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Towards Innovative, Liveable, and Prosperous Asian Megacities: Medical Tourism

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Abstract

Thanks to rapidly improving technology and medical practice standards, medical travel is able to combine the allure of exotic tourist destinations with the promise of affordable and high-quality health care as well as alternatives to western medical knowledge and procedures (such as traditional medicine including yoga, homeopathy, and "Chinese medicine"). Rising medical costs and lengthening queues for medical procedures in the Western world also contribute to making medical services in countries like India, the Philippines and Thailand more than acceptable substitutes to those offered in their developed country counterparts.

Moreover, the literature on the industry indicate that other than the significant price differences of medical services, factors like "favorable foreign currency exchange rates [in developing economies], rapidly improving technology and medical practice standards" (Garcia & Besinga, 2006) together with the "tourism" element seemingly compensate for the lack of insurance portability in developing countries. Accordingly, medical travel is among the fastest growing sectors, particularly in Asian economies, expanding at an estimated rate of 20 percent annually and should be worth about US$4 billion by 2012 (Yap, Chen & Nones, n.d.).

Accordingly, medical tourism is becoming a significant source of growth for Asian economies such as India, the Philippines, Singapore, and Thailand. This paper discusses the evolution of the medical travel industry and highlights the impact of the sector on the domestic economy (Part I). It tackles the various theories involved in the development of medical tourism infrastructure (Part II). The document also identifies the sector's strengths, obstacles, and prospects (Part III). The last section, Part IV, summarizes the paper by analyzing the health tourism sector as a city innovation.

I. INTRODUCTION

Health tourism is defined as "the attempt on the part of a tourist facility (i.e., hotel) or destination (i.e., Baden, Switzerland) to attract tourists by deliberately promoting its health-care facilities, in addition to its regular tourist amenities" (Goodrich & Goodrich, 1987). Also known today as medical tourism or medical travel, the sector traces its origin to the Neolithic period when people "traveled long distances to specific geographic

locations across Europe in order to conduct rituals and for other perceived health benefits" (Smith, 2008). Not only did the practice continue throughout medieval times but records show that it has blossomed into a global, multi-billion dollar industry in the 21st century.

Contemporary times credit Cuba for being one of the first countries to actively promote medical treatments with tourism between developed and developing nations (Goodrich, 1993). In an attempt to boost both the tourism and medical industries, Cuba launched its "sun and surgery" package, which combined dental, cardiac, organ transplant, and cosmetic procedures with its spa and "wellness adventures", in the early 1990s (Smith, 2008).

Owing to the skyrocketing medical and healthcare services in developed countries such as the United Kingdom, US, and Europe, patients are outsourcing their medical needs to Thailand, India, the Philippines, and other Southeast Asian countries. Other than the significant price differences of medical services, factors like "favorable foreign currency exchange rates [in developing economies], rapidly improving technology and medical practice standards" (Garcia & Besinga, 2006) together with the "tourism" element seemingly compensate for the lack of insurance portability in developing countries. Accordingly, medical travel is among the fastest growing sectors, particularly in Asian economies, expanding at an estimated rate of 20 percent annually and should be worth about US$4 billion by 2012 (Yap, Chen & Nones, n.d.).

Not unlike its Asian neighbors, medical tourism is becoming an important driver of the Philippine economy. Accordingly, Section I of this paper discusses the evolution of the medical travel industry and highlights the impact of the sector on the domestic economy. Part II tackles the various theories involved in the development of medical tourism infrastructure. Part III identifies the sector's strengths, obstacles, and prospects. Lastly, Part IV summarizes the paper by analyzing the health tourism sector as a city innovation.

II. EVOLUTION OF PHILIPPINE MEDICAL TOURISM

The Philippines' medical tourism industry emerged in the 1960s when American and European patients visited the country in search of relief from Catholic faith healers (De Vera, Huang, Khan, Qin & Tan; 2008). The sector expanded its range of services to include cardiovascular and pulmonary treatments with the establishment of the Philippine Heart Center, National Lung Center, National Kidney and Transplant Institute, which not only attracted patients from North America, Europe, and Southeast Asia but also medical experts – such as doctors, nurses, and other healthcare professionals – from the region "to study, train and practice [their respective specializations] in these hospitals" in the 1970s (Garcia & Besinga, 2006).

The Philippine Heart Center (PHC), for example, was established as a center for cardiovascular treatment in the 1970s. The hospital was initially called the Heart Center for Asia because it is the first heart center in Asia that provides cardiovascular treatment, management, diagnosis, and treatment and is, thus, considered as a pioneer in Asian medical tourism as far as cardiovascular treatments are concerned. Accordingly, PHC attracted patients from India, Malaysia, Thailand, Singapore, Nepal (the Queen of Nepal was once a patient of PHC), and others. In the 1980s, PHC found itself serving patients from the Middle East as well (Santos, 2010).

Accordingly, the impact of the health tourism is not limited to the medical field – which includes health providers such as doctors, private hospitals, etc. – and the patients they serve – foreign and domestic – but also the tourism industry (i.e., hotels, restaurants, travel consultants, spa clinics, etc.), business processing outsourcing (i.e., medical transcription segment, assistants for medical tourists, etc.) and the various institutes for collaboration such as learning institutions (i.e., medical colleges), government institutions, and industry associations like the Spa Association of the Philippines and the Pharma and Health Association (De Vera, Huang, Khan, Qin & Tan; 2008).

Thus, as the industry continued to grow, specifically in the early years of the 21st century, the government launched the Philippine Medical Tourism Program (PMTP) in 2004 with the objective of implementing a cohesive development strategy that would successfully promote the industry (Garcia & Besinga, 2006). The task force, which aims to anticipate and respond to the needs of the sector, is comprised of representatives from the public sector including the Department of Health, the Board of Investments, the Department of Energy, Department of Tourism, and Department of Trade and Industry, among others, as well as the European Chamber of Commerce, Freedom to Fly Coalition, Hotel and Restaurant Association of the Philippines, National Association of Independent Travel Agents, Philippine College of Physicians, and Philippine Medical Association, among others, the private sector counterpart.

A. Impact of the Medical Industry on the Philippine Economy

Today, owing to the support of public policy and private sector investments, the domestic industry is able to provide a number of procedures and treatments under the medical care, surgical care, women's health, dental care, and optometric sub-sectors. Table 1 enumerates some of these medical treatments. Indeed, the Philippine government estimates the country's health and wellness tourism to have contributed US$1.65 billion to the country's 2005 GDP (1.26%). The sector is also said to have grown by 2.4% in 2006 and 8% in 2007. With the aid of the public-private partnership, however, the government puts the potential of the industry to the tune of US$2 billion a year – equivalent to some 700,000 medical tourists annually (Vequist & Valdez, 2008).

Table 1: Medical Treatments and Procedures Available in the Philippines

Medical Care	Surgical Care	Women's Health	Dental Care	Optometric Care
Allergology	Bariatric Surgery	Infertility, A.I.D. and A.I.H.	Cosmetic Dentistry	Contact Lens & Ocular Prosthetic
Cardiology	Cardiothoracic Surgery	Obstetrics and Gynecology	Prosthetics	General Optometry
Critical Care	Cosmetic, Plastic, and Reconstructive Surgery	Urologic Gynecology	General Dentistry	Low Vision Care
Complementary and Integrative Medicine	ENT, Head and Neck		Implant Dentistry	Neurooptometry
Endocrinology and Metabolism	General Surgery		Maxillodental Dentistry	Orthoptics and Binocular Vision
Gastroenterology	Gastrointestinal		Oral Surgery	Pediatric Optometry
Geriatric Care	Maxillofacial		Orthodontics	Sports Vision Care
Hermatology	Neurosurgery			
Infectious and Tropical Diseases	Ophthalmology			
Lifestyle Health Services				
Neonatology				
Neurology				
Oncology (Cancer Medicine				
Pain Management				
Rheumatology				

Source: Garcia and Besinga, 2008[1]

Moreover, the industry helps to utilize the more than 85,000 bed capacity – 50.4% in the private sector and 49.6% accounted for by the public sector – in the 1,832 hospitals – 61.7% is privately managed and the, balance, 38.3% is government operated – in the country. Appendix 1 and Appendix 2 present the distribution of licensed government and private hospitals and healthcare facilities, respectively, in the country. The largest facilities are located in the National Capital Region, which accounts for 0.25% of hospitals and healthcare establishments but 27% of the hospital beds. The CALABARZON (Southern Tagalog Region) area, on the other hand, has the most number of facilities, accounting for 13% of the total but only 10% of the bed capacity. The sector also taps into the wealth of healthcare professionals, which, in turn, keeps the cost of medical care in the Philippines competitive.

Most of the private clinics and hospitals that participate in health tourism, however, are located in Manila, where the supporting infrastructure and human resources are well within reach. Hospitals such as University of Sto. Tomas (Cabatu, 2010), St. Luke's Medical

[1] The table contains a partial list of the medical treatments included in from the Garcia and Besinga (2008) paper.

Center (1903), Medical City (1967), Makati Medical Center (1969), and Asian Hospital (2002) provide a wide range of medical treatments – from elective and less invasive surgery such as Dermatology and Ophthalmology to more invasive or complex treatments like Cardiology, cancer treatment, and organ transplants. Critical to these establishments' success are factors such as: international accreditation (i.e., Joint Commission International) and collaborations with developed-country hospitals and teaching institutions (i.e., St. Luke's and New York Presbyterian Hospital); range of medical services performed promptly; cultivation of market niches (i.e., cosmetic surgery procedures targeting overseas Filipino workers); and the perpetual upgrading of medical skills through participation in medical conferences and seminars (De Vera, Huang, Khan, Qin & Tan; 2008).

