKinsey Study identifies global accreditation as a critical aspect of the continued viability and expansion of India's medical tourism industry.¹¹⁵ The Study recommends, specifically, that the government "define and enforce minimum standards for healthcare facilities."¹¹⁶ "To ensure that all facilities deliver quality healthcare" the Study suggests that the Indian government

make the registration of all facilities (including diagnostic centres) mandatory. It should define the minimum standards of infrastructure (e.g., basic medical equipment), manpower (e.g., minimum staffing levels of qualified doctors, nurses and other manpower) and information (e.g., patient records, display of services and tariffs) required at all types of facilities, whether public or private. These standards should be defined and legislated by the Central government in consultation with the states and

113. *Id.* at 47–49.

114. See Brown, *supra* note 3 (noting that this question of quality is crucial).

115. See CII-MCKINSEY STUDY, *supra* note 2, app. C at 246 (stating that key actions required by the medical tourism industry include accreditation); *Just What the Hospital Ordered: Global Accreditations*, INDIA BUS. INSIGHT, Oct. 17, 2006 (stating that the Confederation of Indian Industry (CII) concedes that Indian healthcare hospitals are looking for global accreditation).

116. CII-MCKINSEY STUDY, *supra* note 2, at 6.

other stakeholders. Statutory bodies at the state level, which include a cross-section of stakeholders from within and without the government, should enforce these standards. Such steps will improve the quality of care for patients, create healthy competition between providers and foster the growth of insurance due to greater consumer confidence in the provider base.¹¹⁷

In response to the CII-McKinsey Study, and to address the quality concerns voiced by Dr. Cunningham and others, both the Indian government and Indian medical facilities have made a concerted effort to use several forms of accreditation to promote the legitimacy of India's medical services to consumers abroad.¹¹⁸

Accreditation is one of several models of external evaluation used by healthcare entities throughout the world "to regulate, improve and promote health care services."¹¹⁹ Other types of external evaluation include inspection and peer assessment.¹²⁰ The International Society for Quality in Health, "known as the accreditor of accrediting bodies,"¹²¹ explains that accreditation

- is public recognition of achievement by a healthcare organisation, of requirements of national healthcare standards
- is generally available to public and private sectors
- covers a range of healthcare environments from local community-based care through to tertiary level providers and healthcare system
- may have specialised healthcare services as a particular focus

117. *Id.* at 6-7.

118. See generally Meera Mohanty, *Hospitals Go in for Overseas Accreditations*, HINDU BUS. LINE (India), Dec. 26, 2006, at 1 (noting that hospitals are preparing for the accredited healthcare era that the Health Ministry is hoping to establish with the proposed Clinical Establishment Act).

119. The International Society for Quality in Health Care Inc., ISQua and ACCREDITATION: Setting the Standard for Health Care, at www.isqua.org/isquaPages/Accreditation.html (last visited Aug. 17, 2008). See generally K. Tina Donahue & Paul vanOstenberg, *Joint Commission International Accreditation: Relationship to Four Models of Evaluation*, 12 INT'L J. FOR QUALITY HEALTH CARE 243, 244 (2000) (noting that accreditation standards focus on the internal capacity of an organization; whereas, an assessment of professional competence is conducted by external peers).

120. See generally The International Society for Quality in Health Care Inc., *supra* note 119 (noting that accreditation, peer evaluation, and inspection fit within the larger quality evaluation system).

121. Joint Comm'n Int'l, *Joint Commission International Achieves Accreditation from ISQua* (Jan. 3, 2008), at www.jointcommissioninternational.org/28758/ (last visited Aug. 17, 2008).

- is awarded based on achievement of quality standards and the independent external survey by peers of an organisation's level of performance in relation to the standards.¹²²

The World Health Organization believes that, in countries like India where the healthcare industry is governed by market forces,¹²³ accreditation is required to be competitive in the healthcare business.¹²⁴

A strength of the accreditation system is that it is voluntary, so participants in the process have decided for any number of reasons that the delivery of quality care is important.¹²⁵ A corresponding weakness, however, is that voluntary standards lack the enforcement power of mandatory regulations.¹²⁶ Generally, the penalty for falling below the level of quality required to meet an accreditation standard is a change in accredited status.¹²⁷ In the United States, for example, failure to comply with a regulation may result in more serious repercussions, such as fines or criminal charges.¹²⁸

122. The International Society for Quality in Health Care Inc., *supra* note 119.

123. The Indian government provides little oversight or regulation of private healthcare facilities in India, which suggests that, in the absence of substantial government regulation, healthcare, particularly in the private sector, is governed by market forces. Compare World Health Organization Regional Office for the Eastern Mediterranean, *Role of WHO in Hospital Accreditation*, at www.emro.who.int/mei/HARole.htm (last visited Aug. 17, 2008), with Terry, *supra* note 2 (explaining that healthcare in the United States appears to be resistant to market forces because of state, as opposed to national, licensure and immigration policy, among other factors; healthcare is the United States' most regulated industry).

124. See World Health Organization Regional Office for the Eastern Mediterranean, *supra* note 123 (noting that in countries where healthcare is left to market forces, accreditation is required to be competitive).

125. See generally Interview by Andrew Everett, editor of *Medical Tourism Insight*, with Karen Timmons, CEO of Joint Commission International, at www.medicaltourisminsight.com/articles/0704-jci.htm (last visited Aug. 17, 2008) (discussing that accreditation is voluntary, not mandatory).

126. See Timothy Stoltzfus Jost, *Oversight of the Quality of Medical Care: Regulation, Management, or the Market?*, 37 ARIZ. L. REV. 825, 826-30 (1995) (noting the continuing role of regulation in assuring the quality of medical care); Timothy Stoltzfus Jost, *The Necessary and Proper Role of Regulation to Assure the Quality of Health Care*, 25 HOUS. L. REV. 525, 542-53 (1988) (stating that professional self-regulation, through certification programs, lack enforcement tools, but they can sanction those who fail to qualify for certification).

127. Full revocation of accredited status is rarely enforced. Probation, usually a demotion from full to conditional accreditation, is a more common penalty. See, e.g., Lawrence K. Altman, *Hospital is Disciplined by Agency After Errors*, N.Y. TIMES, Apr. 16, 1995, at 12 (noting that a Harvard teaching hospital was put on probation for prescribing large overdoses of an anti-cancer drug for two patients).

