MEDICAL TOURISM IN HYDERABAD: AN EXPLORATORY STUDY

By

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BSc NCHMCT- IHM (HYD)

AN ABSTRACT OF A DISSERTATION

Submitted in partial fulfilment of the requirements for the degree

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Abstract

Medical tourism comprises a phenomenon where over five million patients a year are traveling across international borders to obtain various forms of health care. Most of these patients travel from developed countries to developing countries, seeking highly invasive medical treatments to less invasive and recreational medical procedures. By the year 2024, the medical tourism industry generated over $204.4 billion with over 50 countries making it a priority in trade for their country. With active government promotions, India has become one of the leading destinations for medical tourism.

The objective of this research was to answer the questions: 1) how do the attitudes and behaviours of patients towards the concept of medical tourism influence their decision to become a medical tourist; 2) why do medical tourists seek treatment in India; and 3) what are the issues and challenges they face before coming to India as well as while in India. Interviews of twenty-One foreign patients were conducted in three sites spread across the city of Hyderabad which revealed useful information in addressing the research objectives. The three most important reasons that these medical tourists chose India for their treatments were: 1) the high quality of the doctors and medical facilities in India, 2) the affordable cost of treatments, and 3) the availability of specific treatments that might not have been available in their home countries. Patients also researched the topic thoroughly before they came to India. Knowledge was gained primarily from the Internet, print media, television shows and friends. Overall, the patients had very positive attitudes towards medical tourism. Most of them felt that they could get treatment because of their positive opinion on medical tourism, their ability to get treatment if they desired, and support from their families and loved ones.

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Approved by:

Professor Rajesh

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Chapter 1 - Introduction

Over five million patients a year travel abroad to seek and consume Healthcare that may be too expensive, too delayed, altogether unavailable, or even proscribed in their country of residence. This phenomenon of traveling to foreign countries to obtain medical, dental, surgical, and wellness care is known as “medical tourism, ”health tourism,” or “wellness tourism;” Despite these names, the motivation of this type of traveling is far from recreational. Medical tourists generally originate from developed countries, and an overwhelming majority of them seek treatments in developing countries. More specifically, the primary flow of medical tourists is from the United States and Western Europe to mainly South and Southeast Asian countries, including India, Thailand, Malaysia, Singapore, and South Korea, and European countries, including Latvia, Czech Republic, and Hungary. Brazil, Mexico, Guatemala, Costa Rica, and other Latin. American countries also attract medical tourists, particularly from the United States. Several Middle Eastern countries were initially sources of medical tourists, but now these countries attract patients from affluent developed countries.

Medical tourists from developed countries also seek treatment and Medical procedures in other developed countries. For example, Canada provides Medical treatment to many Americans. Europeans traveling within Europe for fertility treatment are also common largely because some European countries restrict certain fertility procedures, forcing their procurement elsewhere. The European Society for Human Reproduction and Embryology reports that between 20,000 and 25,000 cross-border fertility treatments are carried out each year. Over half of all British women who seek treatment abroad go to the Czech Republic, where it is easier to obtain donated Eggs. Many Italians escape legal restrictions at home by traveling to Spain for Egg donation and to Switzerland for sperm donation.

French women go to Belgium for the latter. Some of the most well-traveled medical tourists are from the U.K. Nearly 50,000 U.K. residents seek treatment abroad every year. Significant numbers of medical tourists also come from the U.S., many of whom are among the nearly 47 million Americans who lack health insurance and 108 million who lack dental insurance. Though the new “Affordable Healthcare for America Act” is expected to reduce the number of uninsured and underinsured Americans, only time will tell how this might impact the number of Americans seeking health care abroad.

Medical tourism is nothing new – it has existed in different forms for Centuries– but its frequency has intensified concomitant with contemporary globalization. According to Hancock “medical tourism is one of the fastest growing Businesses on earth”. Gill and Singh claim that “More travelers than ever before are now traveling abroad to get high quality medical treatments for less cost, which includes treatments such as general surgery, transplant surgery, cancer treatment, stem cell therapies, dental implant, facial implant, and liposuction, just to name a few”. Over 50 countries around the world are promoting packages that

combine health care along with recreation. Gill and Singh maintain that medical tourism has reformed the health-care industry and has set a new benchmark for many countries. Both developed and developing countries are considering investing in their infrastructures to stay on top of the aggressive competition as well as to arrest the outflow of patients to foreign countries.