B. Location Distribution of Hospitals with Medical Tourism Program

In general, most of the government and private tertiary hospitals and clinics are located in the National Capital Region (NCR) and the CALABARZON area. As mentioned earlier, the infrastructure and human resources needed for medical services are concentrated in these areas. Table 2 shows the disparity, in terms of number of tertiary hospitals and beds, between NCR and the other regions.

Most of the private and government tertiary hospitals are concentrated in the NCR region, with a total of 56 hospitals for the year 2005. CALABARZON and Central Visayas region are the regions with the second highest number of private hospitals, with a total of 9 hospitals. The concentration of the tertiary hospitals in NCR can be explained by localization economies – the details of this theory will be discussed in the next section. A closer look at the number of bed statistics per region depicts the almost bleak situation of tertiary hospitals in the regions other than NCR and CALABARZON. For instance, the Zamboanga Peninsula registered only 350 beds, a number lower than the national average. In fact, other regions such as CAR, ARMM and CARAGA did not have any value for number of hospitals and beds.

Table 2: Distribution of Licensed Private and Government Hospitals and other Health Facilities by Region for Year 2005

Region	Private Tertiary Care/TLRC		Government Tertiary Care/TLRC		Total	
	Hospital	Beds	Hospital	Beds	Hospital	Beds
Ilocos Region	5	446	6	1,050	11	1,496
Cagayan Valley Region	-	-	2	600	2	600
Central Luzon Region	6	771	6	1,405	12	2,176
Southern Tagalog Region (CALABARZON)	9	1,032	2	450	11	1,482
Southern Tagalog Region (MIMAROPA)	-	-	-	-	-	-
Bicol Region	2	250	4	900	6	1,150
Western Visayas Region	8	1,655	3	1,000	11	2,655
Central Visayas Region	9	1,980	4	1,350	13	3,330
Eastern Visayas Region	1	140	1	250	2	390
Zamboanga Peninsula	1	100	1	250	2	350
Northern Mindanao Region	5	460	2	450	7	910
Southern Mindanao Region	4	691	2	600	6	1,291
Central Mindanao Region	3	400	3	400	6	800
National Capital Region	32	8,147	24	8,102	56	16,249
CAR	-	-	1	350	1	350
ARMM	-	-	-	-	-	-
CARAGA	-	-	-	-	-	-
PHILIPPINES	**85**	**16,072**	**61**	**17,157**	**146**	**33,229**

Source: Department of Health

In NCR, there are five government and private tertiary hospitals marked as centers for the medical tourism program (Department of Health). The list of government hospitals includes East Avenue Medical Center, Lung Center, National Kidney Institute, Philippine Children's Medical Center, and Philippine Heart Center. All of these government hospitals are located in Quezon City, the largest city in Metro Manila. There are also several private hospitals located in the area and they include St. Luke's Medical Center, and Capitol Medical Center. The others are Asian Hospital (Muntinlupa City), Makati Medical Center

(Makati City), and Medical City (Pasig City). It is apparent that these tertiary hospitals marketed as centers for medical tourism are located in large cities with access to other amenities such as hotels, transportation and others.

II. URBAN ECONOMICS OF MEDICAL TOURISM INFRASTRUCTURE

The concentration of certain services and infrastructure in a location can bring about various benefits not only to the locality but to its neighboring areas as well. This is true for the medical tourism industry in the Philippines. Although medical tourism is relatively new in the country and is in its primary stage compared to Thailand, there is so much potential in the industry in terms of creating employment opportunities and attracting retiring foreigners. This section will discuss the theoretical underpinnings of the medical tourism industry.

A. Localization Economics

One of the main reasons why tertiary hospitals are located in large cities is due to localization economies. The literature on urban economies point out that localization economies happen when a firm's unit costs are lower in an urban area that has many firms in the same industry (Ebert & McMillen, 1999). The scale economy is external to the firm so that firms remain small, but internal to the industry so that industrial concentration is high in an urban area. It was stressed by Ebert and McMillen (1999) that the assumption that economies are external to the firm is important in making a competitive market system compatible with aggregate increasing returns to scale. With regard to internal scale economies, specialization may create localization economies as greater city size permits firms within an industry to concentrate on one type of production (Ebert & McMillen, 1999).

A source of localization economies are labor-market economies. The reason behind this is that start-up costs are small but the risks are high. Firms routinely fail and their employees look for new jobs elsewhere. If the concentration of employment is in one area, it will be

easy for firms to find skilled employees and workers can quickly find employment after an enterprise fails. Matching costs are low when an industry concentrates in one area (Ebert & McMillen, 1999). Applying this to the medical tourism industry in the Philippines, the presence of skilled labor in health services in areas where most of the hospitals are clustered can easily facilitate transactions between hospitals.

Furthermore, one firm's internal scale economies may lead to another industry's localization economies. For instance, shipping costs may lead to a considerable cost advantage to locating near the large firm if its output is an input to the industry's production process. The strategic location of the commercial establishments and suppliers of medical equipment near the hospitals allows for the exploitation of relatively low costs.

Ebert and McMillen (1999) pointed out that localization economies may also exist in retail establishments by allowing customers to comparison shop. A localization economy exists because small establishments in the same industry find it profitable to locate near one another. A similar argument lies behind the idea of "communication economies": firms locate near each other to reduce the cost of obtaining information, for themselves and their customers. An essential role of communication economies is to increase the rate of technological innovation in urban areas (Ebert & McMillen, 1999).

B. Urbanization Economies

Urbanization economies happen when economies are external to both the firm and industry. Because of this, small establishments find it profitable to locate in an urban area even when there are no cost advantages to geographic concentration for their industry (Ebert & McMillen, 1999). An example of which is specialized services in large urban areas that do not exist in smaller areas. Public infrastructure is an important source of urbanization economies: by providing good highways, public utilities, communication facilities and the like, an urban area significantly lowers the cost to all firms of doing business in an urban area (Ebert & McMillen, 1999). This is true for tertiary hospitals in

NCR. As it was pointed out earlier, most of the hospitals are located in NCR and one of the driving forces is the availability of infrastructure and other services that complement their own.

The previous discussions on localization and urbanization economies are linked to agglomeration economies. Agglomeration economies explain the stage of urban development which focuses on how company towns can further develop into large industrial cities. The activities of dissimilar businesses generate positive externalities that lower the production costs of one establishment as the output of other businesses increases (Ebert & McMillen, 1999). The externalities result from businesses sharing non-excludable inputs such as common labor pool, technical expertise and communication and transportation networks. Urban public infrastructure is one shareable input that directly affects the efficient operation of cities, particularly large cities. This would promote and lead to realization of agglomeration economies (Ebert & McMillen, 1999).

C. Urban Amenities

Health care infrastructure is part of the amenities that attract people with various health needs to go to a particular area. Bartik and Smith (1987) stated that amenities can be classified using many dimensions such as geographic scale, degree of permanence, and the extent to which they are physically tangible. Amenities can differ in how rapidly they change and while some are closely related to physical phenomena, others are quite subjective and difficult to define. Moreover, amenities should be central to any realistic description of consumption. Other amenities surface from private actions and the public sector attempts through regulation or other measures to affect their actions. An amenity may be the result of a long process and often, they are accidents of history (Bartik & Smith, 1987). Nonetheless, local policies such as zoning, housing codes, and community development programs can influence the prospects for these amenities to arise and may maintain or destroy those that already exist.

The medical tourism sector is expected to expand to a larger scope in the near future. The increasing demand from both international and local markets for health care services would bring about more privatization initiatives. Moreover, prices of these health care services catering to the promotion of medical tourism are expected to stay attractive to the market, even competitive among Asian countries. Not only does competition in health care value or price exist among Asian countries, but also technological competence through hospital amenities (Connell, 2006).

Urban development has evolved and made an impact to help not only the local scene but the neighboring areas and international scene as well. One of the urban developments resulted to health-related travel, once promoted by individual medical amenities, which is now driven by government agencies, public–private partnerships, private hospital associations, airlines, hotel chains, investors and private equity funds, and medical brokerages. Because of this, destination nations regard medical tourism as a resource for economic development and start to invest more on various development programs that may commence a new plan for medical amenities, and advance or debase the prevailing ones.

Moreover, the establishment and improvement of urban amenities for urban economic development entails complex strategies, techniques, and rationale. An example is the elaborated relationship between development per se and the preservation of the ecological side of the locality. Jamieson (2006) pointed out that this knowledge may be critical in the development of a new project for which the proximity to natural amenities must be balanced against the cost of improving existing infrastructure. Suitably, it must also be planned as thorough as possible for better standards and continuous improvement of (hospital) amenities, which invite more tourists who are more inclined to obtain services from institutions (hospitals) accredited by internationally recognized organizations. In the long run, these changes translate to better institutions, in this case, hospitals and clinics that will serve not just foreign patients, but local ones as well.