128. For example, violation of the federal Health Insurance Portability & Accountability Act of 1996 (HIPAA) can result in civil money penalties. See generally OFFICE FOR CIVIL RIGHTS, U.S. DEP'T OF HEALTH & HUMAN SERVS., COMPLIANCE AND ENFORCEMENT: HOW OCR ENFORCES THE HIPAA PRIVACY RULE, at www.hhs.gov/ocr/privacy/enforcement/hipaarule.html (last visited

The often discussed fear¹²⁹ of receiving substandard care in India is notable in light of the fact that, by some accounts, “[t]he United States spends the most money on medical care of all advanced industrialized countries, but it performs more poorly than most on many measures of health care quality.”¹³⁰ In 1997, the Institute of Medicine estimated that, annually, 44,000 to 98,000 deaths in U.S. hospitals are attributable to medical error.¹³¹ The Narayana Hrudayalaya Hospital in Bangalore, for example, “has a lower infection rate than U.S. hospitals, and a death rate from open-heart surgery of less than 5 percent.”¹³² Many of the doctors at Indian corporate hospitals are “trained in the United States or are diplomats of the American Medical Association,”¹³³ and a number of these hospitals are affiliated with prominent U.S. hospital systems, including Johns Hopkins, the Mayo Clinic, and the Cleveland Clinic.¹³⁴

Aug. 17, 2008) (discussing that if an entity does not take action to resolve a complaint in a way that is satisfactory, the Office for Civil Rights (OCR) can impose civil money penalties).

129. See, e.g., Kerr, *supra* note 15 (discussing how if something goes wrong weeks or months after a procedure is conducted overseas, finding a doctor to fix the problem or suing over surgery gone wrong would be difficult); *US Workers Fume over ‘Medical Tourism’ to India*, INDIA BUS. INSIGHT, Oct. 7, 2006 (stating that the President of the United Steel Workers has asked that no U.S. citizen be exposed to the dangers involved in traveling abroad for healthcare services).

130. NAT’L COAL. ON HEALTH CARE, FACTS ON THE QUALITY OF HEALTH CARE 1, available at www.nchc.org/facts/2006%20Fact%20Sheets/Quality%20-%202006.pdf (last visited Aug. 14, 2008) (footnotes omitted); see also Uwe E. Reinhardt, Peter S. Hussey & Gerard F. Anderson, *U.S. Health Care Spending in an International Context*, 23 HEALTH AFF. 10, 10-11 (2004) (noting that the U.S. per capita health spending continues to exceed per capita health spending in other developed nations); THE COMMONWEALTH FUND COMM’N ON A HIGH PERFORMANCE HEALTH SYS., THE COMMONWEALTH FUND, WHY NOT THE BEST?: RESULTS FROM A NATIONAL SCORECARD ON U.S. HEALTH SYSTEM PERFORMANCE (2006), available at www.commonwealthfund.org/usr_doc/Commission_whynotthebest_951.pdf?section=4039 (last visited Aug. 17, 2008) (noting that although national health spending is significantly higher than most industrialized countries, the U.S. has millions who go without essential healthcare).

131. See COMM. ON QUALITY OF HEALTH CARE IN AM., INST. OF MED., TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM 22 (Linda T. Kohn, Janet M. Corrigan & Molla S. Donaldson eds., 1999) (“When extrapolated to the over 33.6 million admissions to U.S. hospitals in 1997, the results of these two studies imply that at least 44,000 and perhaps as many as 98,000 Americans die in hospitals each year as a result of medical errors.”). *But see* Clement J. McDonald, Michael Weiner & Siu L. Hui, *Deaths Due to Medical Errors Are Exaggerated in Institute of Medicine Report*, 284 JAMA 93, 93 (2000) (attempting to shed light on the headline number of 98,000 yearly deaths due to medical errors).

132. KAMDAR, *supra* note 44, at 259.

133. *Id.* at 255.

134. CONAN, *supra* note 20. Perhaps the quality concerns surrounding medical tourism are based on the underlying rationale that the risks associated with medical treatment are acceptable if patients can sue for damages in the event of malpractice. Thus, the absence of

Despite uncertainty about the actual value of accreditation as a quality control mechanism, accreditation has been embraced by Indian medical facilities. As a group, India's hospital administrators generally advocate government standardization, accreditation, and certification of the medical sector for several economic and social reasons.¹³⁵ As Daljit Singh, Chief Executive Officer of Fortis Healthcare Ltd., commented, "[g]ood quality is good business."¹³⁶ U.K. Ananthapadmanabhan, Vice-President of the Coimbatore Management Association (CMA), believes that even though accreditation is a voluntary process, "market pressures will force hospitals to join the system."¹³⁷ Further, the prevailing view is that accreditation is required to be a competitive medical tourism facility because of medical tourists' desire for transparency in their medical institutions.¹³⁸

Accreditation is a widely accepted indicator of quality in the United States. Beyond the healthcare industry, sectors such as education and business use accreditation.¹³⁹ Consistent with the value placed on accredited status in the United States, the majority of entities in the United States that offer advice to medical tourists recommend that patients choose facilities that have earned accredited status.¹⁴⁰

Economic benefits may not be the sole consideration driving accreditation efforts. CII Coimbatore Chapter's Healthcare Panel Governor K.S. Ramalingam believes that Indian medical facilities would have become

legal remedies for medical malpractice occurring in India makes the risks associated with medical treatment unacceptable for medical tourism critics.

135. See Pandeya, *supra* note 19 (noting that "[h]ealthcare experts . . . feel the need for medical standardisation, accreditation and certification in the medical sector").

136. Mohanty, *supra* note 118 ("The primary driver has to be patient safety. Healthcare systems that can generate confidence and bring in reliability in delivery of clinical treatment, will find patients who do not mind paying that little bit extra . . . [a]nd yes, when international health insurance players come in, organisations flaunting international quality certificates will be the preferred choice." (quoting Daljit Singh, Chief Executive Officer of Fortis Healthcare Ltd.)).

137. *Stress on Accreditation for Hospitals*, HINDU (India), Aug. 7, 2006, at 2.

138. *Id.*

139. See, e.g., U.S. DEP'T OF EDUC., ACCREDITATION IN THE UNITED STATES, at www.ed.gov/print/admins/finaid/accred/accreditation.html (last visited Aug. 17, 2008) (noting that "[t]he goal of accreditation is to ensure that education . . . meets acceptable levels of quality").

