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The Ethics of For-profit Healthcare and Medical Tourism in South Korea

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I. INTRODUTION

On December 18, 2015, South Korea's Ministry of Health and Welfare formally approved the establishment of what is being described in the Korean media as the country's "first for-profit hospital" [1-3]. The hospital, which will be located in the new "Jeju Healthcare Town" on Korea's southernmost island of Jeju, will be named Greenland International Hospital (GIH). The hospital is expected to be operational by March 2017. According to reports in the Korean media, the government's approval of GIH has drawn strong public criticism, with one coalition of medical and civic groups claiming that the Ministry of Health and Welfare has effectively abandoned its duty to protect the Korean healthcare system and calling for the resignation of the head of the Ministry [1,2]. Most of the criticism that has been expressed thus far against the government's decision relates to the negative effects that some people believe this decision will have on the Korean healthcare system. Critics fear that the decision will "open the floodgates to more [for-profit hospitals] across the nation" [2], which will "accelerate the commercialization of the medical industry" [1], and perhaps "lead to the dismantlement of the domestic medical insurance coverage scheme" [3]. On the other hand, since GIH will be established in a special economic zone on Jeju Island and will operate outside of the Korean medical insurance system, officials at the Ministry of Health and Welfare are confident that GIH will have no adverse effects on the Korean healthcare system or the domestic medical insurance scheme

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[3]. While the dispute between these two groups presents an interesting debate, and one which I comment on below, it is important to note that the establishment of GIH raises ethical concerns that go beyond the question of whether or to what extent this decision will adversely affect the Korean healthcare system.

As I will explain in more detail below, the South Korean government's decision to approve GIH was propelled by two highly contentious trends that are reshaping healthcare, not only in South Korea, but in countries around the world: (a) the market liberalization of the healthcare sector and (b) the explosive growth of the global industry in medical tourism. How the government responds to these trends may be a matter of politics, but how it should respond is a matter of ethics. Should the government allow, encourage, or rather prohibit for-profit healthcare? And is medical tourism an industry that the government should play an active role in promoting? These questions converge in the Korean government's decision to approve the establishment of GIH, for once it becomes operational, GIH will be engaged in for-profit healthcare and will cater primarily to medical tourists [2,3]. Additionally, according to Ministry of Health and Welfare officials, GIH will also serve as "a test bed for the feasibility of such ventures in the future" [3]. In other words, if it is determined to be successful, it is entirely possible that more such hospitals will be established in Korea in the future. Thus, now is a good time to reflect upon the ethical issues related to the government's decision to approve the establishment of GIH.

The ethical issues related to for-profit healthcare and medical tourism have received a good deal of attention in the medical ethics literature but at different times and in different contexts. Ethical concerns over for-profit healthcare first surfaced in the United States in the 1970s and 1980s with the rise of Health Maintenance Organizations (HMOs) and the privatization and corporatization of healthcare. On the other hand, the ethical concerns over medical tourism have received academic attention only in the past decade or so with the rise of the global industry in medical tourism. In this article I attempt to synthesize and clarify the ethical concerns raised by for-profit healthcare and medical tourism and explain how they relate to the decision by the South Korean government to approve the establishment of GIH.

As with all important decisions in the practice of medicine, whether at the clinical level or at the level of government policy, decisions should be examined not only from a narrow economic point of view, but also from a broader social and ethical perspective. In what follows I attempt to do just that by clarifying the main ethical issues at stake in the decision to approve GIH. In section 2, I examine the ethical is-

sues associated with for-profit healthcare. In section 3, I clarify the ethical issues associated with medical tourism. In section 4, I bring these considerations together and explain how they bear on the decision by the South Korean government to approve the establishment of GIH.

II. ETHICAL ISSUES WITH FOR-PROFIT HEALTHCARE

Concerned by the growing presence of for-profit hospitals and HMOs in the US in the late 1970s and early 1980s, the National Academy of Science's Institute of Medicine set up an expert committee to look into the matter and make policy recommendations. Two of the most outspoken members of the committee, Arnold Relman and Uwe Reinhardt, had very different attitudes towards the rise of for-profit healthcare and what should be done about it. Relman, a medical doctor, educator, and long-term editor of *The New England Journal of Medicine*, believed that medical practice has an essential moral component which is complicated, if not undermined, by for-profit healthcare. On the other hand, Reinhardt, a professor of political economy at Princeton University, insisted that physicians are not unlike other purveyors of goods and services and should not be held to higher moral standards. The Committee's report took years to complete but when it was finally published in 1986 the 550-page report contained an extended exchange between Relman and Reinhardt that took place over the course of the Committee's deliberations. The debate between Relman and Reinhardt, which was later published in the journal *Health Affairs*, crystallizes the main ethical issues and questions concerning for-profit healthcare [4]. While much has been written on the topic of for-profit healthcare in the past three decades, the debate between Relman and Reinhardt still stands as an excellent overview of the main issues and points of contention. In what follows I summarize but also update that discussion with some more recent material. The terms "for-profit" and "non-profit" are used below in their standard senses: for-profit hospitals may distribute accounting profits as they please while non-profit hospitals must reinvest them in their institutions; furthermore, non-profit hospitals enjoy tax exemptions [5].