The emergence of medical tourism has opened opportunities for many relevant businesses and industries both in destination and source countries. Some U.S. companies are promoting medical tourism; in fact, some insurance companies offer discounts to patients willing to go abroad for health care. In 2006, Blue Ridge Paper Products, Inc., a company based in North Carolina, incentivized its employees to travel to India for non-emergency surgeries. Similarly, a European owned Supermarket chain in the U.S. also promoted medical tourism in India among its Employees due to the high cost of treatments in the U.S. This cycle of savings and incentives benefits the insurance companies, the employers, and the employees. Another benefit of medical tourism is its economic boost to health and tourism sectors. Med Retreat, the first medical tourism agency in the United States, assists North Americans seeking any of 183 medical procedures in any of seven countries: India, Thailand, Malaysia, Brazil, Argentina, Turkey, and South Africa. Planet Hospital, a California-based organization, connects patients to international health care providers, nearly two-thirds of whom have either a fellowship with medical societies in the United States or the United Kingdom, or are certified for a particular specialty by a medical board. According to York as medical tourism becomes more prevalent, “continuing education, credentialing, and certification services may be required to help assure patient safety”.

Research Objectives and Questions

This study offers insights into the phenomenon of medical tourism, focusing on India as the destination country. One of the major destinations Countries for medical tourists, India has been experiencing a medical tourism Boom since the early 2000s and is at the forefront of this growing phenomenon. Its health care sector is growing briskly and is one of the largest sectors in terms Of employment and revenue generation. In the 1990s, the Indian health care Sector grew at an annual compounded rate of 16%. It generated $34 billion in 2006 and is projected to generate $202.4 billion by 2024. It is estimated that a significant portion of this revenue jump will be due to medical tourism growth. In the early 2017, approximately 495,056 foreign patients traveled to India for different types of treatments. In the year 2015, India has generated about $3 billion in revenues from medical tourism, which will account for nearly 46 percent of all medical tourism-related revenues to be earned by all Asian countries in that year. In the year 2017, India’s share of medical tourism is expected to be about three percent. India is an ideal place for medical-tourism-related research. Currently, India is second only to Thailand in the number of medical tourists it has attracted since the early 1990s. Also, starting in 2002, India was one of the first countries to promote medical tourism as an export industry by offering special tax incentives to medical tourists’ care providers. The country’s diverse medical-care offerings further enhance India as a good case study. These offerings include advanced, hi-tech medical care such as heart surgeries, dental procedures, and hip resurfacing as well as more holistic forms of treatment such as Ayurveda, yoga, and spa therapy. This range provides abundant research opportunities. Additionally, the

author is from India, which enables a familiarity with the research destination. The author speaks several Indian languages and also has a network of people that may assist in procuring interviews for this research. The author's familiarity with the cultural norms might also help while speaking with people who promote medical tourism. The author is also well-acquainted with Western culture and at ease collecting relevant information from Western patients who have sought medical and other related care in India. The research design includes primary and secondary data collection. A Questionnaire survey administered to Western medical tourists seeking treatment In India provided primary data. Literature on medical tourism, in general, and India, in particular, provided secondary data related especially to past and

Current trends in medical tourism, an understanding of which may help in predicting future trends in the industry. This research on medical tourism provides information on what countries medical tourists most often come from and for what types of treatments and reasons. It also indicates what reasons are more or less important in a medical tourist's decision to pursue medical tourism.

Specific Research Objectives/Questions

This study has three research questions:

1. How do the attitudes and behaviors of patients towards the concept of medical tourism influence their decision to become a medical tourist?
2. Why do medical tourists seek treatment in India?
3. What are the issues and challenges they face before coming to India as well as while in India and what is the patients' level of knowledge on the topic?

The research questions were explored through a questionnaire survey. The first Half of the questionnaire was a set of Likert Scale questions that sought Understanding of and ranked the importance of medical tourists' attitudes regarding issues such as cost of treatment, cost of overall trip, competence of Physicians, opinion on facilities, privacy concerns, concept of vacation, getting Treatment in a developing country, health insurance, and other factors. The Theory of Planned Behavior (TpB) framework was used to understand the factors Involved in the decision making process of a medical tourist.