140. See, e.g., IndUShealth, Frequently Asked Questions: What about the Quality of Medical Care in Indian Hospitals? Is It as Good as Here in America?, www.indushealth.com/what_ask.htm (last visited Aug. 17, 2008) (noting that the U.S. Medicare program requires Joint Commission on Accreditation of Healthcare Organizations (JCAHO) accreditation as a condition of payment and that Indian hospitals are seeking JCI accreditation, which is the international arm of JCAHO); MedRetreat, Frequently Asked Questions: Are the Hospitals Safe?, www.medretreat.com/medical_tourism/faq_s.html (last visited Aug. 17, 2008) (noting that advocates work with management of foreign hospitals to seek accreditation status).

accredited even in the absence of medical tourism.¹⁴¹ Dr. Naresh Trehan of the Escorts Heart Institute and Research Center, a Fortis Network Hospital in New Delhi, commented that Indian doctors “must [provide healthcare services] with decency and sensitivity towards the community” because “[h]ealthcare is a business with a soul.”¹⁴² To this end, “it is very important that corporate[] [hospitals] run [] in a humane manner, laying their foundation on ethics and ethos associated with the healthcare industry.”¹⁴³ To achieve this goal, “India needs more regulation in healthcare.”¹⁴⁴

In 2006, U.K. Ananthapadmanabhan noted that the healthcare sector is collaborating with Indian universities to design programs that train specialized technicians for imaging departments.¹⁴⁵ The rationale is, “[w]hen such persons are employed in the hospitals, they will add to the credits needed for accreditation. In developed countries, accrediting bodies insist on specialised qualification for staff in such wings.”¹⁴⁶ Indian hospitals recognize the value of accreditation as a means to address medical tourists’ concerns about how the quality of care in Indian hospitals compares to the care that they could expect to receive in their home countries.

[A number of Indian] hospitals that advertise on the Internet spend a significant amount of time in their Frequently Asked Questions section describing how they are equivalent to, if not better than, hospitals in the United States and Western Europe.

Generally, this sales pitch includes one of two items. Destination hospitals often either boast that they have been accredited by the Joint Commission International, a governing body that is part of the Joint Commission on Accreditation of Healthcare Organizations—the independent entity that accredits American hospitals and compiles comparative data—or direct potential tourists to testimonials from satisfied American and Western European patients who generally compare the destination hospital favorably to their home country’s hospitals.¹⁴⁷

141. K.V. Prasad, *Healthcare Sector Readies for Accreditation*, HINDU (India), Nov. 9, 2006.

142. Pandeya, *supra* note 19 (quoting Dr. Naresh Trehan).

143. *Id.* (quoting Dr. Naresh Trehan).

144. *Id.* (quoting Dr. Naresh Trehan).

145. Prasad, *supra* note 141.

146. *Id.*

147. Levi Burkett, Comment, *Medical Tourism: Concerns, Benefits, and the American Legal Perspective*, 28 J. LEGAL MED. 223, 229-30 (2007) (citations omitted).

A. International Accreditation

Accreditation from an internationally recognized accreditation body is certainly beneficial in a marketing context. Consumers generally believe that such recognition “is a powerful symbol of a health care organization’s commitment to high-quality health care, continuous improvement across all aspects of patient care and services, and patient safety.”¹⁴⁸

Indian hospitals eagerly seek accreditation by the Joint Commission International (JCI), the international arm of the Joint Commission, the organization that accredits over 90% of hospitals in the United States.¹⁴⁹ The Joint Commission initiated the international accreditation program and granted its first international accreditation in 2000.¹⁵⁰ According to Karen Timmons, President and Chief Executive Officer of the JCI, accreditation from the organization “demonstrates to the international community that the hospital has voluntarily sought an independent review of its commitment to safety and quality, and has met standards that contribute to good patient outcomes.”¹⁵¹

According to the JCI, the organization’s accreditation “standards for hospitals clearly define the principals and processes needed to assess the key functions of acute care organizations and associated ambulatory settings.”¹⁵² These key functions are access to and continuity of care, assessment and care processes, education and rights of individuals, management of information and human resources, quality leadership, infection control, collaborative integrated management, and facility

148. Partners Harvard Medical International, Hospital Accreditation Readiness, www.hmi.hms.harvard.edu/cc/health_care_sys/hospital_accreditation.php (last visited Aug. 17, 2008).

149. The Joint Commission accredits over 15,000 hospitals in the United States. Interview by Andrew Everett, *supra* note 125 (also explaining that accreditation is becoming an important benchmark for quality standards for hospitals located overseas). See generally Kerr, *supra* note 15 (noting that several hospitals involved in medical tourism have been accredited by JCI); *Medical Tourism: Sun, Sand and Scalpels*, *supra* note 26 (stating that many foreign hospitals are seeking accreditation from the JCI); Karen Timmons, *The Value of Accreditation: Why Americans Needing Health Care Abroad Should Choose JCI-Accredited Facilities*, MEDICAL TOURISM, Dec. 2007, at 12, available at www.jointcommissioninternational.org/site-collections/site-documents/29113.pdf (last visited Aug. 17, 2008) (discussing hospitals abroad often seeking JCI accreditation).

150. The Joint Commission, About Us: A Journey Through the History of the Joint Commission, at www.jointcommission.org/AboutUs/joint_commission_history.htm (last visited Aug. 17, 2008). JCI’s accreditation program is endorsed by the World Health Organization. Timmons, *supra* note 149.

151. Timmons, *supra* note 149.

152. JOINT COMM’N INT’L, JOINT COMMISSION INTERNATIONAL ACCREDITATION: IMPROVING HEALTH CARE QUALITY AND SAFETY AROUND THE WORLD, available at www.jointcommissioninternational.org/fpdf/international/JCI_Accreditation.pdf (last visited Aug. 17, 2008).

management.¹⁵³ The aim of these functions is to help hospitals achieve six international patient safety goals: (1) identify patients correctly; (2) improve effective communication; (3) improve safety of high-alert medications; (4) ensure correct-site, correct-procedure, and correct-patient surgery; (5) reduce the risk of healthcare-associated infections; and (6) reduce the risk of patient harm resulting from falls.¹⁵⁴

Accreditation is a rigorous, multi-step process that actually begins twelve to twenty-four months before the JCI survey team visits the medical facility.¹⁵⁵ The JCI survey team employs a "tracer methodology," a system-wide approach for evaluating a facility, as opposed to a department-by-department assessment.¹⁵⁶ This enables the JCI survey team "to trace the journey of patients as they move through the institution and examine how various departments work together to provide the care they need."¹⁵⁷ Typically, the survey team "traces" eight patients during a site visit.¹⁵⁸ During the trace, the JCI survey team examines and scores a hospital on approximately 300 standards and 1200 measurable elements.¹⁵⁹

The costs of preparing for JCI evaluation and the actual visit by the survey team vary from hospital to hospital, but as a general rule the JCI accreditation process requires significant financial investment.¹⁶⁰ As such,

153. *Id.*

154. JOINT COMM'N INT'L, JOINT COMMISSION INTERNATIONAL ACCREDITATION STANDARDS FOR HOSPITALS, THIRD EDITION, STANDARDS ONLY, at INTERNATIONAL PATIENT SAFETY GOALS (2007), available at www.jointcommissioninternational.org/fpdf/international/Standards%20Only%20-%20Hospital,%203rd%20edition.pdf (last visited Aug. 14, 2008).