Each Asian country has its own competitive advantage over the others. Connell (2005) stressed that even for a country like Singapore where the cost of living is high a million patients are expected to avail of medical travel services by the year 2012. The Philippines would also be one of the most aggressive players in the industry. Infrastructures outside the hospital, including a new airport, were constructed. Through the years, new technological advancements and trainings regarding new medical equipments are also made available to Filipino doctors and local patients residing in the country. Filipino doctors themselves can serve as an amenity provided by Philippine health care. Filipinos including medical practitioners with Filipino descent working in other countries, proficient in the English language and highly trainable, are dispersed across the world. This makes patients from first-world countries put their trust and confidence in receiving medical treatment in the Philippines (Kinavanod, 2005). In the Middle East, Dubai established its Healthcare City to keep its people from going to Asian countries for medical assistance (Connell, 2005). In order to compete for first-world patients, hospitals and health care centers must stay on top of their game since rising income and wealth seemingly requires and demands location-specific amenities (Deller et al, 2001).

III. PHILIPPINE MEDICAL TOURISM STRENGTHS, OBSTACLES, AND PROPSECTS

A. The Philippines' Competitive Edge in the Medical Tourism Industry

In addition to cost advantages, the Philippines offers a high quality medical labor force, continuous improvement of medical facilities and infrastructure with the solid backing of the national government, and a hospitable and English-speaking population. Table 3 clearly illustrates the wide disparity in the cost of healthcare services between the Philippines and the United States. The cost of medical treatments in the US is estimated to be 72% (Rhinoplasty) to 1,073% (Glaucoma) more expensive than in the Philippines (refer to Table 3).

Table 3: Philippines and US Medical Treatment Cost Disparity in 2005 (US$)

Treatment	Philippines	USA	Cost Difference
Breast Augmentation	2,000	5,000	3,000
Cataract Extraction	864	3,595	2,731
Coronary Bypass Surgery	25,000	50,000	25,000
General Medical Check-up	500	5,000	4,500
Glaucoma	331	3,882	3,551
Hysterectomy	2,475	5,783	3,308
Kidney Transplantation	25,000	150,000	125,000
Knee Surgery	2,313	10,335	8,022
Lasik Eye Surgery	1,000	3,000	2,000
Rhinoplasty	2,939	5,050	2,111
Tympanoplasty	1,947	4,993	3,036

Source: De Vera, Huang, Khan, Qin & Tan; 2008[2]

The Philippines likewise edges out Thailand and Mexico in some medical treatments – such as cataract extraction, hysterectomy and knee surgery – but records significantly higher travel costs from the United States, 34% more than Thailand and 66% more than Mexico (refer to Table 4).

Table 4: Medical and Travel Cost Comparisons between the Philippines, Thailand & Mexico; 2005 (US$)

Treatment	Philippines	Thailand	Mexico
Cataract Extraction	864	1,022	1,827
Glaucoma	331	140	n/a
Hysterectomy	2,475	3,071	6,106
Knee Surgery	2,312	2,860	4,706
Rhinoplasty	2,939	n/a	3,930
Tympanoplasty	1,947	806	n/a
Travel Cost (round-trip from the US)	1,204	793	410

Source: De Vera, Huang, Khan, Qin & Tan; 2008

In addition, the Philippines' dedication to providing quality healthcare is apparent in the country's drive to adopt "rigorous procedures using standards that are internationally acceptable" (Editor, 2008). First, healthcare professionals in the Philippines – doctors, nurses, and other staff – are licensed and certified by the Philippine Regulatory Commission

[2] The raw data – medical cost in the Philippines and US – was sourced from the De Vera, Huang, Khan, Qin & Tan (2008) paper.

as well as by individual specialty societies. Professional competence is assessed through an exhaustive review of the medical practitioner's academic training, experience, licensure, certification and registration to practice, peer audits, and sentinel event monitoring. Second, the government requires that tertiary hospitals be accredited for medical tourism. Government evaluates the location, building design and layout, services (i.e., reception, housekeeping, food and beverage, and engineering and maintenance), and staff before a facility is licensed to offer medical travel services. Moreover, once accredited, the hospital is regularly visited to ensure proper operation and maintenance. Appendix 3 contains a copy of the "Rules and Regulation to Govern the Accreditation of Tertiary Hospitals for Medical Tourism" signed by the Secretary of the Department of Tourism, Richard J. Gordon. Furthermore, most of the best practices, particularly in the area of patient safety, pioneered by Evidence-based Medicine (EBM)[3], are observed by establishments recognized by PHILHEALTH (Cabatu, 2010). In addition to local accreditation, international recognition – via the ISO 9001 Certification – has also been achieved by some Philippine tertiary public and private hospitals (i.e., Makati Medical Center and National Kidney and Transplant Institute). Third, feedback mechanisms – through individual and group counseling and e-newsletters and web-based forums – are also incorporated into the evaluation process to guarantee that the patient's inputs are taken into account in assessing the quality of healthcare and patient safety. Fourth, partnerships with external agencies – which, similar to their local associates, undergo accreditation and licensing – are likewise sought "to ensure [a thorough delivery of] quality healthcare" (Editor, 2008).

Additionally, strong government support for the sector is an unquestionable advantage in fueling the growth and development of the medical travel industry. The Philippine government outlines the various resources available to the sector in Medium-Term Philippine Development Plan 2004-2010 (MTPDP), Investment Priorities Plan (IPP), the Philippine Medical Tourism Program (PMTP), and the Philippine Economic Zone Authority.

[3] EBM applies "the best available evidence gained from the scientific method to medical decision making [and seeks] to assess the quality of evidence of the risks and benefits of treatments" (Cabatu, 2010).

Strategies on how best to promote the industry is outlined in the Medium-Term Philippine Development Plan 2004-2010 (refer to Appendix 4). The MTPDP specifically states that the:

- country's job creation thrust shall include medical services and tourism;
- promotion of foreign investments – target sources include Japan, Korea, Taiwan, Pacific Islands, and Singapore – shall focus on the establishment of medical zones and the requisite "policy and administrative reforms to facilitate the entry and practice of foreign medical specialists in designated medical zones shall be looked into" (MTPDP, 2005);
- tourism industry, in general, is a sector "that has the potential to boost the Philippine economy" (MTPDP, 2005). Accordingly, a national strategy that focuses on market-product, destination, building priority zones, tourism infrastructure, and leadership and accountability are essential components of the quest for economic growth and development.

The sector has likewise been included in the Board of Investments' Investment Priorities Plan since 2005. Aside from offering incentives to prospective medical tourism investors, it also "introduces the concept of the 'international medical zone', which is a selected area developed into a center for professional healthcare" (Garcia & Besinga, 2006). A copy of the provisions of the IPP is contained in Appendix 5.

Specifically, the Philippine Medical Tourism Program (PMTP) was formed "to solidify the medical and health and wellness service industries to cater to the foreign market" (Garcia & Besinga, 2006). The PMTP focuses on four important components of the medical travel sector, namely: medical and surgical care, traditional and alternative health care, health and wellness, and the international retirement center. The program details how the local industry ensures high-quality patient care in each category (i.e., DOH accreditation, international accreditation – such as the prestigious Joint Commission International, adherence to World Health Organization standards, continuous upgrading of skills and facilities, etc.). Accordingly, this partnership with the public sector is envisioned to augment the revenue of the healthcare industry, enhance opportunities for medical practitioners, induce the adoption of higher standards of care and improvement of hospital

facilities, and maintain the local industry's cost competitiveness relative to that of developed countries (Garcia & Besinga, 2006).

Similarly, the Philippine Economic Zone Authority (PEZA) offers fiscal and non-fiscal incentives to PEZA-registered Medical Tourism Economic Zone Enterprises and DOH recommended "registrable activities/enterprises" that cater primarily to foreign patients. Fiscal incentives include: 1) four-year income tax holidays (ITH) "on income solely derived from servicing foreign patients"; 2) "5% Gross Income Tax on income solely derived from servicing foreign patients, in lieu of all national and local taxes" after ITH expiration; and 3) tax and duty-free importation of medical equipment (PEZA, 2006). Non-fiscal incentives, on the other hand, take the form of: 1) employment of foreign nationals; and 2) special visitor's visa (refer to Appendix 6).

Finally, there is no substitute to the ability to anticipate, promptly respond and meet the needs and expectations of clients. According to Gasparoni (2008), the following are important matters to consider when planning one's medical trip abroad: "the quality of care received and the physician selected"; and a comfortable environment (i.e., safety, language, mobility, access to local currency, etc.). The Philippines' highly-competent medical practitioners and largely English-speaking population are, therefore, among the principal assets of the local medical tourism industry in providing first-rate medical care.

B. Barriers to the Growth of the Philippine Medical Tourism Industry

Maximizing the potential of the Philippine medical tourism sector requires that a number of issues be successfully addressed, which can be divided into two categories, industry-level concerns and country-level weaknesses.

1. Industry-level Concerns

First, developed country patients rely on health insurance to finance the cost of medical treatments. Most insurance plans, however, do not cover the cost of medical services

offered overseas, which means that the medical treatments received by foreign patients in the Philippines are mostly privately funded or out-of-pocket costs (Kalshetti & Pillai, 2008).

Second, the credibility of the Philippine medical tourism industry would be improved by a narrower gap between the quality of the private and public health services. Currently, despite the priority given by the government to social infrastructure, public health services – particularly in the rural areas – suffer from low investments in facilities and the scarcity of skilled medical practitioners. Consequently, life expectancy in the countryside is about 30 years behind the national average. The literature also attributes the sluggish growth in labor productivity, 1% annually, to inadequate healthcare (De Vera, Huang, Khan, Qin & Tan; 2008).