The second half of the questionnaire was qualitative, consisting of open Ended questions about various destinations and source countries for medical Tourists. This half of the questionnaire also asked for participants' demographic Data for the purpose of better understanding the characteristics and profile of those seeking medical care abroad.

In order to compile a representative sample of medical tourists, patients of both advanced, high-tech hospitals and holistic treatment centres were chosen as participants. The facilities are located within the south Indian city of Hyderabad chosen as participants. English is widely spoken in all twin cities, and each is connected to an international airport. Twin cities are considered information technology (IT) hubs in India, and several medical facilities in these cities actively promote medical tourism.

Significance of Study

Academic literature and research on medical tourism especially that Based on firsthand patient and/or administrative interviews is limited due to the Relative newness of the industry. What is available comes mostly from newspapers, popular magazines, and online articles. This research aims to add new and significant insights to the slowly accruing academic literature on Medical tourism.

In addition to contributing to academic literature, the findings of this research may contribute to other fields. Policy makers, for example, might apply the research to improving India's overall healthcare system. Medical tourism related industries, such as credit card companies, travel agencies, hotels, food and beverage companies, medical facilities and services, and spas could also benefit from this study. The outcomes of this study could also be useful to prospective medical tourists. As per my knowledge, this is the only study on medical tourism that relies solely on patient interviews. Policy makers in source countries may also benefit from this study as they examine reasons, beside cost, people bypass treatment in their home countries to seek medical treatment abroad.

Some physicians and medical facilities in the developed world are becoming concerned with the medical tourism trend. As more patients leave their home country for treatment elsewhere, medical professionals and personnel in the home countries, along with the government, may worry about financial losses and also the potential repercussions associated with treatment complications once patients return to their home country. Also concerning to health-care providers and patients alike are the relatively lax laws and regulations in countries such as India that may actually harm foreign patients. The aforementioned concerns are important to this study as these may become significant factors on how people from various sides of the issue perceive medical tourism.

To fully understand the medical tourism phenomenon in India, aspects of the health care system in both India and the source countries need to be examined. Health is affected by, among other things, government policies, Budget allocation, people's behavior, and physical environment. Looking at the History of medical tourism from various perspectives and examining the current
Policy yields a better understanding of the causes and consequences of Medical tourism.

Chapter Outlines

Chapter Two focuses on medical tourism literature. Following a description of medical tourism's historical development, various definitions of the term will be discussed. The popularity of medical tourism will also be discussed in this chapter, followed by a discussion of major source and destination countries of medical tourism. The last part of Chapter Two provides a general discussion of medical tourism's advantages and disadvantages.

Chapter Three describes this study's research methods. It also explains various health behavior theories, including the theory this study used to examine the decision making of medical tourists, the Theory of Planned Behavior (TpB). The study areas and the rationale for their selection will also be outlined, followed by a discussion of this study's methodological considerations. The chapter Concludes with discussion of the respondents' profiles.

Chapter Four presents the data collection procedures and analyses both the quantitative and qualitative responses of the study participants. The Geographic concept of place is also examined to understand its role in medical Tourism.

Chapter Five discusses the research findings presented in Chapter Four. It also identifies limitations for this research and concludes with Recommendations for future for medical tourism research.

Chapter 2 - Literature Review

Medical tourism is a burgeoning industry. According to Hopkins et al medical tourism is "a rapidly emerging manifestation of global Commercialization of health care". Gupta writes that "Medical Tourism is a multi-billion dollar industry promoted by governments and the Medical and tourism industries". Although some forms of medical tourism may be century's old, medical tourism in the twenty-first century is different from any previous characterization. This aim of this chapter is to provide a range of perspectives on historical and contemporary medical tourism as a way of establishing this study's conceptual framework.

Morphosis of Medical Tourism: Globally and in India

Medical tourism has become a multi-billion dollar industry. According to McKinsey and Company, medical tourism was a $60 billion market in 2006 and they predicted that it could be a $100 billion industry by 2017. Despite its recent popularity, medical tourism is thousands of years old. Goodrich points out that different forms of medical tourism have existed for centuries. Written records of Greeks traveling to Tell Brak, Syria, for eye treatment date back 5000 years. During ancient times, people from afar frequented mineral springs due to their purported healing nature. People traveled for healing from ailments such as skin conditions, arthritis, and muscular injuries. People in ancient times have always gone to rivers such as the Nile, Ganges, Yangtze, and Jordan to be cleansed physically and spiritually.