155. JOINT COMM'N INT'L, ACCREDITATION PROCESS TIMELINE, at www.proyectojci.com/acc-proc-time.jpg (last visited Aug. 17, 2008); Timmons, *supra* note 149, at 13 ("Before accrediting a hospital, JCI sends in a team, usually including a doctor, nurse, and administrator, for a period of 3 to 5 days."). See generally JOINT COMM'N INT'L, HOW TO GET STARTED WITH JCI ACCREDITATION, at www.jointcommissioninternational.org/22758/ (last visited Aug. 17, 2008) (follow "How to Get Started with JCI Accreditation (PowerPoint)" hyperlink under "What is JCI Accreditation?") (noting that the accreditation process can take as long as eighteen to twenty-four months).

156. Timmons, *supra* note 149, at 13.

157. *Id.*

158. *Id.*

159. *Id.* See generally JOINT COMM'N INT'L, *supra* note 154 (noting individual standards used by the JCI survey team).

160. See Joint Comm'n Int'l, Cost of Accreditation, www.jointcommissioninternational.org/30515/, at A1 ("In 2008 the average cost for an accreditation survey of a hospital is anticipated to be about \$41,000 USD.") (last visited Aug. 22, 2008); see *id.* at A2 ("The cost [of JCI accreditation] is determined by the size and complexity of the hospital. This determines the number of surveyors and the number of days needed to survey the standards. This can vary from 2 surveyors for 2 days in a very small specialty hospital to 5 surveyors for 6 days in a large multispecialty university hospital. The details found in an organization's application for accreditation drive the formula to determine survey team size and survey length and this

accreditation probably is cost prohibitive for many facilities, and corporate hospitals are generally the only facilities that can afford to undertake JCI's accreditation process.

Once earned, JCI accreditation is valid for a period of three years.¹⁶¹ After the three year period, the JCI conducts "a full, onsite survey."¹⁶² Further, the JCI "does not review every hospital in the major medical tourism destination countries. Instead, it sends its review board on a paid basis to those foreign hospitals for which there are lengthy waiting lists."¹⁶³

Approximately 140 hospitals in twenty-six countries are JCI-accredited.¹⁶⁴ To date, only ten Indian hospitals are JCI-accredited,¹⁶⁵ and

determines the cost"); cf. *Just What the Hospital Ordered: Global Accreditations*, *supra* note 115 (noting that securing JCI certification costs \$100,000).

161. Timmons, *supra* note 149, at 13.

162. *Id.*

163. Burkett, *supra* note 147, at 230 (citations omitted).

164. *Id.*

165. The JCI-accredited hospitals in India are: Apollo Hospital, Chennai (Accreditation Date, Hospital Program: Jan. 29, 2006); Apollo Hospital, Hyderabad (Accreditation Date, Hospital Program: Apr. 28, 2006; Accreditation Date, Disease-or Condition-Specific Care, Certification for Acute Stroke Programs: Apr. 29, 2006); Asian Heart Institute, Mumbai (Accreditation Date, Hospital Program: Oct. 20, 2006); Fortis Hospital, Mohali (Accreditation Date, Hospital Program: June 15, 2007); Grewel Eye Institute, Chandigarh (Accreditation Date, Ambulatory Program: May 26, 2007); Indraprastha Apollo Hospital, New Delhi (Accreditation Date, Hospital Program, June 18, 2005); Satguru Partap Singh Apollo Hospital, Punjab (Accreditation Date, Hospital Program: Feb. 3, 2007); Shroff Eye Hospital, Mumbai (Accreditation Date, Hospital Program: Feb. 18, 2006); Wockhardt Hospital, Bangalore (Accreditation Date, Hospital Program, Feb. 9, 2008); and Wockhardt Hospital, Mumbai (Accreditation Date, Hospital Program: Aug. 26, 2005). JOINT COMM'N INT'L, JOINT COMMISSION INTERNATIONAL (JCI) ACCREDITED ORGANIZATIONS, at www.jointcommissioninternational.org/23218/iortiz/ (last visited Aug. 17, 2008). Indraprastha Apollo Hospital, New Delhi, India, was India's first JCI-accredited hospital. Indraprastha Apollo Hospitals, Medical Tourism, at www.apollohospdelhi.com/medical-tourism.html (last visited Aug. 17, 2008). India's regional medical tourism competitors also boast JCI accredited institutions. Indonesia has one (Siloam Hospital Lippo Karawaci); the Philippines has two (St. Luke's Medical Center and The Medical City); Singapore has thirteen (Alexandra Hospital; Changi General Hospital; Institute of Mental Health/Woodbridge Hospital; Johns Hopkins Singapore International Medical Centre; KK Women's and Children's Hospital; National Skin Centre; National University Hospital; Parkway Hospitals Singapore Pte Ltd—East Shore Hospital; Parkway Hospitals Singapore Pte Ltd—Gleneagles Hospital; Parkway Hospitals Singapore Pte Ltd—Mount Elizabeth Hospital; Singapore General Hospital; and Tan Tock Seng Hospital); and Thailand has four (Bangkok Hospital Medical Center; the well-known Bumrungrad International; Samitivej Srinakarin Hospital; and Samitivej Sukhumvit Hospital). JOINT COMM'N INT'L, JOINT COMMISSION INTERNATIONAL (JCI) ACCREDITED ORGANIZATIONS, at www.jointcommissioninternational.org/23218/iortiz/ (last visited Aug. 17, 2008).

all are large corporate entities, including hospitals in the Apollo, Fortis, and Wockhardt Hospital systems.¹⁶⁶

The widespread desire to obtain JCI's seal of approval has even influenced the planning and construction of future facilities designed to cater to medical tourists. U.K. Ananthapadmanabhan observed that not only are specialty and corporate hospitals committed to the expansion of their facilities, but "[t]he buildings are designed according to the Joint Commission International (JCI) standards . . . an indication of the healthcare sector gearing up to measure up to the requirements."¹⁶⁷

But are the high expectations of accreditation seekers being met? Some believe that accreditation is a fairly superficial process.¹⁶⁸ The Kerala Institute of Medical Sciences (KIMS), for example, is not JCI accredited and was recognized in 2006 by Kerala's government "for being the highest foreign exchange earner and for attracting the most number of patients from abroad."¹⁶⁹ KIMS was the first Indian hospital to earn accredited status from the Australian Council for Healthcare Standards International and is considered to be "pioneering medical tourism in Kerala."¹⁷⁰ The Escorts Heart Institute and Research Center, a facility affiliated with Harvard Medical International, is not JCI-accredited. Over 35,000 open-heart surgeries have been performed at Escorts since its establishment in 1988,¹⁷¹ and the facility boasts a miniscule death rate of 0.8% for coronary bypass surgeries.¹⁷²