At the heart of the debate between Relman and Reinhardt is the following question: Is there something special about health care that makes it socially undesirable for facilities to be owned by private investors or for physicians to be entrepreneurial businessmen? However, in the course of debating that question, two others emerged. One of these concerns the effectiveness of for-profit and non-profit hospitals: Relative to health care delivered by non-profit institutions, what effect does the for-profit motive have on (a) the quality of

care, (b) the cost of care, and (c) access by the poor to the care rendered by investor-owned institutions? The other question concerns conflicts of interest: Does for-profit healthcare introduce conflicts of interest that do not exist in the practice of medicine carried out by non-profit institutions and, if so, what steps can or should be taken to minimize or eliminate those conflicts of interest? Let us briefly consider each of these questions in turn, beginning with the first.

Is there something special about health care which makes it inappropriate for it to be distributed through the marketplace? Relman thought that there is indeed something special about health care that gives it an essentially moral dimension and distinguishes it from many other goods or services. What makes healthcare special is the unique nature of the relation between the doctor and patient. "That relation," Relman wrote, "is based on trust by the patient and a commitment by the doctor to serve the patient's interests first" [4]. The fact that most doctors are also interested in being well-paid for their services does not, in Relman's view, change the primacy of the doctor's ethical commitment to serve the patient's interests first. But why must patients trust their doctors and why must doctors put their patients' interests first? According to Relman, it is because of (a) "the virtual total dependence of the consumer on the advice of the physician" and (b) "the often intimate and immediate relation of healthcare to the quantity and quality of life" [4]. In response to these points, Reinhardt pointed out that physicians are not the only purveyors whose work we are not technically competent to judge and whom we often have no choice but to trust. While Relman agreed he nevertheless insisted that a sick patient is dependent upon his or her doctor in a way that is not matched by any commercial relationship. According to Relman, "The sick patient must rely on the physician to ensure that he gets the services he needs and to make choices for him, upon which the quality and quantity of his life may depend" [4].

It is debatable whether patients are, or should be, as dependent upon the advice of their physicians as Relman suggests. In light of the explosive growth of information technology in the past few decades, patients today have access to a wealth of medical information that they did not have in the mid-1980s. Furthermore, in countries like the United States or South Korea, where doctor-shopping is not uncommon, patients can and often do exercise a high degree of autonomy in certain aspects of medical decision-making. Thus, from the vantage point of the 21st century, Relman's view of patient dependency seems somewhat dated and paternalistic. Furthermore, physicians are clearly not the only ones who offer advice that can affect the quality or quantity of one's life: so too do financial advisers, lawyers, and other professionals,

none of whom are frowned upon for working on a for-profit basis or for profit-oriented corporations. Thus, while it is no doubt desirable for all professions to have ethical codes of conduct and for members of those professions to abide by them, it is unclear why doctors should be held to higher ethical standards than other professionals. The standard justification for the idea that they should be held to higher ethical standards, as expressed by Relman, may ultimately be based on nothing more than a dated and paternalistic view of patient competence with respect to medical decision-making. Nonetheless, the idea that physicians must always place patients' interests first remains a core concept of medical ethical theory and is embraced by many physicians in principle if not in practice. Writing in the *Journal of the American Medical Association*, a group of physicians, disturbed by the social and economic forces that are turning physicians into commercial agents, reasserted the view that "medicine is, at its center, a moral enterprise grounded in a covenant of trust" that obliges physicians "to use their competence in the patient's best interests [6].

Consider next the question of the effects of for-profit healthcare: Relative to healthcare delivered by not-for-profit institutions, what effect does the for-profit motive have on (a) the quality of care, (b) the cost of care, and (c) access by the poor to the care rendered by investor-owned institutions? While there was an absence of clear evidence on this question at the time Relman and Reinhardt discussed it, evidence has since emerged. Two meta-analyses are especially worth mentioning in this context. The first one was carried out by a team of 17 researchers, led by P. J. Devereaux from the department of clinical biostatistics and epidemiology at McMaster University in Canada [7]. The meta-analysis examined 15 American studies comparing death rates in for-profit and non-profit hospitals, including data on 38 million patients in 26,000 hospitals between 1982 and 1995. The study found that the death rate in for-profit hospitals was two percent higher than in non-profit hospitals. The explanation for this difference, according to Deveraux, is that since for-profit hospitals must typically achieve a 10 to 15 percent profit margins for shareholders, as well as pay taxes (which non-profits are not required to pay), they spend less money on hiring highly skilled doctors and nurses and provide a lower quality of healthcare. The second relevant meta-analysis, conducted by a group of 19 researchers also led by Deveraux, was based on 8 studies involving 350,000 patients at 324 hospitals [8]. The study found that private for-profit hospitals result in significantly higher payments for care than private non-profit hospitals. These two meta-analyses provide strong evidence in support of the idea that non-profit hospitals are superior to for-profit hospitals in