Today, many Hindus bathe in the Ganges to be eternally cleansed. The ancient site of Epidauria, Greece, was professed to be the home of Asclepius, the god of health. The salt saturated Dead Sea in the Middle East is believed to have skin cleansing properties and has been used as such for many years. The ancient Romans and English went to Bath, England, to bathe in the warm mineral springs. Between the 15th-17th centuries, Europe's poor sanitary conditions prompted the rich to seek out medicinal spas, seaside resorts, and mineral springs for health purposes. Before the American War of Independence, many Americans traveled to mineral springs, spas, and seaside resorts such as Yellow Springs near Philadelphia, Stafford Springs in Connecticut, and Berkeley Springs in Virginia to benefit from their purported health-enhancing facilities. In the early 1980s and 1990s, European and Israeli spas were popular for medical tourism.

Medical tourism today is much more diversified, both technologically and geographically. Medical tourists travel to distant locations around the globe for treatment. Over 50 countries have identified medical tourism as a national industry. In past decades, affluent people from developing countries came to developed areas such as the U.S. and European countries for medical treatment. Most of these patients came to the West to attain highly advanced medical

treatments that were not available in their home countries. However, a reversal is taking place. People from developed countries are traveling to developing countries such as India, South Africa, and Thailand to receive medical treatment.

Although many of these patients are traveling to receive highly advanced medical procedures, a significant amount of them are also pursuing more less advanced and holistic types of treatments. According to Johnston et al, most of the hospitals that promote medical tourism are within lower and middle income countries (LMICs), "where favorable exchange rates have given them a competitive advantage in attracting price-conscious international patients." Figure 2.1 shows some of the top medical tourism destinations in the world. Although Asian countries are among the most popular medical tourism destinations, Figure 2.1 highlights countries from the Americas, Europe, and Africa as well.



Figure 2.1 Some of the major countries that promote medical tourism
Source: CBC News, 2018

India is at the forefront of the medical tourist industry. With its economic boom starting in the 1990s, India became a destination for outsourcing and not just for information technology (IT) but also medical treatment. Subsequently, medical tourism in India has become a business sector and not just a trend. A recent *Time* magazine article titled "Outsourcing Your Heart" compared the difference in prices of various treatments between the U.S., India, Thailand, and Singapore. All treatments listed in the article were the cheapest in India.

Additionally, the governments of many developing countries are now promoting medical tourism. For example, India's 2002 National Health Policy states that:

"To capitalize on the comparative cost advantage enjoyed by domestic health facilities in the secondary and tertiary sector, the policy will encourage the supply of services to patients of foreign origin on payment. The rendering of such services on payment in foreign exchange will be treated as "deemed exports" and will be made eligible for all fiscal incentives extended to export

earnings". The government of India even introduced the "medical visa" Which allows foreign patients to get a visa for the duration of their treatment and extend it for up to a year. This is not possible with a regular tourist visa. Several factors contribute to India's popularity as a medical tourism destination, including the experience and Western training of medical care providers, its large network of private hospitals, and its pharmaceutical industry.

India has a long history of subsidized medical education, and Indian medical institutions graduate nearly 30,000 nurses and physicians each year. Also, many physicians have western training, which, coupled with modern technology and widely spoken English, have allowed India to become an ideal destination for medical tourists from around the globe. Due to the sheer volume of patients, surgeons in India are more experienced in some medical procedures. For example, hip resurfacing surgery has been practiced in India for many years, while in the U.S. it has been available only since 2006. India also offers a plethora of world-class treatments in cosmetic surgery, cardiac care, joint replacements, and neurological and orthopaedic procedures, to name a few.

According to Grennan, some Western health care workers have combined their work with the opportunity to travel to exotic places. These physicians are known as physician voluntarists. For example, Artemis Health Institute in Gurgaon, India, claims that they regularly receive inquiries from doctors in the U.S. and E.U. who are interested in working at the institute. Also, Indian origin physicians from Western countries are traveling to India to deliver health care. Some of these Indian doctors travel to India temporarily but an increasing number of them are immigrating back to India on a permanent basis.