In the case of the Philippine Heart Center (PHC), a pioneer in cardiovascular treatment in Asia, for instance, participation in medical tourism requires further improvements in facility, bed capacity, equipment, and staff. Indeed, PHC is considered to be a relatively small and highly-specialized facility by international standards. Thus, despite the fact that it operates at full capacity, PHC can, at best, only accommodate local demand. According to Dr. Romeo Santos (2010), although PHC serves a few foreign patients, it cannot fully pursue its participation in medical tourism owing to fixed or limited resources.

Third, similar to developing countries that offer medical travel services, the Philippines does not have a mechanism to address the concerns of unhappy clients. Dissatisfied patients have to resort to lengthy legal procedures to resolve their grievances. Accordingly, developed country customers, who are accustomed to company-based solutions to these types of problems – are discouraged from patronizing treatments offered abroad (Garcia & Besinga, 2008).

Fourth, according to Keckley and Underwood (2008), building a reputation as a "quality healthcare" provider requires: 1) the use of clinical information technologies; 2) use of evidence-based clinical guidelines; 3) affiliations with reputable, top-tier US provider organizations; 4) coordination of pre- and post-charge care; 5) provision of adverse events requiring services unavailable in the facility; and 6) certification for safety and quality by the Joint Commission International or others.

Fifth, an important step in enhancing the competitiveness of the health tourism industry is the public-private sector partnership created in 2004 under the Philippine Medical Tourism Program (PMTP). Presently, the collaboration between the sectors is limited to making basic services available like the yellow book registration. The partnership could be a boundless source of ideas and resources that aid the growth and development of the sector (De Vera, Huang, Khan, Qin & Tan; 2008). Indeed, it could be a venue to create the enabling environment needed to create a system that successfully integrates the services offered by both the tourism and medical sectors. Among the key components of this system should be the creation and/or improvements in business processes: 1) tie-ups with target markets (i.e., Japanese and Korean health insurers); 2) point persons with whom potential and actual medical tourists can discuss the services offered by the industry – from the required documents (i.e., visas, health records, hotel reservations, transportation, etc.) to available medical procedures and their alternatives to tourist spots and activities; 3) staff who will meet patients and their families at the airport, process documents at immigration, assist in claiming their luggage and complying with customs requirements, provide transportation throughout the duration of the visit; and 4) medical tourism coordinators who will meet and attend to the needs of the patient and his/her family; they should be knowledgeable about tourist attractions that would entertain the family of the patient as well as the medical procedure the patient would undergo; the medical tourism coordinators would be the patient's and his/her family's link to the tourism (i.e., plan museum visits, recommend restaurants and shopping destinations, etc.) and medical (i.e., respond to concerns/queries regarding medical procedures from pre-operation to post-operation care)

aspects of the trip; it would thus be advantageous if the medical tourism coordinators can speak the native tongues of and are familiar with the cultural and religious needs of the medical tourists. Similar systems, with varying degrees of sophistication, already exist in the top medical tourism destinations in the world (i.e., India and Thailand).

Thus, according to Galvez-Tan (2010), independently, the tourism and health industries may be successful in addressing the needs of their respective markets. If the Philippine medical tourism is to flourish, however, it requires the faultless union of the two in terms of knowledge, processes, infrastructure, and expertise. In other words, a medical tourism personnel is neither a tourist guide nor a medical practitioner but an individual who is proficient in both professions.

Furthermore, it cannot be denied that a robust tourism industry can expand the market for medical travel sector. In the past five years, visitor arrivals have been growing at an annual average of 8.31%, from 2004's 2.91 million to 3.14 million in 2008. The top three subcontinents from which Philippine tourists originate in 2008 are East Asia (43.64%), North America (21.72%), and the ASEAN (8.09%). Overseas Filipinos, on the other hand, account for 6.22% of visitors arrivals during the year (refer to Table 5).

Table 5: Philippine Visitor Arrival by Subcontinent of Residence, 2004-2008

Subcontinent of Residence	2008	2007	2006	2005	2004	2008 % Share to Total
Grand Total	**3,139,422**	**3,091,993**	**2,843,335**	**2,623,084**	**2,291,347**	
ASEAN	254,077	235,615	202,886	179,386	149,017	8.09
East Asia	1,370,059	1,430,077	1,338,777	1,242,518	1,078,053	43.64
South Asia	43,662	37,596	31,975	28,485	24,997	1.39
Middle East	40,508	35,688	31,503	27,053	22,773	1.29
North America	681,922	671,744	648,929	602,250	543,616	21.72
Central America	-	-	-	-	-	
South America	3,505	3,177	2,776	2,543	2,246	0.11
Western Europe	134,663	128,199	117,167	112,109	100,337	4.29
Northern Europe	136,260	124,684	106,088	98,502	86,557	4.34
Southern Europe	31,229	28,961	23,097	21,889	19,017	0.99
Eastern Europe	16,819	14,599	14,042	11,428	4,304	0.54
Oceania	174,583	163,403	149,276	143,455	132,186	5.56
Africa	3,317	3,090	2,246	2,294	1,700	0.11
Others and Unspecified Residences	53,531	34,421	28,208	25,777	22,802	1.71
Overseas Filipinos	195,287	180,739	146,365	125,395	103,742	6.22

Source: National Statistical Coordination Board

The latest available data on the distribution of travelers in the country revealed that of the more than 11 million people who toured the Philippine islands in 2002, 80.28% are residents, 19.13% are foreigners, and 0.59% are overseas Filipinos. Table 6 shows that most Philippine domestic travelers spend their holiday in the Southern Tagalog Region (30.22%), the Cordillera Autonomous Region (13.69%), and Central Visayas (8.34%). Similarly, an estimated 62.95% of all foreign visitors go to the Southern Tagalog. The next most popular destinations are Central Visayas (14.72%) and Central Luzon (5.97%). Majority of the overseas Filipino tourists, on the other hand, take trips to Western Visayas (19.78%), the Southern Tagalog Region (18.83%), and Central Luzon (15.03%).

Table 6: Distribution of Philippine Regional Travelers, 2002

Region/Province/City	Domestic Travelers	Foreign Travelers	Overseas Filipinos
CAR	13.69	2.13	8.50
Region I	3.25	3.00	0.13
Region II*	6.23	1.12	0.00
Region III	3.19	5.97	15.03
Region IV***	30.22	62.95	18.83
Region V	4.21	0.43	4.52
Region VI	7.98	5.08	19.78
Region VII	8.34	14.72	1.98
Region VIII	1.82	0.43	4.30
Region IX	2.09	0.35	8.37
Region X	5.96	0.74	1.62
Region XI	5.33	2.56	11.94
Region XII**	4.69	0.14	2.87
Region XIII	2.99	0.37	2.11
Total	100.00	100.00	100.00

Legend: * Data for overseas Filipinos are lumped under foreign travelers
** No submission for breakdown by province/city
*** Partial report; data not available for regions and/or province not mentioned in table
Source: NSCB Website

Meanwhile, reported average occupancy rates of deluxe, first class, standard, and economy hotels point to a, roughly, 30 percent capacity underutilization from 2004-2008: 27.5% for deluxe, 29.3% for first class, 30.8% for standard, and 39.5% for economy accommodations (refer to Table 7). Thereby indicating that, in terms of lodging, the country can comfortably host more visitors annually.

Table 7: Philippine Hotel Average Occupancy Rates, 2004-2008

Year	Average	Deluxe	First Class	Standard	Economy
2004	68.2	71.0	65.8	64.3	54.1
2005	72.0	74.0	70.2	68.7	65.9
2006	72.0	73.6	72.3	70.3	58.4
2007	73.1	73.8	75.9	71.8	61.8
2008	69.8	70.1	69.0	70.8	62.3

Source: NSCB Website

Based on the data discussed above, the tourism industry in the country needs more would benefit from increased advertising and funding from the government and private sector. There is a vast potential in the Philippine tourism industry that has yet to be tapped. Indeed, the data shows that most of the tourists who holiday in various parts of the country

are Filipino nationals. This is not surprising due to various barriers that hinder foreign tourists to choose the Philippines as their vacation haven. One is the peace and order situation especially in the provinces that becomes sensationalized in the media. Another barrier is the lack of investment in infrastructure that will link the various provinces.

Finally, the Philippines has to distinguish its services from its closest rivals in the Asian region. India, Malaysia, Singapore, and Thailand have well-defined market niches. India and Singapore, for example, are well-known for complex procedures like heart surgery. Malaysia focuses mainly on cosmetic surgery and alternative medicine (Keckley & Underwood, 2008) and is, in fact, the preferred destination of Muslim patients. Thailand, on the other hand, is popular among Western European tourists who are in search of cosmetic surgery. While the cost of medical services in the Philippines, in general, is more reasonable relative to their Asian neighbors, the country has to identify, cultivate, and promote its own market niche (De Vera, Huang, Khan, Qin & Tan; 2008).

2. Country-level Weaknesses

Documented in previous sections is the fact that the cost of medical services in the Philippines is lower than its Asian competitors – cheaper by about 19% across selected treatments as compared to Thailand and 57%-195% below the cost of selected procedures in Singapore. The disadvantage of selecting the Philippines, in terms of expenditures, stems from the cost of medical travel. A roundtrip visit to the Philippines from the US, for instance, is 34% and 33% more expensive relative to Thailand and Singapore respectively (De Vera, Huang, Khan, Qin & Tan; 2008).