terms of both the costs and the quality of the care they provide. And it is clear that with their higher fees, and a documented tendency to refuse patients unable to pay [9], for-profit hospitals are inferior from the point of view of access to care, especially for those of limited means. A further way in which for profit hospitals reduce access to healthcare is by concentrating their care only or primarily on highly services. A study of American hospitals from 1988 to 2000 found that "although all hospitals must earn sufficient profits to operate…for-profits are more likely to respond to profitability than the other types are when making supply decisions" [5]. Some advocates of publicly funded health-care systems, such as Michael McBane of the Canadian Health Coalition, claim on the basis of the evidence from the studies described above that it would be unethical if not criminally negligent for the government of a country with a public healthcare system, such as Canada, to attempt to privatize it [10].

Let us turn to the third question concerning the ethics of for-profit healthcare: Does for-profit healthcare introduce conflicts of interest that do not exist in the practice of medicine carried out by non-profit institutions? In his debate with Relman, Reinhardt correctly points out that doctors can face conflicts of interests—conflicts between caring for their patients and maximizing their own incomes—whether they work in for-profit or non-profit institutions. Non-profit hospitals too must meet revenue targets to cover their operational costs (salaries, equipment expenses, etc.). In order to meet these large and ever-expanding operational costs, even non-profit hospitals will experience pressure to increase their revenues. This institutional pressure can in turn put pressure on physicians working within those institutions to maximize their "output" by, for example, increasing the number of patients they see, shortening the length of patient visits, prescribing more diagnostic tests, carrying out more medical procedures, and extending hospital stays. It is within the context of these economic realities that physicians must care for their patients. Many do an admirable job of putting patients' interests first, but it cannot be denied that modern medical practice inevitably presents doctors with conflicts of interest whether they work in for-profit or non-profit hospitals.

The question then is not whether for-profit healthcare creates conflicts of interest that do not arise in the context of non-profit institutions, but rather whether for-profit healthcare increases or worsens existing conflicts of interest. There is good reason to believe that for-profit hospitals do exacerbate the conflicts of interest that doctors inevitably face in the practice of medicine in a market economy. Non-profit hospitals may be content with generating enough revenue to meet their operating expenses, but corporate-owned for-profit

hospitals must also generate profits for their investors. As was noted above, the need to generate greater profits is what causes for-profits hospitals to have higher fees and higher mortality rates than non-profit hospitals [7,8]. It is therefore reasonable to expect that for-profit hospitals would lead to greater conflicts of interest. A recent study using 2012 data from 4,483 hospitals in the US found that 50 had fee markups of approximately ten times their costs, and that of the 50 hospitals with the highest charge-to-cost ratios, 49 were for-profit hospitals [11]. Indeed a full half of those 50 hospitals are owned by a single corporation [11]. Nevertheless, while there is evidence that price inflation, corruption, and conflicts of interest are greater with for-profit than non-profit hospitals, greed is by no means unique to for-profit institutions. For example, the CEO of the Mayo Clinic, a well-known non-profit hospital in the US, earned more than $2 million in 2011 [12], and the CEO of BlueCross/Blue Shield, a non-profit insurance company, earned over $16 million in 2012 [13]. Salaries such as these raise the question of how the term "profit" should be defined in this context and they thereby serve to blur the distinction between for-profit and non-profit hospitals. Nevertheless while the salaries of some non-profit hospital executives may be surprising, even shocking, they still pale in comparison to top-paid executives at for-profit hospitals in the US. For example, in 2012 the CEO of the Hospital Corporation of America received a total compensation of $46.3 million [14].

The fact that executives at for-profit and even non-profit hospitals in the US can earn large salaries is not necessarily a problem; ethical problems arise only if the profit-making at these institutions is compromising patient care or increasing the conflicts of interest that doctors face in medical practice. If it is true that for-profit hospitals increase or exacerbate the conflicts of interest that doctors inevitably face in the practice of medicine in a market economy, and if these conflicts of interest should be minimized as much as possible, does it follow that all hospitals should be run as non-profit institutions? Opinions diverge on this question, as was demonstrated by Relman and Reinhardt in their classic debate. Both of these men agreed that doctors' economic incentives should not be aligned with that of for-profit hospitals (against the interests of patients). And they both seemed to agree that this entails, as a minimum, that doctors should not enter into joint ventures with healthcare facilities (for profit or non-profit) or hold any equity interest in healthcare corporations. Relman thought that further restrictions might be necessary on the sort of equipment that doctors may purchase for their own private practices; he believed that doctors who purchase expensive medical equipment will have a need to recoup those costs that may

lead them to overprescribe the use of that equipment. On the other hand, Reinhardt insisted while it was appropriate to regulate the behaviour of doctors in order to avoid conflicts of interest, it was not necessary or appropriate to abolish for-profit hospitals. As long as doctors were not among those investing in for-profit hospitals, Reinhardt thought that there was no good argument against them.