Another danger of solely relying on accredited status when selecting a medical facility is that "quality is a relative concept strongly influenced by the historical, political, economical and cultural context to which it is applied."¹⁷³ In the case of medical tourism, the standards the JCI uses to evaluate international hospitals are not identical to those used in the United States. Anne Rooney, Executive Director of JCI's International Services, notes that although JCI's accreditation standards are "heavily modeled on

166. JOINT COMM'N INT'L, *supra* note 165, at INDIA (Accreditation Date, Hospital Program: Jan. 29, 2006).

167. Prasad, *supra* note 141.

168. See, e.g., CONAN, *supra* note 20, at Interview with Helen Darling (President, National Business Group on Health).

169. Mike Gloss, Executive Editor, *Kerala Institute of Medical Sciences Plans to Set up Clinics in Arab World*, MEDICAL TOURISM ONLINE.COM, Dec. 28, 2006, at www.medicaltourismonline.com/content/view/138/0 (last visited Aug. 22, 2008).

170. *Id.*

171. Libby Peacock, *Medical Tourism Warts-and-All*, THE AUSTRALIAN, May 5, 2007, at 5.

172. John Lancaster, *Surgeries, Side Trips for 'Medical Tourists': Affordable Care at India's Private Hospitals Draws Growing Number of Foreigners*, WASH. POST, Oct. 21, 2004, at A01.

173. Hugo Eduardo Arce, *Hospital Accreditation as a Means of Achieving International Quality Standards in Health*, 10 INT'L J. FOR QUALITY HEALTH CARE 469, 469 (1998), available at <http://intqhc.oxfordjournals.org/cgi/reprint/10/6/469> (last visited Aug. 17, 2008).

the JCAHO standards . . . there are differences to allow for differences' in medical practices and customs in other countries."¹⁷⁴ Karen Timmons notes that "JCI accreditation standards are comparable to Joint Commission accreditation standards, but they are different."¹⁷⁵

"To ensure their international applicability,"¹⁷⁶ an International Standards Subcommittee, comprised of sixteen experts representing seven major regions of the world, developed JCI's accreditation standards.¹⁷⁷ An accredited Indian hospital may not meet the same standards required of a Joint Commission accredited hospital in the United States, which American medical tourists may not realize. A critical difference between the domestic and international hospital standards is that the "U.S. standards reflect many local, state and national laws which do not apply internationally."¹⁷⁸ The Joint Commission's international standards, in contrast, are much broader "in order to respect country and cultural differences."¹⁷⁹ Karen Timmons believes that with each revised version of the JCI's accreditation standards, "international standards are becoming more challenging, rapidly closing the gap between JCI and U.S. standards."¹⁸⁰

Timmons further explains that using a JCI-accredited hospital abroad is "a risk-reduction activity" because adherence to JCI's standards improves patient care and safety which, in turn, increases the probability that patients will have good outcomes.¹⁸¹ Some of the specific advantages that JCI accreditation may afford medical tourists are that

JCI accreditation requires that every patient is spoken to in a language and manner they can understand and that patients are involved in their care decisions. Patient rights must be protected, including confidentiality and privacy. When a patient prepares to leave the hospital and return home to his country, we require that the hospital transfer information to the patient and provide recommendations for follow-up care at home. All of these steps make it less likely the medical traveler will have some type of error or problem with his care.¹⁸²

174. Kerr, *supra* note 15 (quoting Anne Rooney).

175. Timmons, *supra* note 149, at 13. Joint Commission accreditation standards are the standards that are used by hospitals in the United States. *Id.* at 12.

176. Joint Commission International, International Standards, at www.jointcommissioninternational.org/23215 (last visited Aug. 17, 2008).

177. *Id.*; Timmons, *supra* note 149, at 13.

178. Interview by Andrew Everett, *supra* note 125.

179. *Id.*

180. *Id.*

181. Timmons, *supra* note 149, at 13.

182. *Id.*

Although JCI accreditation may be a valuable comparison tool, because it lacks regulatory teeth, it offers little to medical tourists seeking hard and fast rules.

B. National Accreditation

The National Accreditation Board for Hospitals and Healthcare Providers (NABH), an entity under the control of the Quality Council of India,¹⁸³ was formed in October of 2005 after an Indian healthcare delegation's visit to Dubai in 2004.¹⁸⁴ The purpose of the delegation's trip was to promote India as a healthcare destination.¹⁸⁵ The delegation's members were "flabbergasted" when "they were asked whether India had its own healthcare standards."¹⁸⁶

The NABH's purpose is to develop and apply a set of national standards to Indian healthcare organizations "to ensure that the domestic healthcare industry emerges as a global healthcare delivery system."¹⁸⁷ The NABH released this set of national standards in February of 2006.¹⁸⁸ The NABH is not, however, India's first experience with accreditation programs. Prior to the NABH's national standards, individual hospitals adhered to the standards of various international organizations, such as the International Organization for Standardization.¹⁸⁹

India's media reports that the prevailing view throughout the public and private sectors is that "[m]ost of the medical tourists prefer accredited hospitals, as the facilities and services offered are of global standards," and, as such, NABH accreditation is "a boon to medical tourism in India."¹⁹⁰

183. Quality Council of India, National Accreditation Board for Hospitals & Healthcare Providers (NABH), NABH Introduction, www.qcin.org/html/nabh/nabh_intro.php (last visited Aug. 15, 2008).

184. *First Accredited Hospital in Kolkata*, STATESMAN (India), Nov. 2, 2006.

185. See *id.* (noting that the healthcare delegation promoted India as a healthcare center).

186. *Id.*

187. *16 Hospitals Seek Accreditation (NABH to Provide High, Fair and Affordable Benchmarks)*, INDIA BUS. INSIGHT, Aug. 3, 2006.

188. *16 Hospitals Seek Accreditation*, HINDU BUS. LINE (India), Aug. 3, 2006, at 7.

189. See *id.* ("[I]n the absence of a single national standard, individual hospitals have subscribed to norms of different overseas agencies."). The International Organization for Standardization (ISO) is responsible for the ISO 9000 and other international quality standards in a variety of industries. See generally International Organization for Standardization, ISO 9000 and ISO 14000, at www.iso.org/iso/iso_catalogue/management_standards/iso_9000_iso_14000.htm (last visited Aug. 17, 2008) (noting that the International Organization for Standardization (ISO) manages ISO 9000 and ISO 14000).

190. *NABH Accreditation to 50 Hospitals Soon (Receives Applications from 38 Hospitals)*, INDIA BUS. INSIGHT, Mar. 29, 2007.