Furthermore, a well-functioning infrastructure is important to all industry. Health tourism is no different, particularly since it is highly dependent on efficient airports, highways, and transport systems. Likewise, reliable power and telecommunications sectors are critical to the delivery of quality medical services (De Vera, Huang, Khan, Qin & Tan; 2008). Presently, additional investment not only in hard (i.e., roads) and soft (i.e.,

telecommunications) infrastructure but also in public health facilities is necessary to attract more tourists and induce medical professionals to serve the local market.

In contrast, competing East Asian neighbors – particularly Malaysia, Singapore and Thailand – "have adopted and invested in the latest medical technology to provide state-of-the-art care for their patients who can afford such services" (Yap, Chen & Nones, n.d.). Indeed, many of the establishments in these countries are characterized by the following:

- "employ US or European-trained physicians and care teams,
- use clinical information technologies,
- use evidence-based clinical guidelines,
- are affiliated with reputable, top-tier U.S. and European provider organizations
- coordinate pre- and post-discharge care,
- provide for adverse events requiring services unavailable in the facility, and
- are certified for safety and quality by the Joint Commission International, which accredits hospitals around the world, or another accrediting institution" (Yap, Chen & Nones, n.d.).

Lastly, the Philippines may have an abundant supply of medical practitioners (i.e., doctors, nurses, etc.) but a considerable number of them work abroad. Expanding the scope and scale of the sector in the immediate future, therefore, necessitates that the country find ways and means of encouraging these skilled professionals to serve the local industry (Garcia & Besinga, 2006).

C. The Competition: India and Thailand

Thanks to rapidly improving technology and medical practice standards, medical travel is able to combine the allure of exotic tourist destinations with the promise of affordable and high-quality health care as well as alternatives to western medical knowledge and procedures (such as traditional medicine including yoga, homeopathy, and "Chinese medicine"). Rising medical costs and lengthening queues for medical procedures in the Western world also contribute to making medical services in countries like India, the Philippines and Thailand more than acceptable substitutes to those offered in their developed country counterparts.

While the significant differences between medical costs in developed and developing and among developing countries certainly go a long way in attracting foreign patients, a close examination of the characteristics of key medical travel industry players – India and Thailand - in Asia reveal that success in the sector is determined by a host of other factors that give a country an advantage over its competitors that seemingly offer similar services.

1. India

The Medical Travel Quality Alliance (MTQUA) ranked the Fortis Hospital in Bangalore, India as the world's best hospital for medical tourists (http://www.imtj.com/news/?EntryId82=180265). Aside from offering "excellent surgery option for medical travelers", Fortis Hospital, according to the MTQUA, "has a transparent process [that is] sensitive to the needs of patients and families for their cultural, language, and religious requirements, their medical needs and emotional support" (http://www.imtj.com/news/?EntryId82=180265.). Moreover, the hospital ensures patient safety and security by assigning patient coordinators and treating physicians who are responsible for the needs of the patient for the duration of his/her stay.

Thus, apart from the apparent discrepancies in costs – about one-tenth of that of western countries - studies focusing on the medical tourism sector in India list the following as the industry's strengths: 1) offers both modern and traditional/conventional medical treatments (i.e., yoga and naturopathy, unani, and homeopathy); 2) highly trained doctors and other medical professionals, some are US-trained, favored by medical tourists; 3) internationally recognized state-of-the art facilities and diagnostic centres; and 4) government support for industry participants including tax breaks and export incentives and cleared medical visa - avoiding delays and hassles - for foreign patients and their families (Chakravarthy, Kumar & Deepthi; 2008). A wide variety of medical treatments from which patients can choose is an important factor that influence's an individual's decision of the source of medical services. Traditional medicine, one such option, relies on the use of

hundreds of natural sources of remedies such as plants, animals, minerals, balance between an individual's mental, physical, emotional, and spiritual health and similar natural methods. It is not normally employed in western knowledge and procedures and is, thus, predominantly an edge of medical tourism sectors in countries like India over developed-country alternatives. In addition, as quality healthcare is among the primary considerations of foreign patients, India combines it supply of highly-qualified medical professionals with state-of-the art facilities making its medical sector inputs - a clear source of competitive advantage. Lastly, an enabling environment provided by the government attracts not only visitors but also investors.

According to findings of studies, however, the continued growth of the health tourism industry in India would depend on the improvement of the coordination between the medical and the tourism sectors. Cooperation between airline operators, hotels, hospitals and policymakers would certainly provide a seamless provision of health and tourism/entertainment services to patients and their families. Incentives offered to hospitals that serve foreign patients, for example, would be more effective if the taxation norms (i.e., service taxes and fringe benefit taxes) in the tourism sector are calibrated accordingly (Kalshetti & Pillai, 2008).

2. Thailand

Ranked 6th and 7th by the MTQUA in the world's top ten hospitals for medical tourism are hospitals in Thailand, namely, Bumrungrad International and Bangkok Hospital Medical Center – both in the city of Bangkok. Similar to India, Thailand boasts of low-cost but high-quality medical services – achieved through a combination of highly-trained medical professionals (i.e., doctors, nurses, etc.), well-functioning facilities and strong government support (manifested, among other measures, through fast-tracked issuance of visas for foreign visitors) as among it's sectors recognized strengths. Moreover, the industry presents a wide range of medical treatments and wellness alternatives including traditional massages, herbal treatments, and other types of alternative medicine. Cooperation among the medical

and tourism-related sub-sectors is also evident through "package deals", which includes airfare, hotels, medical treatment and post-operative vacation for foreign patients and their families (Haaryono, Huang, Miyazawa & Sethaput, 2006).

Stakeholders, however, note that Thailand[4] could enhance its position in the industry further by addressing key concerns, the first of which is the need for more hospitals to be internationally accredited. Haaryono, Huang, Miyazawa & Sethaput (2006) report that while the Bumrungrad Hospital in Bangkok was the first hospital to be internationally accredited in Southeast Asia in 2002 by the Joint Commission International, no other medical institution in the country has been able to earn worldwide recognition. Rivals in the region like Singapore[5], India[6], China[7] and the Philippines[8] now lay claim to nine, two, two, and 1, respectively. Furthermore, the sector would benefit from additions to the supply of professional interpreters as well as the presence of an institution or agency that would expand and strengthen the collaboration of services between hospitals and tourism-related establishments (Haaryono, Huang, Miyazawa & Sethaput, 2006).

Despite the above issues, nonetheless, Mattoo & Rathindran (2005) reported that in the years 2002 and 2003, Thailand catered to the medical needs of 632,000 foreign patients – 316% more than Singapore's 200,000 and 421% higher than India's 200,000. In 2005, Thailand continued to lead the countries in the region with an estimated 1.28 million foreign patients as compared to Malaysia's 300,000 and Singapore's 410,000 (Yap, Chen & Nones, n.d.).

[4] To date JCI reports 11 medical institutions accredited in Thailand (http://www.jointcommissioninternational.org/jci-accredited-organizations, 2010.
[5] To date JCI reports 16 accredited medical institutions in Singapore (http://www.jointcommissioninternational.org/jci-accredited-organizations, 2010.
[6] To date JCI reports 16 accredited medical institutions in India (http://www.jointcommissioninternational.org/jci-accredited-organizations, 2010.
[7] To date, JCI reports 6 accredited medical institutions in China (http://www.jointcommissioninternational.org/jci-accredited-organizations, 2010.
[8] To date, JCI reports 3 accredited medical institutions in the Philippines, namely: St. Luke's Medical Hospital, Medical City, and Chong Hua Hospital (http://www.jointcommissioninternational.org/jci-accredited-organizations, 2010 and Lichauco, 2010).

In summary, India, Thailand and the Philippines share most of the identified strengths and weaknesses of the medical tourism industry. Studies show that all of them offer medical treatments at a fraction of the cost of services provided in their developed country counterparts. India, the Philippines and Thailand combine western medical knowledge with traditional or alternative remedies that may not be readily available in First World countries. Their respective health tourism sectors also contend to be comparable in quality, if not better, than that of hospitals operating in rich nations. Experts cite the presence of licensed, highly-trained and skilled medical practitioners (i.e., doctors and nurses) in local hospitals that cater to the needs of foreign patients and state-of-the art hospital facilities as bases of quality assurance. Lastly, medical travel industries in the three countries are supported by their respective governments through tax and non-tax incentives.

India, the Philippines and Thailand also admit to similar weaknesses. Concerns pertaining to international accreditation, the successful integration and seamless operation of the combined medical and tourism sectors, and the differentiation of services, which lends to the creation of market niches, are shared by the three economies.

Accordingly, shaping the future of the local industries in these countries depend on how each is able to maintain and capitalize its strengths and remedy or compensate for its weaknesses. In other words, how would the sector build on, or at the very least, maintain/keep - for instance - its highly-trained personnel and modern facilities? What is the best way of utilizing current government support and vie for assistance that would most benefit the industry? What steps does the sector need to take to motivate and assist hospitals in securing international accreditation? How could the stakeholders build on the collaboration, if any, between the medical and tourism stakeholders to ensure the improvement of business processes and continued product/service innovation?

Moreover, prioritizing and maximizing the opportunities identified by studies on the sector would certainly lead to lead to larger market shares of the US$4 billion pie by 2012. These

include: 1) increasing number of insurance plans that extend their networks to include selected health care institutions around the world, which should increase the number of potential clients; 2) availability of technology that enhances marketing (i.e., web-based promotions) and modes of payment (i.e., credit cards) that aid in attracting foreign patients; and 3) increased demand from countries with aging population as well as nationals of emerging/newly-industrialized economies. The geographical location of these countries, which affords them a warm, tropical climate year-round, also makes them ideal places for treatment and recovery.