To sum up the discussion so far, for-profit healthcare raises three related ethical concerns. In the first place, some have argued that there is something special about the doctor-patient relation that requires doctors to put patients' interests before their own financial interests. On this line of thinking, for-profit healthcare damages the trust at the heart of the doctor-patient relation and thereby corrupts the practice of medicine. I have argued above that this view that doctors should be held to a higher moral standard than other professionals may be based on a dated and paternalistic view of patient competence and therefore unjustified. Secondly, there is the question of whether or not for-profit hospitals are inferior to non-profit hospitals in terms of the costs and the quality of the care provided. There is, as we have seen, strong evidence that non-profit hospitals outperform for-profit hospitals on both of these counts. This fact is relevant to questions concerning healthcare policy at the national level. Thirdly, there is the question of whether for-profit institutions tend to present doctors with greater conflicts of interest than are experienced by doctors working at non-profit institutions. While there are good reasons to believe that they do, it does not necessarily follow from this that there is no place or justification for for-profit hospitals. In order to reduce such conflicts of interest it may be sufficient, as Reinhardt thought, to regulate the relationships that doctors have with such hospitals.

III. ETHICAL ISSUES WITH MEDICAL TOURISM

The term "medical tourism" is generally understood to refer to the intentional travel of residents of one country to access non-emergency medical services abroad [15,16]. One can also distinguish more finely between different types of medical tourism. For instance, Cohen coined the term "transplant tourism" to refer to "travel abroad to purchase organs for transplant" [17]. For the purposes of this discussion, the more general term will suffice. While medical tourism is not a new phenomenon, it has grown dramatically in recent years, and the dynamics of the industry have shifted. Whereas most medical tourists not long ago were patients from less economically developed countries travelling to richer countries in search of a higher quality of medical care, increasingly many medical tourists now travel from developed to less

developed countries in search of more affordable medical care or to avoid long wait times [18].

Because academics have only recently turned their attention to medical tourism, the scholarship on this booming industry is scant and scattered. In their 2010 study, Johnston et al. followed a scoping review protocol to synthesize all that is known about the effects of medical tourism in departure and destination countries [15]. The study found that five themes tend to dominate scholarly discussions of medical tourism. In particular, these discussions present medical tourism as a) a user of public resources; b) a solution to health system problems; c) a revenue generating industry; d) a cause of concern for standards of care; e) a source of inequity [15]. While the specific effects of medical tourism can vary from one destination country to the next, depending on the nature of the healthcare systems in question, Johnson et al.'s scoping review provides a general framework for understanding the effects of medical tourism. Let us briefly consider each of the points they raise in more detail.

First, medical tourism can be a user of public resources in both destination and departure countries. Governments that seek to promote medical tourism often use public resources by providing subsidies, such as the provision of public lands or corporate tax breaks, to hospitals that serve medical tourists. The government of India in particular has offered extensive subsidies in an effort to boost the medical tourism industry in its country [19,20]. But public resources can also be used when medical tourists make use of a destination country's publicly-funded healthcare services, as they do in countries such as Cuba and Singapore [21]. At the same time, the revenue generated by medical tourism in these countries can help to make up for losses incurred in the use of public resources. For example, it has been suggested that the $20 million or more that Cuba brings in each year through medical tourism helps to pay for the costs of free universal health care for Cuban workers and their families [21].

As for departure countries, public resources are often wasted when medical tourists experience complications from treatment they have received in other countries. For example, when medical tourists traveling from countries with a publicly-funded healthcare system experience complications from medical procedures performed abroad the costs of follow-up treatment are typically paid by the public healthcare system the tourists originally tried to bypass. However, in the absence of clear data on the comparative rates of surgical complications at home and abroad, there is no reason to believe that this particular aspect of medical tourism represents a net waste of public resources in any particular departure country. At the same time, medical tourism can help to reduce

public expenditures in departure countries. For example, Canadians who travel abroad for non-essential medical services pay for it out of pocket and thereby reduce the use of public resources in Canada.

Second, medical tourism can be a solution to health care problems both in destination and departure countries. In destination countries, markets in medical tourism can attract local and foreign investments into health care infrastructure that can benefit not only tourists, but local residents as well. Lucrative markets in medical tourism may enable some hospitals to invest in expensive medical equipment or human resources that they otherwise could not afford. And medical tourism certainly addresses some of the problems with healthcare systems in departure countries. In the US for example, the cost of medical care is often unaffordable, not only for uninsured patients, but even for those who have some form of insurance. And in countries with a public healthcare system, such as Canada, wait times can be excessive and even fatal. Thus, for some residents of the US or Canada the only realistic option for timely or affordable medical care may be to travel abroad. Furthermore, the increasing recognition that patients in developed countries can receive quality treatment abroad at a fraction of what they pay in the US, for example, may have the further beneficial effect of reducing healthcare prices in the US through global competition.