One important reason for this immigration is the highly advanced private medical facilities available in India today that were not available just a decade ago. India has one of the biggest private hospital groups in the world – Apollo Hospitals. Most of these hospitals are for-profit hospitals that not everyone in India can afford. However, due to the demand from the affluent and burgeoning middle-class in India, more and more of these for-profit hospitals are offering signing bonuses, stock options, and other incentives to Indian doctors in the U.S. to return and practice in India. These Indian doctors bring their specialized training and knowledge base from a Western country to treat patients in India.

Many of the Apollo Hospitals are in business relationships with notable American hospitals and companies in order to improve the quality of care in India. For example, "Medcity" is a $250 million collaboration between India and General Electric with the goal of creating a multi-specialty hospital similar to Johns Hopkins and Mayo Clinic in the U.S. Super specialty Wockhardt Hospital in the city of Bangalore is associated with Harvard medical school in the U.S. Wockhardt was the first super specialty hospital in Asia to become Joint Commission International (JCI) accredited, which is the international accreditation unit for hospitals.

One other factor significant to India's popularity as a medical tourism destination is its pharmaceutical industry, one of the largest in the world. It is highly self-sufficient and also exports drugs for a fraction of the cost to countries all around the world. It is ranked fourth in the world, producing about 8% of the world's pharmaceuticals. Pharmaceutical export from India stood at US$ 19.13 billion in 2018-19 and reached US$ 9.36 billion in 2019-20 (till

October 2019)It is expected to grow by 30 per cent to reach US$ 20 billion by the year 2020. In 2018-19, top importers of India's pharmaceutical products were USA (US$ 119.18 million), Russia (US$ 10.33 million), UK (US$ 9.83 million), South Africa (US$ 3.63 million) and Nigeria (US$ 1.71 million). India is expected to rank amongst the top three pharmaceutical markets in terms of incremental growth by 2020. India is the largest supplier of generic medicines globally (20 to 22 per cent of global export volume) India has one of the lowest manufacturing costs in the world. It is lower than that of USA and almost half of Europe.

Defining Medical Tourism

Medical tourism is a problematic term because it is not defined and applied consistently. Generally speaking, medical tourism is travel across national borders with the aim of improving one's health. Although many definitions concur that medical tourism entails medical treatment via travel, there is no consensus over the types of treatments. The terms "medical tourism" and "health tourism" will be used interchangeably in this research.

Goodrich and Goodrich defined health tourism as "the promotion by a tourist destination of its health care facilities and services". Laws defines health tourism with a broad view: it is "leisure taken away from home, where one of the objectives is to improve one's state of health". Since health is a broader term than medical, some researchers are reluctant to interchange "health tourism" with "medical tourism." Some use "health" synonymously with "wellness," and sometimes "health" is used to mean both medical and wellness, or even a subset of medical tourism or wellness tourism. Bookman and Bookman use the term "medical tourism" and "health tourism" interchangeably: "the sale of high-tech medical care to foreigners has come to be called medical or health tourism". In contrast, Tabacchi defines health tourism as "any kind of travel to make yourself or a member of your family healthier".

Tabacchi's definition is closely associated with wellness tourism, which involves people who travel to a different place to proactively pursue activities that maintain or enhance their health and well-being. Wellness tourists stay in specialized hotels and seek unique, authentic, or location-based experiences that are not available at home. They often purchase a service package comprising physical fitness, beauty care, healthy nutrition, relaxation, meditation, and mental activity. The difference between medical and wellness tourism is that one is undertaken by people who are sick and the other by people who are healthy.

According to Grennan, medical tourism is when "Western health care providers, including nurses, have seized the opportunity to combine travel with seemingly exotic work opportunities consisting of short-term medical work in countries of the global South". This practice is similar to physician voluntarism, which is usually considered a component of medical tourism. CBC, on the other hand, defines medical tourism as: "Patients going to a different country for either urgent or elective medical procedures"

According to Hunter-Jones, medical tourism is travel for recovery rather than travel for direct treatment. Carrera and Bridges define medical tourism as "organized travel outside one's natural health care jurisdiction for the restoration of the individual's health through medical intervention". According to Bies and Zacharia, "medical tourism is simply the outsourcing of medical services, primarily expensive surgeries, to low-cost countries, such as India and Thailand". Marsek and Sharpemore recently define medical tourism as "the practice of traveling abroad in search of high-quality, low-cost medical care". Attempts to define medical tourism bespeak its prominence and the desire to understand it as a phenomenon.