Word-of-mouth, according to researches, however is among the most effective marketing tools. Thus, pioneers in the industry, particularly those that already possess sizeable shares of the market, and economies that are currently hosting the most number of foreign visitors are in the best positions to expand their local medical travel sectors through this medium. Among the three countries examined in this section, Thailand, ranked as the 18th most popular tourist destination in the world and 3rd in Asia based on export value, appears to have an edge.

Finally, effectively countering the treats experts revealed by various studies would shape the nature and scope of competition between the three countries. These obstacles include: 1) ensuring the safety of visitors; 2) overcoming cultural and psychological barriers for both the host country nationals and foreign patients; 3) providing malpractice insurance; 4) fast-tracking the processing of medical licenses; and 5) maintaining adequate supply of skilled medical personnel.

For the Philippines, the list would also include: 1) the high cost of travel not just for patrons of the medical tourism industry but for all tourists, including local ones; 2) low-quality and lack of infrastructure (i.e., roads and telecommunications); and the 3) egress of Filipino medical professionals as well as the inability to attract western-trained medical professionals to practice in the Philippines.

C. Prospects of the Philippine Medical Tourism Industry

Notwithstanding the "tourism" aspect of medical travel, experts attribute the growth of health tourism to the high cost of treatment in developed countries, the long waiting period for medical care in first world economies, rising incomes worldwide, declining travel costs, and improving technology and medical practice standards in developing nations (Garcia & Besinga, 2006; Kalshetti & Pillai, 2008; Smith, 2008). Estimates of medical travel to, for example, Thailand, Malaysia, and Singapore are 1.28 million foreign patients in 2005; 300,000 visitors in 2006; 410,000 in 2005, respectively. The US market, which provided 750,000 patients in 2007, is forecasted to grow to 6 million medical tourists in 2010 (Keckley & Underwood, 2008). Accordingly, the industry is expected to grow by 20% or US$4 billion in the next three years in Asia alone (Yap, Chen & Nones, n.d.).

Medical travel clients can be classified according to the follow-up care needed relative to the complexity of treatment: 1) elective (i.e., lasik, cosmetic, etc.); 2) less invasive surgery (i.e., laproscopic procedure); 3) more invasive (i.e., hip/knee replacement); and 4) more invasive surgery/complex (i.e., bypass, transplant, cancer treatment, etc.)[9]. Less invasive surgery and elective treatments initially formed the industry's customer base. Cosmetic, under elective treatment, is also among the fastest growing segments in the area of health tourism (Smith, 2008). Nevertheless, the growing concerns regarding healthcare access coupled with improving life expectancies worldwide will attract more patients needing hip/knee replacement, bypass, transplant, etc. In fact, based on comparisons between costs in developed and developing countries these types of treatments in the Philippines, for instance, are only 17% to 58.2% of the cost in the US. Considering the trend, the Philippine medical tourism industry can establish a niche in one of these growing sectors.

Opportunities in the sector are enhanced as more and more health insurance providers "extend their networks to include selected healthcare institutions around the world"

[9] Classification of medical tourists was adopted from the Yap, Chen & Nones (n.d.) paper.

(Kalshetti & Pillai, 2008). In time, a greater number of foreign patients can use their insurance plans to finance procedures performed abroad; thus expanding the global market for medical tourism.

Employing strategies that are explicitly designed to draw customers from a particular market – for example, being familiar with the needs of US market and how to appeal to its citizens – has the potential of enlarging the US client base of local providers of health services. Piper (2008) claims that the US market is classified into two main sections: business (which includes the government) and consumer. It is vital that the sector targets the category with the most number of employees (i.e., business and government). Medical travel packages intended for Americans must also be devised with health insurance plans in mind for corporations and government entities in the design, deliverance, and administration of healthcare programs. The socio-economic characteristics (i.e., age, gender, financial obligations, etc.) and the buying habits (i.e., propensity to purchase essential and non-essential commodities/services, etc.) of the target market should also be taken into account. Lastly, suppliers of medical travel should "speak the customers' language", which translates to familiarity with their needs and wants.

Furthermore, with health care costs in the U.S. rising every year at a rapid rate, more and more Americans are and will be looking to countries like the Philippines to meet their medical services needs. The US market is certainly promising, in 2004, for instance, total national heath expenditures rose 7.9 percent, which was over three times the rate of inflation. Total health care spending reached $1.9 trillion for the year – or $6,280 per person – and represented 16 percent of the gross domestic product (GDP of the United States.

According to former Department of Health Secretary, Galvez-Tan (2010), the more lucrative markets to target for the Philippine health tourism industry, however, may be Japan and Korea. Working to the advantage of the Philippines is that the Japanese and the Koreans lead the number of tourists who visit the country annually. In addition, estimates

place Japanese and Koreans currently residing in the Philippines at one million and 1.2 million, respectively. Potential clients from these countries alone – which, in terms of distance to the US or to their home countries for that matter, make the Philippines a more convenient choice for medical services – run up to more than two million a year. Moreover, Japan and Korea only have one health insurer for their respective populations. Philippine hospitals that engage in medical tourism need only to be accredited by these two entities to tap into the Japanese and Korean markets. Transaction costs in creating the necessary network in developing the Philippine medical travel sector certainly lower for Japan and Korea relative to that of the United States wherein Philippine hospitals have to be recognized by well over a thousand health insurers if they are to attract American patients.

Lastly, while Philippine government support in terms of policies is well-documented, an assessment of the of the effectiveness of these measures must be undertaken, not only to determine which initiatives are most successful in aiding the sector but also in identifying the needs of the medical health industry that are not being currently met and, thus, enabling stakeholders to fully realize the potential of the Philippine medical tourism sector.

IV. PHILIPPINE MEDICAL TOURISM AS A CITY INNOVATION

A. Novelty

As explained in Part I, health tourism in the Philippines can be traced to the 1960s with foreigners visiting the Philippines to patronize the services of Catholic faith healers. The sector gradually expanded when the government invested in specialized healthcare facilities like the Philippine Heart Center. The rising medical cost disparity between Western and developing countries coupled with improved medical care in the latter, among other factors, contributed to the industry's unparalleled growth and development in the early years of the 21st century.

In addition, combining health services with "tourism" created an attractive package not only for developed-country nationals but also for Asians whose incomes have dramatically escalated in the past twenty years. A favorite of tourists is the health and wellness sub-sector, which offers the services of spas and massage therapies. Traditional and alternative medicines, often unique options in developing countries, are also obtained with ease. Available in the Philippines, for example, is the Traditional Chinese Medicine, which includes acupuncture, herbal medicine, and qigong exercises (Lukban, 2008).

The Philippine Heart Center (PHC) defined medical tourism in the mid-1980s as "offering treatment and management that is comparable with other countries and is also available in the Philippines" (Santos, 2010). Beyond offering state of the art cardiovascular treatment, PHC broadened the definition to include: responding to international requests for assistance; providing medical assistance, health-care, security, and risk management services to corporations, governments, and individuals; assisting organizations with developing integrated, strategic risk management programs helping to fulfill obligations within the context of travel risk management; helping plan, organize and develop an appropriate strategy to minimize risk and to protect human assets; and promulgating worldwide proprietary industrial and commercial standards (Santos, 2010).

B. Impacts

Health tourism stakeholders include: foreigners seeking medical treatment, medical professionals (i.e., doctors and nurses), hospitals, tourist resorts and tourism-related industries, and government agencies. Indeed, the medical tourism cluster proposed by De Vera, Huang, Khan, Qin & Tan (2008) identifies four distinct components, namely: the health providers, the tourism-related sectors, business process out-sourcing, and the institutes for collaboration. Accordingly, medical travel contributes, directly and indirectly, to national income and employment through these industries. Specifically for the Philippines, health tourism added US$1.65 billion to the 2005 GNP and continued to grow at 2.4% in 2006 and 8% in 2007 (Vequist & Valdez, 2008); providing steady

employment to the country's more than 238,955 health and wellness workers (McCormick, 2008). Certainly, the sector supplements the Philippines' foreign exchange earnings.

In addition, as the Philippine medical tourism continues to grow, it offers opportunities for U.S. sellers of medical equipment and instruments to expand their market. Indeed, as local hospitals strive to improve facilities by adapting new technologies to address demand for health care services, the United States – with a 25 percent share - has emerged as the second major supplier, China being the first, to the Philippines' $177 million import market for medical equipment (Vequist & Valdez, 2008). The local medical market, comprised of US-trained Filipino doctors, prefers the US-made medical equipment and instruments and is thus partial to American product. Some of the best prospects for medical equipment sales in the Philippines are: electro-medical equipment; ultrasonic scanning machines; X-ray and radiation equipment; dialysis instruments and apparatus; and medical and surgical instruments.

Lastly, the Philippines is recognized by the World Health Organization in 2000 – with a ranking of 60 in the world's health systems - as one of a few countries that sends qualified nurses, physicians and dentists to the US. Moreover, the thousands serving in American medical facilities is a testament to its quality of medical education.

C. Equity

As mentioned in Part II of this paper, despite the priority given by the government to social infrastructure, public health services still suffer from low investment in facilities and scarcity of skilled medical practitioners. In fact, total expenditure on health as a proportion of the Philippine's GDP ranged from 3%-3.8% from 2002 to 2006 and accounted for about 5%-6.3% of the total national budget. Thus, per capita government spending on health (US$)[10] was pegged at a high of US$39/Filipino in 2005 and 2006 and a low of US$29 in 2002.