Third, medical tourism can be a revenue generator in destination countries in terms of a) the foreign and local investments made in the destination country's medical infrastructure, b) the financial gains of the medical institutions providing care to tourists, and c) other local businesses that receive spill-over economic benefits from increased tourism. Estimates of the size of the medical tourism industry and the amount of revenue that it generates vary, but according to one study done by Transparency Market Research, the global medical tourism market was valued at US$10.5 billion in 2012, and is expected to reach US$32.5 billion in 2019, growing at a rate of 17.9% from 2013 to 2019 [22].

The fourth issue associated with medical tourism uncovered in Johnston et al.'s scoping review relates to standards of care. While standards of care in destination countries have risen alongside the growth of medical tourism, issues of quality and liability still remain in certain places. Furthermore some destination countries have limited malpractice laws and so it can be difficult for medical tourists to recover the costs of damages they may incur in the course of receiving medical treatment abroad.

The fifth issue widely discussed in connection with medical tourism is that of equity. There are concerns that medical tourism will negatively affect fair or equal access to medical services both in destination and

departure countries. Medical tourism can negatively affect equity in departure countries by creating a two-tier medical system, one for general population and another for patients who can afford to travel and pay out of pocket for their medical care. As long as such options exist, departure countries may feel little need to address or reform the problems with their own healthcare systems. Destination countries on the other hand can experience a "a brain drain" as highly skilled doctors transition to the more lucrative tourist market. Medical tourism can also drive up the costs of medical care and thereby price some patients out of their own healthcare system. Furthermore, the investments that medical tourism attracts are usually investments in high-technology care that benefit only a limited number of residents in the destination countries.

Whether or not medical tourism really does push patients out of their own healthcare systems has not yet been established. According to Cohen, a leading expert in medical tourism research, there is at the present time little empirical evidence to suggest that medical tourism has adverse effects on healthcare access in destination countries [16]. Flood and Chen concur but suggest that there are at least some signs that medical tourism negatively affects health care equity specifically in lower-and middle-income countries [18]. And Cohen identifies a number of "triggering conditions" which could lead to reduced access. Patients in destination countries are in danger of reduced access to their own healthcare system when a) the health care services consumed by medical tourists come from those that would otherwise have been available to the destination country's poor; b) health care providers are "captured" by the medical tourist patient population, rather than serving some tourist clientele and some of the existing population; c) the supply of health care professionals, facilities, and technologies in the destination country is inelastic; d) the positive effects of medical tourism are outweighed by its negative effects on the availability of health care resources; or e) profits from the medical tourism industry are unlikely to "trickle down" [16].

From an ethical point of view, then, medical tourism is a mixed bag. It can bring significant benefits to both destination and departure countries, but it also comes with certain costs and risks. The main benefits of medical tourism are the economic gains for the destination countries (i.e. the increased income for domestic medical institutions as well as the beneficial spill-over effects on the local economy) and the medical benefits for patients from departure countries who receive medical treatment that they cannot get in their own countries in a timely or affordable manner. The main costs associated with medical tourism are borne by domestic countries and relate to the use of public resources in ways that do not di-

rectly benefit the public, the possible brain drain out of the domestic healthcare system toward the more lucrative medical tourism market, and the possibility that the medical tourism industry will effectively price some of the domestic population out of their own healthcare system. While there is little evidence to date of this actually happening, it is a possibility that governments promoting medical tourism must be on guard against.

VI. ETHICAL ISSUES WITH THE APPROVAL OF GIH

Having identified the main ethical issues associated with for-profit healthcare and medical tourism let us now turn to the question how the South Korean government's decision to allow for the establishment GIH should be assessed from an ethical point of view. Let us first consider the decision in terms of its tacit approval of for-profit healthcare and then consider it in terms of its promotion of the medical tourism industry.

The discussion above revealed that there are primarily two facts about for-profit hospitals that generate ethical concerns: the first is that for-profit hospitals are generally inferior to non-profit hospitals in terms of mortality rates, costs, and access to care; the second is that for-profit hospitals present doctors with greater conflicts of interest than do non-profit hospitals. Let us now consider how each of these points bears on the government's decision to approve GIH.

As we have noted, the evidence that non-profit hospitals are superior to for-profit hospitals in certain crucial respects might make for a strong case against privatizing a public health care system, but that argument cannot be made in South Korea, where over 90% of medical institutions are already privately owned [23]. Furthermore, it is not the case, as has been reported in the Korean media, that GIH will be the nation's first for-profit hospital. The claim that "all hospitals in Korea are non-profit" [2] is false, as is the suggestion that the current law in Korea does not allow for hospitals to be run on a for-profit basis. The relevant laws governing who can and cannot establish medical institutions in Korea and what ends or purposes they must serve are found in the Medical Service Act and The Enforcement Decree of the Medical Service Act [24,25]. Article 33(2) of the Medical Service Act restricts the establishment of medical institutions in Korea to the following agents: (a) medical doctors, dentists, Oriental doctors, or midwives; (b) the State or local governments; (c) medical corporations; (d) non-profit corporations; and (e) quasi-government agencies [24]. Article 33(2) further states that medical doctors may establish general hospitals, hospitals, convalescent hospitals, or medical clinics [24].