United States-based medical travel resources also reinforce this view in choosing which facilities to recommend.¹⁹¹

As of March 2007, over 700 Indian hospitals had applied for NABH accreditation.¹⁹² To be awarded accreditation from the NABH, which is valid for three years,¹⁹³ a facility must demonstrate compliance with “100 standards and 503 objective elements”¹⁹⁴ The NABH’s standards fall within one of ten categories: access, assessment, and continuity of care; patient rights and education; patient care; medication management; hospital infection control; continuous quality improvement; responsibility of management; facility management and safety; human resource management; and information management systems.¹⁹⁵

Presently, the NABH only accredits private hospitals and nursing homes in India. The organization is, however, currently working to develop standards for blood banks, diagnostic centers, nursing homes, dental clinics, and Ayurvedic centers.¹⁹⁶ In 2006, the NABH announced that it planned to evolve a separate set of accreditations for government hospitals.¹⁹⁷ The then Secretary-General of the Quality Council of India, Giridhar Gyani, noted that a set of standards for primary government health centers had already been developed and were incorporated into the National Rural Health Mission.¹⁹⁸ As of January 1, 2008, only twelve medical facilities

191. See, e.g., MedRetreat, *supra* note 73 (noting that MedRetreat seeks overseas hospitals with the same high standards as found in the States); IndUShealth, *supra* note 74 (noting that IndUShealth has managers ready to provide the necessary guidance about the exceptional healthcare options available in Indian hospitals); PlanetHospital, *supra* note 75 (discussing that PlanetHospital facilitates affordable and immediate healthcare options at some of the best hospitals around the world); Information and Reviews for Medical Tourists - HealthAbroad.net, *supra* note 76 (noting that HealthAbroad.net is your one-stop portal for information on hospitals in areas such as Asia and Eastern Europe).

192. *Adopt Integrated Approach to Promote Medical Tourism*, *supra* note 78.

193. NABH approved facilities must seek renewal after the period of accreditation expires. *First Accredited Hospital in Kolkata*, *supra* note 184.

194. Quality Council of India, NABH Frequently Asked Questions: What are NABH Accreditation Standards for Hospitals?, at www.qcin.org/html/nabh/nabh_faq.php (last visited Aug. 17, 2008).

195. NATIONAL ACCREDITATION BOARD FOR HOSPITALS & HEALTHCARE PROVIDERS (NABH), GENERAL INFORMATION BROCHURE 7 (2008), available at www.qcin.org/html/nabh/documents/nabh_gib_issue3.pdf (last visited Aug. 17, 2008).

196. *NABH Accreditation to 50 Hospitals Soon (Receives Applications from 38 Hospitals)*, *supra* note 190.

197. See generally Special Correspondent, *NABH Plans Accreditation for Govt. Hospitals Too*, HINDU (India), Aug. 13, 2006, at 5 (noting that a separate set of standards for government hospitals is now in the process).

198. *Id*; see also NAT’L RURAL HEALTH MISSION, GOV’T OF INDIA, NATIONAL RURAL HEALTH MISSION (2005-2012): MISSION DOCUMENT, available at <http://mohfw.nic.in/NRHM/Documents/NRHM%20Mission%20Document.pdf> (last visited Aug. 15, 2008) (discussing the standards for primary government health centers in rural areas).

have earned NABH accreditation.¹⁹⁹ Interestingly, none of these hospitals are accredited by the JCI, raising questions about consistency across different accreditation schemes and their net ability to provide a globally recognized seal of quality medical care.

The NABH has received reciprocal recognition for its accreditation program from the Australian Council of Health Standards (ACHS) and the International Society for Quality in Healthcare.²⁰⁰ In July of 2006, the NABH signed a memo of understanding with the ACHS "to adopt the Australian framework in its agenda."²⁰¹ The NABH has not, however, received reciprocal recognition from the JCI or the United Kingdom's Healthcare Quality Standards, or any other international accreditation bodies.²⁰² Interestingly, the JCI just recently received accreditation from the ISQua in January of 2008, and the NABH is an institutional member of both the ISQua and its Accreditation Council.²⁰³ In 2006, the NABH initiated talks with the JCI about awarding joint accreditation. A goal of the NABH-JCI negotiations, to reduce the cost of the accreditation process for hospitals, has yet to come to fruition.²⁰⁴ CII is also developing a regulatory framework for its member facilities to complement its previously implemented ethical code.²⁰⁵ As of March 2007, one quarter of CII's member hospitals had earned CII certification.²⁰⁶

199. Quality Council of India, NABH ACCREDITED HOSPITALS, www.qcin.org/ (follow "NABH, Introduction" hyperlink under "Quality Council of India" logo, then follow "NABH Accredited Hospitals" hyperlink under "NABH Accreditation, Hospital Accreditation" heading) (last visited Aug. 17, 2008). Possible explanations for the small number of NABH accredited facilities are that NABH accreditation is not mandatory and NABH accreditation has not yet proven to be economically beneficial. As of June 8, 2008, however, fifty-nine Indian hospitals have applied for NABH accreditation. Quality Council of India, Applicant Hospitals for NABH Accreditation, at www.qcin.org/html/latest/appli_nabh_acc.htm (last visited Aug. 17, 2008).

200. *First Accredited Hospital in Kolkata*, *supra* note 184.

201. *16 Hospitals Seek Accreditation*, *supra* note 188.

202. *First Accredited Hospital in Kolkata*, *supra* note 184.

203. Joint Comm'n Int'l, *supra* note 121; see also Quality Council of India, *supra* note 194, at Does NABH have any International Linkages? ("NABH is an institutional member of ISQua as well as member of ISQua Accreditation Council. NABH standards for hospitals are being reviewed by ISQua. NABH is also one of the founder members of newly emerging Asian Society for Quality in Healthcare (ASQua).") Such an "initiative is to strengthen the Asian representation at international level and improve the quality structure in healthcare.").

204. See generally Bhuma Shrivastava, *Cost-Effective Accreditation for Hospitals in the Offing*, BUS. STANDARD (India), July 18, 2006, at 5 (noting that the cost of the process would be reduced by 30-50%).