Medical Tourism's Popularity

Several factors contribute to medical tourism's increasing popularity, and one of the most important is affordability. Table 2.1 illustrates cost differences between treatments in the U.S. versus countries that promote medical tourism. Often, surgeries in developing countries cost only a fraction of what one might pay in the U.S. or U.K. Many surgeries cost only a tenth of what they would cost in the U.S. In order to illuminate the cost savings, some companies/agencies and hospitals that promote medical tourism provide cost estimators for patients. These cost estimators are very simple to use and a patient can input all the pertinent costs related to medical tourism along with the costs the company estimates. This will give prospective patients a good idea about medical tourism related costs. A primary reason for treatment being so affordable in countries like India may be low labour costs.

Surgery	USA	Colombia	Costa Rica	India	Jordan	Korea	Mexico	Singapore	Thailand
Heart Bypass	$144,000	$14,630	$25,000	$8,500	$10,000	$24,000	$20,000	$13,500	$24,000
Angioplasty	$57,000	$7,106	$13,000	$8,500	$5,000	$19,600	$16,000	$7,500	$7,000
Heart Valve Replacement	$170,000	$10,450	$30,000	$1,200	$12,000	$36,000	$30,000	$13,500	$22,000
Hip Replacement	$50,000	$8,360	$12,500	$8,000	$8,000	$16,450	$13,125	$11,100	$14,000
Hip Resurfacing	$50,000	$10,500	$12,000	$8,000	$8,000	$20,900	$12,800	$12,100	$16,000
Knee Replacement	$50,000	$7,106	$11,500	$7,000	$7,000	$17,800	$10,650	$10,800	$12,000
Spinal Fusion	$100,000	$14,500	$15,000	$12,000	$10,000	$17,350	$7,000	$18,300	$11,000
Dental Implant	$2,000-10,000	$1,672	$1,000	$700	$500	$3400	$910	$2,900	$3,000
Lap Band	$30,000	$6,500	$8,500	$7,500	$5,000	$9,500	$8,430	$12,000	$12,000
Breast Implants	$10,000	$2,600	$3,500	$4,500	$3,000	$11,000	$8,000	$5,400	$3,700
Rhinoplasty	$8,000	$1,677	$5,500	$3,500	$2,500	$4,000	$4,165	$2,700	$3,400
Face Lift	$15,000	$3,305	$5,900	$7,000	$3,000	$3,000	$7,200	$4,000	$6,600
Hysterectomy	$15,000	$1,845	$5,500	$5,500	$2,500	$9,000	$6,675	$4,000	$5,000

Table 2.1 Medical treatment cost comparison
Source: Consumerism Commentary Website, 2018
(Adapted from the Medical Tourism Association)

Patients' sense that they can enjoy a vacation while abroad also factors into medical tourism's popularity. A recent poll in the U.S. found that about 40% of American health care consumers were willing to travel abroad for care. Many medical tourism companies will arrange the whole trip for their clients. They book the airline tickets, pick them up from the airport, and arrange for accommodations based on the type of surgery and location and whatever else is needed by the patient. Many hospitals and health resorts that are geared towards medical tourism build rooms more akin to those in a hotel than a hospital. Often times, patients have the necessary surgeries and then recover at a resort. This is only possible with less intrusive surgeries, but it adds to the overall appeal of medical tourism. Cosmetic surgery has become one of the more popular treatments sought by medical tourists. With many of the doctors being foreign trained, treatment is believed to be just as good as in the U.S. After the surgery, many of these patients recover on beaches and resorts.

Advantages of Medical Tourism

Medical tourism has many advantages. First, medical tourism has become a lucrative business for many private companies in India. Since labour is cheap as well as the cost of living, even with the low charge for treatments, private corporations are making large profits. Furthermore, even though medical tourism services are performed in the country, "India's National Health Policy has deemed it to be legally an 'export' and 'eligible for all fiscal incentives extended to export earning". With the government catering to and promoting medical tourism, private companies are incentivized to start health care facilities geared towards foreigners. In the next six years, analysts estimate that India's $17 billion-a-year health care industry could grow at a rate of 13% per year. One administrator from the interviews said, "apart from IT, health care is the next big sector. Not only do hospitals get a boost, but a lot of new jobs are created, advancement of technology, quality of care improves and a reverse brain drain takes place."