Restrictions on the legitimate purposes of medical institutions are found in The

Enforcement Decree of the Medical Service Act, Article 20 of which reads as follows: "Medical corporations as well as the non-profit corporations that have established medical institutions under Article 33(2) of the Act shall contribute to public hygiene and *shall not seek profit*, in conducting the business of medical treatment" [25] (italics mine). Article 20 is admittedly vague in not clearly starting what is allowed or prohibited by the decree against seeking profit. However, one thing that is clear is that Article 20 applies only to medical corporations and non-profit corporations; it says nothing about individual doctors who establish hospitals or clinics. For these privately owned hospitals—those owned by individual doctors or groups of doctors—there are no laws that prohibit them from being run as for-profit entities. As noted above, the distinction between "non-profit" and "for-profit" is generally understood in terms of what can or cannot be done with the profits generated from a productive entity: not-for-profit hospitals are prohibited from distributing their profits (i.e. profits must be reinvested in the hospitals) whereas for-profit hospitals can freely distribute profits to their owners or shareholders [5,26,27]. Given this distinction and the fact that there are no laws in Korea against doctor-owned hospitals or clinics distributing their profits to their owners, it follows that the hospitals and medical clinics in Korea that are owned by doctors are for-profit entities. This is not to say or suggest that these hospitals are any less ethical or less professional than non-profit hospitals owned by corporations. Rather it is merely to state the fact that doctor-owned hospitals and medical clinics in Korea do generate profits and that there is no legal prohibition against these profits being distributed to their owners.

Nevertheless, while GIH will not be the first or only for-profit hospital in South Korea, it is still a novel phenomenon on the Korean medical landscape. What makes GIH unique is not that it is a for-profit hospital but rather that it is the first for-profit hospital in Korea that is owned by a *corporation* and the first hospital of any kind in the country that is owned by a *foreign* corporation. GIH is owned by Greenland Group, a major multinational corporation and one of China's largest real estate developers. While based in Shanghai, the company has large-scale real estate projects in cities around the world, including a $3 billion investment in new high rise buildings in Seoul [28]. Furthermore, the majority owner of the Greenland Group is the Shanghai city government [29], making the establishment of the GIH one of the most bizarre arrangements in medical history: the hospital is in effect a state-owned institution, but the state that owns it is not the state in which it will be located. Complicating matters further is the fact that the hospital is being established with the goal of serving, not the citizens of the state

in which it is located (Korea), but rather tourists coming mainly from the state that owns it (China).

From an ethical point of view, does it matter whether a for-profit hospital is owned by a doctor or corporation? There are two reasons for answering this question in the affirmative. First, doctors who own their own hospitals can decide for themselves whether or to what extent to try to maximize profits. A privately owned hospital can choose to prioritize profit maximization or it can choose to put patients' interests first, even when doing so detracts from the profitability of the hospital. However, corporate-owned, for-profit hospitals have significantly less freedom in this regard. Corporate executives are employed by boards of directors who are responsible to the owners of the company, its shareholders. Aside from small groups of activist investors, most shareholders invest in corporations for the sole purpose of maximizing returns on their investments. The expectation of shareholders—the owners of a corporation—that corporate managers will prioritize their profit interests over other competing interests, seriously constrains the behavior of corporate executives, including those who run for-profit hospitals. When the interests of patients conflict with the interests of investors, as they sometimes do, the executives of for-profit hospitals may have a legal obligation to side with the investors. This is what is known as "the principle of shareholder primacy," a well-established norm in Anglo-American managerial culture and corporate law [30,31].

So there is good reason to believe that corporate-owned for-profit hospitals will give rise to more or greater conflicts of interest than both non-profit hospitals and private for-profit hospitals. However, this does not necessarily mean that corporate-owned for-profit hospitals should not be allowed under any circumstances. Doctors are the ones who most directly confront the conflicts of interests that can arise between patients' interests and profits. In order to minimize these conflicts of interest in the context of for-profit healthcare, it may be sufficient to prohibit doctors from owning shares in for-profit hospitals or entering into business relations with them. As we have observed, this was the view of Reinhardt [4]. However, if such regulations or codes of conduct are established, it seems that they should apply also to doctor-owned for-profit hospitals or clinics. For a doctor who works in a hospital or clinic that he or she owns is in the same conflict of interest as doctors who work in or do business with hospitals that they have an equity interest in. Conversely, if doctors are not prohibited from working at the hospitals or clinics they own, then it is difficult to see why doctors should be prohibited from owning shares in corporate for-profit hospitals.

Let us turn now to the question of medi-

cal tourism. The discussion in the previous section revealed that medical tourism has the potential to bring significant benefits to both destination and departure countries, but that it can also come with significant costs or risks, especially in destination countries. Whether or not the South Korean government should promote medical tourism in general, and specifically in the case GIH, involves a complex calculation of the relevant costs and benefits. While this cost-benefit calculation must be based on detailed data that lie beyond the scope of this article, the following are some of the general points that must be kept in mind in making the calculation.