205. See Chinai & Goswami, *supra* note 25, at 165.

206. See *id.* ("CII has a certification system and has already approved 30 of its 120 hospital members.").

C. Accreditation of Ayurveda Facilities

Traditionally, Ayurvedic knowledge was passed down “from father to son, uncle to nephew.”²⁰⁷ Today, Ayurveda is professionalized, and Ayurveda physicians earn advanced degrees from five-year Ayurvedic medical schools.²⁰⁸ To cater to Ayurveda tourists, and to combat the dilution of traditional knowledge by “unscrupulous operators,” the Kerala Government has developed accreditation guidelines.²⁰⁹ In Kerala, the state’s tourism brochures and other advertising materials promote accredited Ayurveda hospitals.²¹⁰ To earn accreditation, Ayurveda hospitals in Kerala must comply with specific guidelines governing equipment, facilities, technical personnel, and consulting physicians.²¹¹

D. Accreditation at District and Village Levels

In August of 2006, the Union Health Minister, Anbumani Ramadoss, revealed that the Indian “Government was considering a Clinical Establishment Bill that would mandate accreditation for hospitals down to the district and village levels as well as ensure quality healthcare at the grassroots.”²¹² The Clinical Establishment Act, which took effect in May of 2007,²¹³ requires that all private and government hospitals register with the

207. Brown, *supra* note 97.

208. *Id.* See generally DEP’T OF AYURVEDA, YOGA & NATUROPATHY, UNANI, SIDDHA AND HOMOEOPATHY, LIST OF AYURVEDIC MEDICAL COLLEGES IN INDIA, at <http://indianmedicine.nic.in/html/institutions/augpgg.htm> (last visited Aug. 17, 2008) (listing 196 Ayurvedic Medical Colleges located in India).

209. Brown, *supra* note 97.

210. See, e.g., Kerala to Give Accreditation to Select Pvt Hospitals, HINDU BUS. LINE (India), July 31, 2006, at www.thehindubusinessline.com/2006/07/31/stories/2006073100430200.htm (last visited Aug. 17, 2008) (noting that the names of accredited hospitals would be a part of the promotional campaigns).

211. For example, the massage table must be made of fiberglass or good quality wood, there must be a mud bath facility and a yoga hall, at least one male and one female masseur with sufficient training from a Government-recognized institution, and a consultant physician must have a Government-recognized degree in Ayurveda. SOUTH INDIA TRAVEL TOURS, KERALA AYURVEDA: REQUIREMENT FOR ACCREDITAION [sic], at www.tourismsouthindia.com/kerala-ayurveda/ayurveda-requirements.html (last visited Aug. 17, 2008); see also BACKWATER TOURISM INDIA, KERALA AYURVEDA: REQUIREMENTS FOR ACCREDITATION, at www.backwater-tourismindia.com/kerala-ayurveda/ayurveda-accreditation.html (last visited Aug. 17, 2008) (listing the same requirements for accreditation); KERALA TOURS ONLINE, AYURVEDA IN KERALA, REQUIREMENTS IN ACCREDITATION, at <http://keralatoursonline.com/ayurveda-information/kerala-ayurveda-accreditation.html> (last visited Aug. 17, 2008).

212. *India to Be Promoted As Global Healthcare Hub*, HINDU BUS. LINE (India), Sept. 1, 2006, at 19; *Medical Tourism on the Rise in India*, TIMES INDIA, Aug. 31, 2006.

213. See *India to Register All Health Care Infrastructure: Ramadoss*, INDIA ENEWS, Nov. 20, 2006, at www.indiaenews.com/health/20061120/29376.htm (last visited Aug. 17, 2008).

government within a two year period and that all medical facilities meet uniform standards promulgated by the government.²¹⁴ The Act amends the Bombay Nursing Home Registration (BNHR) Act of 1949.²¹⁵ The law also mandates that all healthcare facilities register with the government.²¹⁶

Additionally, state governments such as Kerala are accrediting select private hospitals.²¹⁷ In Kerala, accreditation standards are developed by a committee composed of representatives from the state's Health and Tourism Departments with the primary objective being, according to Kodyeri Balakrishnan, Kerala's Tourism Minister, "to ensure certain standards in service and treatment in hospitals that admit foreigners."²¹⁸ The Kerala Department of Tourism plans to feature the names of accredited hospitals in the state's tourism promotional campaigns.²¹⁹

E. Medical Tourism Agencies

A growing number of medical tourism companies are offering medical tourists another model of external evaluation to consider when choosing their destination. Generally, these companies conduct extensive research about the quality of foreign facilities and make recommendations to their clients. Others "help schedule surgeries, send medical records to doctors, book hotel rooms, arrange excursions and make air and ground transportation arrangements."²²⁰

MedRetreat, a United States-based company, is an example of a medical tourism broker. In an interview on National Public Radio's "Talk of the Nation" in March of 2007, Patrick Marsek, Managing Director of

(noting that India will bring a new law (Clinical Establishment Bill) into effect in May of 2007 to register all healthcare infrastructure in the country).

214. See *id.*; see also, Mike Gloss, Executive Editor, *India Proposes Clinical Establishment Act*, MEDICAL TOURISM ONLINE.COM, Dec. 26, 2006, at www.medicaltourisonline.com/content/view/136/1/ (last visited Aug. 22, 2008) (noting that in two years health centers must apply for mandatory registration); Siddhartha D. Kashyap, *New Act to Curb Corruption in Hospitals*, TIMES INDIA, Nov. 30, 2002 (stating that if passed, the bill would "bring all clinical establishments under a common law for the first time in the country").

215. The Clinical Establishments (Registration and Regulation) Bill, 2007, No. 71, Acts of Parliament, 2007, at Chapter III-V, available at http://rajyasabha.nic.in/legislative/amendbills/health/Clinical_bill.pdf (last visited Aug. 24, 2008); see also Kashyap, *supra* note 214 (noting that the Bombay Nursing Home Registration Act was 53 years old in 2002). The Bombay Nursing Home Registration Act only applies to private hospitals and nursing homes, and its jurisdiction only extends to four cities, including Mumbai and Pune. *Id.* The Clinical Establishment Act, in contrast, provides regulations that will be applied across the states for a variety of medical facilities, including medical laboratories. *Id.*

216. *Law on Health Centres*, HINDUSTAN TIMES (India), Nov. 20, 2006.

217. *Kerala to Give Accreditation to Select Pvt Hospitals*, *supra* note 210.

218. *Id.*

219. *Id.*

220. Kerr, *supra* note 15.

MedRetreat, described the process that his company uses to put its seal of approval on foreign hospitals:

[F]irst of all, we look for hospitals that are accredited [by the JCI] . . . [t]hat's always the best alternative. Other than that, there are also hospitals that are ISO certified, as well as certified in their own countries. Although many of the doctors overseas are trained in either the U.S., the U.K. or Australia, they tend to go back home to work in their respective countries . . . [s]o it's a great situation for them to come here for the training. With that being said, also, many of the hospitals we work with have affiliations here in the U.S. – hospitals such as Johns Hopkins, Mayo Clinic, Cleveland Clinic – and these hospitals have associations overseas where they cross-train with the doctors and they share their procedures. And it's a very good way for them to make this global health care issue actually a good alternative for Americans to go abroad.²²¹

Yet, despite the diverse efforts to allay medical tourists' fears surrounding the quality of medical care in India, the sparse legal remedies for medical malpractice may impede the country's ability to attract American medical tourists in the future.²²² One of the primary reasons medical tourists travel to India is the low cost of medical services. This low cost results from Indian doctors having lower labor costs due, in large part, to an almost non-existent malpractice bar.²²³ Thus, if the incidence of malpractice increased coexistent with the demands of medical tourists to have legal recourse, one of India's main draws for medical tourists, low cost, could be adversely affected.