[10] The values are calculated using the purchasing power parity to facilitate comparisons across countries.

According to the World Health Organization, the Philippine government contributed about 32.9%-40.2% to the country's total health spending during the six-year period; the balance is accounted for by the private sector, 59.6%-67.1% (refer to Table 8).

Consequently, as majority of health expenditure is financed by the private sector and about 80% of health costs is paid for by the individual himself (out-of-pocket), access to healthcare in the Philippines is still limited to individuals or households belonging to the upper economic classes. The wide disparity between the quantity and quality of health services available to low-income and high-income households is evidenced by, for example, the country's infant mortality rate. The incidence of death of children under five years old in the lowest quintile (20%) of the population is more than three times that of the top 20%. Almost twice as many of these children live in rural areas, where investments in health facilities are low and skilled medical professionals are scarce, and have mothers who have virtually no education (refer to Table 9). Furthermore, De Vera, Huang, Khan, Qin & Tan (2008) reported that life expectancy in the countryside is behind the national average by as much as 30 years.

Table 8: Philippine Health Indicators, 2002-2006

Variable	2002	2003	2004	2005	2006
Total Expenditure on Health as a % of Gross Domestic Product	3.0	3.4	3.4	3.3	3.8
General Government Expenditure on Health as % of Total Government Expenditure	5.0	5.9	6.3	6.3	6.1
Per Capita Government Expenditure on Health (PPP int. $)	29.0	36.0	38.0	39.0	39.0
General Government Expenditure on Health as % of Total Expenditure of Health	40.0	40.2	40.4	39.7	32.9
Private Expenditure on Health as % of Total Expenditure on Health	60.0	59.8	59.6	60.3	67.1
Out-of-Pocket Expenditure as % of Private Expenditure on Health	78.0	78.4	78.7	80.3	83.5

Source: World Health Organization (http://www.who.int/nha/country/en/)

Table 9: Philippine Under-5 Mortality Statistics

Wealth/assets quintiles	Lowest	Highest	Ratio
	66	21	3.1
Urban/Rural	Rural	Urban	Ratio
	52	30	1.7
Mother's Education Quintiles	None	Higher	Ratio
	105	29	3.7

* Rate per 1,000 live births for 10-year period preceding the survey.
Source: 2003 DHS

As the local healthcare industry gears up to serve the international market, access to quality health services may all the more be out of the reach of low-income households.

Galvez-Tan (2010) proposed a mechanism to address this important concern which is the establishment of an equity-sharing agreement, facilitated and enforced by the government, between medical tourism hospitals and public healthcare facilities. The policy will require hospitals that cater to foreign patients to contribute a designated percentage of its profits to the improvement of medical services (i.e., acquisition of medical equipment, upgrading of facilities, training of medical practitioners, enhancement of public medical personnel compensation and benefit packages, etc.) provided by government operated hospitals and clinics. Accordingly, growth in the industry will not only directly benefit the private sector but public healthcare sector as well in terms of a higher standard of healthcare for all (Galvez-Tan, 2010, and Lazo, 2010). A model for this type of arrangement is the cross-subsidy policy to which the University of Sto. Tomas Hospital adheres.

D. Economic and Financial Feasibility

Evaluating the economic and financial feasibility of the medical tourism industry requires that an inventory of the necessary resources – inputs to the sector - be taken, namely: natural resources, human capital, and physical capital/investment.

1. Natural Resources

The Philippines is rich in natural resources. Blessed with beautiful sceneries, pristine beaches, and abundant forests and marine resources; the country has the potential to draw

more than the current three million visitors annually. Accordingly, the Medium-Term Philippine Development Plan 2004-2010 aims to capitalize on the country's innate allure by prioritizing the improvement and construction of infrastructure to pre-identified major tourist destinations, namely: Cebu, Bohol, Camiguin, Palawan, Manila plus Tagaytay, and Davao. It also provides for the development of more attractions for "minor destinations", which are Vigan, Laog and Clark, and Subic. Likewise, designated as "special interest destinations: Baguio, Banaue and Boracay shall enjoy increased accessibility and support in the improvement of existing tourism products under the MTPDP (MTPDP, 2005).

Tourism economic zones (TEZs), which will be built as per the provisions in the MTPDP, are intended to be "the main vehicle for focused development at a local level within the priority destinations", thereby establishing accountability and removing "national barriers that impede the free flow of investment and tourists to and within the country" (MTPDP, 2005). TEZs shall also house tourism-related establishments like hotels, restaurants, resorts, etc. Lastly, the promotion of health tourism – along with ecotourism, agritourism, and cultural tourism – is clearly indicated in the document (MTPDP, 2005).

2. Human Capital

In the recent past, the Philippines has benefited from "a higher percentage of medical professionals [– nurses in particular – as compared] to other developing countries" (Vequist & Valdez, 2008). In 2000, for instance, nurses in the country numbered in excess of 330,000, or about 4.4 nurses per one-thousand population, whereas doctors in 2003 were estimated at more than 95,000, 1.2 per one-thousand population (Vequist & Valdez, 2008). More importantly, the Philippines is capable of training future medical professionals with its more than 313 health education institutions to support the needs of the health tourism sector.

Table 10: Deployment of Philippine Medical Professionals, 2004-2006

Skill Classification	2004	2005	2006	3-year Average Growth Rate (in %)	% Share in Deployment of Professionals
Physiotherapists and Occupational Therapists	473	421	716	29.54	0.77
Pharmacists	70	99	80	11.13	0.14
Pharmaceutical Assistants	91	95	95	2.20	0.16
Optometrists & Opticians	54	57	117	55.41	0.14
Nursing Personnel (n.e.c.)	323	674	452	37.87	0.85
Nurses Professional	8,611	7,094	13,525	36.52	17.90
Midwives Professionals	253	230	367	25.24	0.51
Midwifery Personnel (n.e.c.)	28	49	18	5.87	0.05
Medical Assistants	24	11	27	45.42	0.04
Doctors Medical	96	97	171	37.63	0.22
Dieticians & Public Health Nutritionists	146	75	100	-7.65	0.17
Dentists	89	70	74	-7.82	0.13
Dental Assistants	255	344	414	27.63	0.67
TOTAL	10,153	9,316	16,156	32.59	21.80

Source: Philippine Overseas Employment Administration (http://www.poea.gov.ph/html/statistics.html)

Nonetheless, the seemingly reliable local supply of health professionals is threatened by the "brain drain" phenomenon. According to the latest available Philippine Overseas Employment Administration (POEA) data, the deployment of medical professionals accounted for an annual average of 4.05% of the total number of workers who left the Philippines from 2004 to 2006. Every year, nurses alone made up 3.5% of the total deployment from 2004 to 2006. Table 10 lists the types of medical professionals tracked by the POEA during the three-year period and the corresponding number of overseas Filipino workers classified under each category. Note that the share of medical professionals to the total number of professional, technical and related workers deployed was pegged at an average of more than 20% per year from 2004 to 2006. Once again, the share of nurses to the total was significant at an average of 17.9%.

Moreover, foreign patients associate "quality healthcare" with "US-trained physicians and care teams" (Keckley and Underwood, 2008). Accordingly, in addition to stemming the egress of Filipino medical personnel, the government must also address the challenging task

of persuading US-trained Filipino doctors and nurses to return and serve the Philippine economy.

3. Physical Capital

Local and foreign investments into the medical travel industry qualify for incentives under the 2009 Investment Priorities Plan. Accordingly, these establishments – subject to the result of the evaluation of their applications – can avail of tax incentives such as tax holidays, deductions "from taxable income of up to 100% of expenses incurred in the development of necessary and major infrastructure facilities" (2009 IPP, 2009), and exemptions from tariffs on inputs and/or capital equipment.

4. Supporting Industries

The viability and sustained growth of the medical travel industry is dependent upon well-developed transport system (i.e., air, land, and water transport), well-developed infrastructure (i.e., airports, roads, power, telecommunications, etc.), access to world-class human resources – thus the quality of tertiary level education specifically in the medical field comes into play, and a vibrant tourism cluster including facilities like hotels, restaurants, wellness centers, and other tourism-related institutions.

E. Environmental Sustainability

Environmental sustainability is akin to the concept of sustainable development, which pertains not only to a sector's steady growth but also to its effect on the environment. Numerous studies on sustainable development - refers to the "processes that must be undertaken [to ensure] that future generations can enjoy what the present generation now enjoys" (Jalal, 1993) - concluded that reducing the incidence of poverty "is a necessary and central condition of any effective program to deal with environmental concern" (Ministerial Brief, 1990).

Significant proportions of the population in developing countries who are left with little choice but to exploit the environment to fulfill their basic needs continue to exert pressure on marginal lands and costal resources – resulting in the degradation of "fragile natural resources in those areas" (Jalal, 1993). Thus, among the most important steps in ensuring that the natural resources (i.e., nature trails, pristine beaches, coral reefs, etc.) of the Philippines are preserved to attract patrons for the medical travel industry, is the prevention and elimination of the rapid spread of material deprivation in country.