The establishment of GIH is clearly part of a larger effort by the Jeju Free International City Development Center (JDC) to transform Jeju Island into a medical tourism hub [32]. The market in medical tourism in South Korea has grown dramatically in recent years, attracting more than 210,000 patients in 2013, many of them coming from China for the purpose of receiving cosmetic surgery treatment [33]. The Korean Tourism Organization predicts that the average amount that medical tourists to Korea spend will grow from 2.53 million won in 2013 to 3.56 million won in 2020; furthermore, it expects the number of medical tourists coming to Korea to reach about 1 million per year by 2020 and generate a yearly revenue of 3.5 trillion won (US$3.2 billion) [34]. The JDC wants to exploit this lucrative market in medical tourism in an effort to boost its own tourism industry, a major source of revenue for the island. Accordingly, the officials at the Ministry of Health and Welfare who approved the plans for GIH expect that almost all of the patients seeking treatment at GIH will be foreign nationals, primarily Chinese tourists, and that the main areas of business will be cosmetic surgery and medical check-ups [3]. Additionally, the Greenland Group has already agreed to make a $1 billion investment in Jeju Healthcare Town. So it is fairly clear that there are significant economic benefits to be gained through the government's approval of GIH.

In terms of costs, there are several questions or issues to consider. In the first place, what public resources are being used to attract this sort of investment? In 2003 the government changed the tax laws to promote foreign investments. Under the new laws, companies investing in Jeju Free International City are exempt from paying taxes for 3 years and enjoy a 50 percent reduction in tax payments for the next 2 years [35]. Other government subsidies may also have been provided to secure this deal with the Greenland Group, all of which need to be factored into the cost-benefit analysis.

Moreover, there are other sorts of costs related to the government's support for medical tourism that are not tied specifically to its approval of GIH. For example, foreign citizens who can document "Ko-

rean ancestry" can now qualify for national health insurance in Korea [36]. Therefore, people who are neither citizens nor residents of South Korea can now receive medical treatment in Korea, subsidized by the Korean government, as long as they can document Korean ancestry. Additionally the lucrative market in medical tourism, especially for cosmetic surgery, has lured many illegal brokers and unregistered clinics in South Korea to become involved in the business, leading to a raft of botched surgeries and malpractice claims being launched by tourists [33]. In response the Ministry of Health and Welfare has had to take a number of measures at the public's expense to deal with the growing number of complaints, including setting up agencies to regulate the medical tourism industry and provide medical tourists with information and legal advice [33].

The final but not least important cost or risk to take into consideration is how the decision to approve GIH will affect the Korean healthcare system or the national health insurance scheme. Will it drive up prices and help to dismantle the national insurance scheme as some critics allege? Officials from the Ministry of Health and Welfare are confident that the approval of GIH and the other investor-owned for-profit hospitals in Korea that may be approved in the future will have no adverse effects on the Korean healthcare system [37]. Their confidence seems to be based primarily on two points. First, such hospitals will be restricted to "special economic zones," such as Jeju Free International City and a handful of other free economic zones in Korea [3]. Secondly, since none of the medical services offered by GIH will be covered under the nation's medical insurance scheme, residents of Korea who seek treatment at GIH will have to forego the medical insurance coverage that they would receive at other hospitals in Korea [3]. Accordingly, it is unlikely that GIH will attract large numbers of Korean patients. It is for these reasons primarily that government officials believe the establishment of GIH will have no adverse effects on the Korean healthcare system or the national health-insurance scheme. In denying national medical insurance coverage to any medical care provided by corporate–owned for-profit hospitals, and restricting such hospitals to special economic zones, government officials seem to believe that these hospitals have in effect been placed outside of the nation's healthcare system.

But whether or not the Korean healthcare system is truly impervious to the existence of GIH and the other such hospitals is debatable. Looming large on this question is the free trade agreement between the United States and South Korea (also known as the "KORUS FTA"), the final version of which was signed in 2010 and went into effect in 2012. In order to protect Korea's healthcare system from the negative ef-

fects of market liberalization, health and medical services were specifically exempted from the agreement. However this exemption does not apply to medical institutions operating in Jeju Free International City or other free economic zones in Korea. Therefore, hospitals such as GIH will be subject to all of the liberalization rules of the FTA including the so-called "ratchet clause," which guarantees that once regulations are relaxed they can never be re-implemented [38]. Furthermore, the KORUS FTA's investor-state dispute resolution mechanism enables corporations to seek compensation for regulatory costs before foreign tribunals rather than domestic courts. These are powerful tools that GIH and other foreign corporations doing business in Korea can use to block the Korean government from regulating it in the public interest. In the future, as healthcare costs rise with an aging population and shrinking tax-base, there may be no choice for the South Korean government but to cut back on the types of medical procedures covered by the national health insurance scheme. At the same time, South Korea is already witnessing a dramatic growth in the use of private health insurance. As these two trends continue—a shrinking of the national health insurance scheme and an increasing reliance on private health insurance—the distinction between hospitals inside and outside the free economic zones will begin to blur. In that case, corporate-owned for-profit hospitals in Korea will likely have the predictable effects of driving up prices and reducing healthcare access for those who cannot afford it.