The "Legal Issues" link on India's official medical tourism Web site provides limited information on the subject, stating only that "India meditourism believes in buliding [sic] lasting relations. Unfortunately if any legal disputes come up they shall be subject to Delhi (India) jurisdiction."²²⁴ Currently, the only venue for patient complaints for both medical tourists and Indian patients is India's State and National Consumer Disputes Redressal Commissions, which already has a large backlog of cases.²²⁵ The CII, however, is developing a standard contract for medical tourism facilities

221. CONAN, *supra* note 20 (quoting Patrick Marsek).

222. See generally Philip Mirrer-Singer, Note, *Medical Malpractice Overseas: The Legal Uncertainty Surrounding Medical Tourism*, 70 LAW & CONTEMP. PROBS. 211 (2007) (noting that there is no international legal regulation of medical tourism, and, despite the growth of medical tourism, information on the quality of foreign providers is sparse).

223. See generally Price, *supra* note 11 (noting that medical malpractice is not so ruthless overseas).

224. India Meditourism, Legal Issues, at <http://indiameditourism.com/legal.htm> (last visited Aug. 17, 2008) (emphasis omitted).

225. Chinai & Goswami, *supra* note 25, at 165.

that gives Indian courts jurisdiction over any litigation arising from treatment obtained in India.²²⁶

Dr. Mohan Thomas, Chairman of CII's Healthcare Committee and Medical Director of the Cosmetic Surgery Institute in Mumbai, has commented that "[a]ny litigation launched against an Indian hospital will expose the poor system of justice that exists" in India.²²⁷ Although hospitals stand to benefit from the lack of legal regulation, some still choose to alert prospective patients to this fact.²²⁸ In the absence of better alternatives, medical tourism agencies generally advise clients that medical tourism is probably not something that they should consider if one of their major concerns is being able to sue if something goes wrong.²²⁹

Medical tourism also raises big question marks about the logistics of post-operative care, both in the regular course of treatment and in the event of complications. Due to legal liability, among other reasons, doctors are generally not eager to inherit problems created by other doctors.²³⁰ Medical tourism organizations are working to eliminate post-operative care concerns by establishing pre- and post-operative care networks in the United States for surgeries that are actually performed in foreign hospitals. One such program, "Best of Both Worlds," is offered by California-based PlanetHospital.²³¹ This approach has several benefits, including the "proprietary offering that delivers savings to PPOs, employers and patients," while simultaneously expanding PlanetHospital's "global footprint."²³² According to PlanetHospital's Chief Executive Officer Rudy Rupak, "[p]atients receive care from a world class surgeon from start to finish, only the geography of their surgery changes."²³³ Consumers have direct access to this program through an employer's cafeteria plan or through PPOs.²³⁴

226. *Id.*

227. *Id.* (quoting Mohan Thomas).

228. See *Mirr-Singer*, *supra* note 222, at 212 ("[A] website for India's largest medical-tourism hospital, Apollo, presents a grim message: 'A prospective medical tourist should also be aware of possible legal issues. There is presently no international legal regulation of medical tourism. All medical procedures have an element of risk. The issue of legal recourse for unsatisfactory treatment across international boundaries is a legally undefined issue at present.'").

229. See, e.g., *CONAN*, *supra* note 20.

230. See *id.* (discussing that if something goes wrong overseas, a doctor in the U.S. is going to be leery of treating you).

231. *PlanetHospital Announces Medical Tourism Services with American Surgeons*, *MANAGED CARE WKLY. DIG.*, Oct. 16, 2006, at 109.

232. *Id.*

233. *Id.* (quoting Rudy Rupak).

234. *Id.*

IV. LOOKING FORWARD

Is medical tourism a passing trend, or will growth persist? Several factors will likely influence the industry's continued viability. In general, "[m]ost analyses of India's future see impediments to future growth that arise from important physical and human constraints: these include poor infrastructure (roads, airports, seaports, and power supply), archaic labor laws, the need to privatize its colossally unprofitable large public sector firms, and the challenges associated with energy security."²³⁵ Kamal Nath, India's Union Commerce and Industry Minister, explains that there is "no shortage of funds," as "many global investors were waiting to invest in the country," but that further development requires "a platform or a forum to channelise [sic] these investments."²³⁶

Despite the costs and benefits of Americans traveling to India for medical care, the trend highlights the complicated current state of healthcare in the United States.²³⁷ Some believe that medical tourism "has the potential of doing to the U.S. health care system what the Japanese auto industry did to American carmakers."²³⁸ Whether the number of American medical tourists will increase in the future will likely be influenced by domestic healthcare reform.

Despite the uncertainties about the quality of care available in India, at the end of the day, many Americans face the difficult decision of forgoing medical care that is too expensive in the United States or getting treatment in India and accepting whatever risks may lurk in India's healthcare system. Nevertheless, those who do go to India will likely be looking at quality measures when choosing a hospital. Thus, as Karen Timmons the Chief Executive Officer of JCI said, "I think it's safe to say that some sort of accreditation is better than none."²³⁹

ELIZABETH GLUCK*

235. Sumit Ganguly & Manjeet S. Pardesi, *India Rising: What is New Delhi to Do?*, 24 *WORLD POL'Y J.* 9, 11 (2007).

236. *Windows of Opportunities Open Up for Health Sector*, *supra* note 24.

237. See generally Kerrie S. Howze, Note, *Medical Tourism: Symptom or Cure?*, 41 *GA. L. REV.* 1013 (2007) (noting the complicated issues regarding healthcare in the U.S. and why patients seek care abroad); *Mirror-Singer*, *supra* note 222 (noting that millions of Americans are uninsured and that citizens needing healthcare are facing long waiting periods in the U.S.).

238. Price, *supra* note 11 (quoting Uwe Reinhardt, a health economist at Princeton University).

239. Interview by Andrew Everett, *supra* note 125.

* J.D., with Certificate in Health Law Studies, anticipated 2009; B.A., with Honors in Biology, Williams College, 2005. The author would like to thank Professor Nicolas P. Terry and Natalie E. Kean for their assistance with this article.