It is expected that as the expansion of medical tourism continues, the cost of this to the environment would largely increase as well. Tourism itself contributes largely to the destruction of the environment. Gossling (2002) discussed the consequences tourism brings to the environment on a global perspective. It was pointed out that the issue of land use the most crucial when it comes to medical tourism. Tourist infrastructure development, especially in coastal zones, contributes to the alteration in land use. This in turn triggers the production of greenhouse gases which is very harmful to the atmosphere. Land alteration has a lot to do with building tourist infrastructures which compromises the preservation of natural resources. Moreover, tourist activities, i.e. picking of produce activities, also play a role in the destruction of natural resources. Indirect effects of tourism are also evident through soil erosion and loss of land caused by infrastructure development (Gossling, 2002).

Another issue according to Gossling (2002) would be the excessive use of energy derived from transportation, accommodation and activity needs; with transportation being the highest energy consumer among the three factors relating to leisure-related energy consumption (Gossling, 2002).

Furthermore, tourism has its dues to the biotic exchange and extinction of wild species. Movement of species is triggered by tourist transportation, disturbance, collection, trampling, and buying of animal and plant species (Gossling, 2002). In some cases, tourist

guides feel compelled to grant requests of tourists for a close interaction with the species, which could be harmful and unsafe for the existence of the animals.

Among others, tourism is also accused of causing the spread and transfer of diseases; the most common of which being traveler's diarrhea, malaria, and sexually transmitted diseases. Changes in human-environmental relations are also a disadvantage caused by tourism. Gossling (2002) pointed out that the result of nature tourism, which is would be people more appreciative and protective of nature, could be the reverse by increased resource consumption of such tourists.

While it can be argued that the influx of tourists in the Philippines would certainly take a toll on the country's natural resources, the economic incentive generated by the health tourism and related industries should motivate the private and public sector alike to invest in their protection.

F. Transferability

Expanding medical travel beyond the boundaries of Manila, where these services are concentrated in the Philippines, necessitates not only the improvement of infrastructure in rural areas but, most importantly, reduction in the gap between the quality of medical care obtained in rural and urban areas. Reputable hospitals – nationally and internationally accredited and staffed with the best medical professionals – that are within hailing distance, so to speak, of top-rated health educational institutions are vital. Promoting these destinations as sources of high-quality medical care as oppose to merely tourist spots is also a critical step.

Certainly, establishments that would like to enter the medical tourism industry can pursue partnerships with local and international provider organizations. Collaboration can take various forms including work-for-hire and equity relationships. Affiliations are venues for

sharing lessons learned, facilities planning, service training, and medical research (Keckley & Underwood, 2008).

G. Political Acceptability

The government recognizes the substantial contributions of the medical tourism industry to the Philippine gross national product and the country's efforts to generate employment and retain its high-skilled workers/professionals as evidenced by the sector's inclusion in the MTPDP, IPP and the creation of the PMTP. Various government agencies – national, regional, and local, give priority to the sector's needs as it endeavors to attract foreign investors, improve infrastructure and efforts to enhance its credibility and maintain its competitive edge through accreditation and upgrading of facilities and skills of medical practitioners. Indeed, integrating science and technology processes in addressing public health issues (i.e., equity, safety, etc.) as well as identifying a market niche for the local medical tourism sector is continuously pursued by the Department of Tourism (Lazo, 2010). Thus, policymakers are presented with opportunities to provide an enabling environment in which the industry can thrive.

References

Books, Journal Articles, and Working Papers

Bartik, T. and K. Smith (1987). Urban Amenities and Public Policy in *Handbook of Regional and Urban Economics* Vol.II edited by E.S. Mills. Elsevier Science Publishers

Board of Investments (2009). *2009 Investment Priorities Plan*.

Chakravarthy, K., C.H. Kumar and Deepthi. (2008). *Swot Analysis on: Medical Tourism.* A paper presented at the Conference on Tourism in India – Challenges Ahead held on 15-17 May 2008.

Connell, J. (2005). Medical tourism: sea, sun, sand and surgery. Tourism Management, Vol. 27, pp. 1093–1100. Accessed on March 4, 2010.

Deller, C. et al. (2001). *The role of amenities and quality of life in rural economic growth*. American Journal of Agricultural Economics, Vol. 83, No. 2, pp. 352-365. Accessed on March 4, 2010.

De Vera, M., B. Huang, O. Khan, Z. Qin & A. Tan (2008). Medical Tourism in the Philippines, 2 May 2008.

Ebert, R. and D. McMillen (1999). Agglomeration Economies and Urban Public Infrastructure in *Handbook of Regional and Urban Economics* Vol.II edited by E.S. Mills and P. Chelshire. Elsevier Science Publishers

Editor (2008). Philippine Quality Healthcare: Excellence is the Standard. *Medical Tourism Magazine, Philippine Issue*, 19 March 2008.

Goodrich, J.N. (1993). Socialist Cuba: A Study of Health Tourism. *Journal of Travel Research*, 32(1), 36-42.

Goodrich, J.N. and G.E. Goodrich (1987). Healthcare Tourism – an Exploratory Study. Tourism Management, 8(3), 217-222.

Garcia, M. and C. Besinga (2006). Philippine Medical Tourism Industry. *SGV Review*, June 2006.

Gasparoni, L. (2008). Planning Your Medical Trip Abroad. *Medical Tourism Magazine, Philippine Issue*, 5 February 2008.

Gossling, S. (2002). Global environmental consequences of tourism. Global Environmental Change, Vol. 12, pp. 283-302. Accessed on March 4, 2010.

Harryono, M., Y. Huang, K. Miyazawa, and V. Sethaput (2006). *Thailand Medical Tourism Cluster*. Harvard School of Business School.

Jamieson, W. (2006). Community Destination Management in Developing Economies. (http://www.google.com/books?hl=en&lr=&id=lBxJqflW3U4C&oi=fnd&pg=PA3&dq=Urban+Amenities+of+Medical+Tourism+Infrastructure&ots=eEHvMzDDOY&sig=YZ_Ka-z29m2MxN_lKAWMKQRj7yo#v=snippet&q=urban%20amenities&f=false)

Jalal, K. (1993). *Sustainable Development, Environment and Poverty Nexus*. ASIAN Development Bank, Economics and Resource Center.

Kalshetti, P. and D. Pillai (2008). *Tourism Products Development and Management Medical Tourism – A Shifting Paradigm*. A paper presented at the Conference on Tourism in India – Challenges Ahead held on 15-17 May 2008.
Keckley, P. and Underwood, H. (2008). *Medical Tourism Cousumers in Search of Value*. Deloitte Center for Health Solutions.
Lukban, F. (2008). Fortifying Western Healthcare with Traditional Chinese Medicine. *Medical Tourism Magazine, Philippine Issue*, 12 May 2008.
Mattoo, A. and R. Rathindran. (2005). *Does Health Insurance Impede Trade in Health Care Services?* World Bank Policy Analysis Working Paper 3667, 12.
McCormick, J. (2008). Medical Tourism is a Search for Value, Not Low Prices. *Medical Tourism Magazine, Philippine Issue*, 13 May 2008.
Ministerial Brief (1990). *Economic Policies for Sustainable Development, Conference on Environment and Development in Asia and the Pacific*.
National Economic and Development Authority (2005). *Medium-Term Philippine Development Plan 2004-2010*.
PEZA, (2006). *Resolution No. 06-512*, Pasay City.
Piper, A. (2008). Marketing to the U.S. – Do You Really Know How? *Medical Tourism Magazine, Philippine Issue*, 21 April 2008.
Smith, K. (2008). *Medical Tourism: For Richer or Poorer*. A paper presented at the Ownership and Appropriation sponsored by the ASA, ASAANZ and AAS held on 8-12 December 2008 at the University of Auckland, New Zealand.
Vequist, D. and E. Valdez (2008). Medical Tourism Economic Report. *Medical Tourism Magazine, Philippine Issue*, 5 February 2008.
Yap. J., S. Chen and N. Nones (n.d.). *Medical Tourism: The Asian Chapter*. Deloitte.

Website Sources

Global: Best ten hospitals for medical tourism. Retrieved on 11 March 2010 from http://www.imtj.com/news/?EntryId82=180265.
Joint Commission International Accredited Organizations. Retrieved on 30 June 2010 from http://www.jointcommissioninternational.org/jci-accredited-organizations.
Douglas, J. (2006). *Medical tourism flourishing in Philippines while U.S. health care costs skyrocket*. Retrieved from http://www.naturalnews.com/020932.html.
National Statistical Coordination Board. (2010). *Tourism statistics*. Retrieved on April 19, 2010 from http://www.nscb.gov.ph/stats/ptsa/statistics/stat_travellers.asp.
Vequist, D.G. and Valdez, E. (2008). *Medical Tourism Economic Report: Medical Equipment Sales.* Retrieved from http://www.medicaltourismmag.com/issue-detail.php?item=155&issue=7

Interviews and Focus Group Discussions

Cabatu, R. (2010). Focus Group Discussion held on 29 January 2010 at the Angelo King Institute Conference Room, De La Salle University.

Galvez-Tan, J. (2010). Focus Group Discussion held on 29 January 2010 at the Angelo King Institute Conference Room, De La Salle University.
Lazo, C. (2010). Focus Group Discussion held on 25 June 2010 at Y508, Don Enrique T. Yuchengco Hall, De La Salle University.
Lichauco, D. (2010). Focus Group Discussion held on 25 June 2010 at Y508, Don Enrique T. Yuchengco Hall, De La Salle University.
Santos, R. (2010). Interview held on 20 May 2010 at the Philippine Heart Center.

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