To sum up, while there are economic benefits, at least in the short-term, to the growth of the medical tourism industry in Korea, there are also economic costs and social risks associated with the way in which this industry is being supported, with the approval of corporate-owned for-profit hospitals operating in special economic zones. Hospitals such as GIH do have the potential to bring about adverse effects on the Korean healthcare system and the national health insurance scheme, especially in the context of the KORUS FTA and other trade agreements, such as the Trans-Pacific Partnership, that the government may into in the future.

V. CONCLUSION

As was noted at the outset, the decision by the South Korean government to approve GIH was propelled by two trends that are reshaping healthcare in many countries around the world, including South Korea. These two trends—the market liberalization of the healthcare sector and the explosive growth of the global industry in medical tourism—are two facets of what is called "globalization." South Korea's overall experience with globalization has been a contentious one in many areas, including

the healthcare sector. The controversy that has recently erupted over GIH should be situated within the broader context of a debate that has been taking place in South Korea for more than a decade over healthcare reform and liberalization of the healthcare market.

In 2003, the South Korean government passed the "Special Act on the Designation and Management of Free Economic Zones," which permitted the establishment of foreign-owned for-profit hospitals in specially designated "free economic zones" [39]. However, due to government regulations concerning the management of for-profit hospitals in free economic zones, no foreign investors were interested in taking advantage of the newly passed law. In 2005, then-president President Rho Moo-Hyun set up a "Healthcare Industrialization Committee" consisting of various stakeholders to look into ways of developing the healthcare sector in the future, with the deregulation of for-profit hospitals one of the main items on the agenda. According to one informative report, the Committee's work did not go smoothly; instead it revealed deep divisions between those who believe that healthcare should be treated on a par with other industries and those who believe that healthcare is unique and should be under the control of the health policy sector [23]. The Ministry of Strategy and Finance, private insurance companies, and certain provider groups, supported the deregulation of for-profit hospitals on the grounds that it will attract foreign investments, encourage healthy competition with non-profit hospitals, and increase choices for consumers; on the other hand, the Ministry of Health and Welfare, civic groups, and labor unions were strongly opposed to for-profit hospitals because they believed that such hospitals will lead to overall privatization of the healthcare system, which will increase inequities in accessing the system, and promote greater social polarization between the rich and the poor [23]. Because of the deadlock in discussions between these two groups, the Committee was suspended in 2007.

A second committee was later set up in 2008 under the new Lee Myung-Bak administration, but it too hit an impasse and its discussions were postponed in 2009. Things changed in 2010, following the signing of the KORUS FTA, when the Ministry of Health and Welfare revised its rules concerning the management of foreign-owned for-profit hospitals in free economic zones so that such hospitals could not only accept domestic patients but also employ foreign doctors [3,37]. Following these revisions and the implementation of the KORUS FTA, foreign investors were suddenly interested in establishing for-profit hospitals in Korea's special economic zones including "Jeju Free International City." It is against this backdrop of the politics of free trade and economic globalization that the contro-

versy over GIH must be understood.

In the foregoing I have attempted to clarify the main ethical issues at stake in the decision by the South Korean government to approve the establishment of GIH. In particular, I have focussed on the ethical issues associated with for-profit healthcare and medical tourism. I have argued that while there are legitimate ethical concerns with both of these things, it does not follow that for-profit hospitals must be prohibited or that the government should not attempt to promote the nation's medical tourism industry. Rather, I have argued that when corporate-owned for-profit hospitals like GIH are established with the intention of developing the nation's medical tourism industry, care must be taken to ensure that the benefits do not come at great social or ethical costs. In particular, strong regulations must be kept in place to ensure that hospitals like GIH work not only in the interests of their investors, but also in the public interest. However, for reasons that have been touched upon, questions remain as to whether this win-win scenario is even possible in the context of free trade and economic globalization. These are the larger questions to which the foregoing discussion should direct one's attention.

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The Ethics of For-profit Healthcare and Medical Tourism in South Korea

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Abstract

On December 18, 2015, South Korea's Ministry of Health and Welfare formally approved the establishment of Korea's first corporate-owned for-profit hospital. The establishment of this hospital, which will be named Greenland International Hospital (GIH), raises two distinct but overlapping sets of ethical concerns. One set of concerns relates to the fact that GIH will be engaged in for-profit medicine, which some believe is incompatible with the ethical principles that are thought to govern medical practice. The second set of ethical concerns relates to the fact that GIH is being established in an effort to further develop Korea's burgeoning industry in medical tourism, an industry that has recently attracted academic interest in light of the ethical concerns that it raises. In this paper I draw on some of the existing literature concerning the ethics of for-profit medicine and medical tourism in an attempt to shed light on the ethical issues involved in the recent decision by the South Korean government to approve the establishment of GIH.

Keywords

for-profit healthcare, for-profit hospitals, non-profit hospitals, medical tourism, South Korea, Greenland International Hospital

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