Medical tourism is advantageous to not only the supplier, but also the clients. The relative affordability of medical tourism brings many clients facing prohibitive out-of-pocket expenses in their home country because either their insurance does not cover/pay the needed procedure or they are uninsured altogether. It is reported that nearly 50% of all bankruptcies in the United States are due to medical reasons. Costs in developing countries are often 25-50% cheaper than in the U.S. and in some cases even less than that. Reasons developing countries can often charge less than developed countries for the same treatment include: little or no third party involvement, fewer malpractice litigations, and limited collaborations between health care facilities and physicians. Even the competition for foreign patients among destination countries brings costs down. Treatment in destination countries also provides privacy and anonymity for the clients. Unlike in the U.S., patients' medical records cannot be viewed by a third party.

Additional advantages of medical tourism to the client are short waiting periods and availability of treatments not yet approved in the source country. For example, the wait times for hip and knee replacement in 2005 were 21.8 and 28.3 weeks, respectively, in British Columbia, Canada, whereas most medical tourism destinations had waiting periods of only a

few days. Also, some procedures and treatments not yet approved by source country governments are already available in medical tourism destination countries.

Disadvantages of Medical Tourism

Though many patients seek medical care abroad because their insurance won't cover it in their home country, others are prevented for that very reason. A lack of insurance portability discourages some prospective clients from obtaining treatment in developing countries. Even if a particular procedure may cost less and be more readily available abroad, insurance won't always cover it because the coordination between private health care facilities in India and insurance companies in the developed countries is not prevalent. Fortunately, this is changing. Several insurance companies (e.g., United Health Care, Aetna, WellPoint, and Health Net of California) now have medical travel and medical tourism packages. Insurance companies are realizing the savings potential.

Weak malpractice laws in developing countries can also present problems. If something goes wrong in the U.S., patients have recourse and settlement options. In a developing country such as India, recourse is limited. Accordingly, gaining the trust of foreigners is a challenge for medical tourism facilities in India.

Potential follow-up care is another drawback. If a complication should arise after a patient returns home, immediate medical attention is difficult to obtain. Having to travel half way around the world not just for the initial surgery but also follow-up care can become extremely tiresome and costly, not just financially but also mentally and emotionally.

An additional disadvantage of medical tourism, specifically in India, is local rather than patient-focused. A common concern about medical tourism in India is that the cost of its success is the already deficient national health care system's ability to meet the needs of its residents. Medical tourism is a growing sector in India. In October 2015, India's medical tourism sector was estimated to be worth US$3 billion. It is projected to grow at a CAGR of 200% by 2020, hitting $9 billion by 2020. In 2017, 495,056 patients visited India to seek medical care. However, much of this revenue benefits only a select few, namely the private health care system. In a BBC article, two Indian doctors claimed that while the rich get treated for their ailments, the poor people of India who are in most need of proper health care are ignored.

India spends less than 1% of its GDP on healthcare for the common person which is one of the lowest levels of public health care spending in the world. As the government seeks to promote India as a health care destination that primarily serves a select few, often the rich, the majority of Indians still suffer from a lack of adequate health care. India has a two-tiered health care system that provides expensive, private care to the elite who can afford it while the poor receive low quality public-funded health care. When poor people seek better health care at some of these private facilities, often times, they end up borrowing money or taking loans which lead to financial hardships. De Arellano argues that medical tourism "exacerbates the brain drain from the public sector to the private sector." Promoters of medical tourism in India counter that profits generated from their international business are used for the improvement of healthcare services for the poor. Regardless, Hazarika suggests

the need to divert some revenue generated from medical tourism to improving the public health sector. Medical tourism has distorting effects and also raises questions about the inequality of resources.

Medical Tourism Destinations and Treatments

Most medical tourists come from developed countries while most medical tourism destinations are developing countries. According to Gahlinger, nearly 50 countries in the world actively promote medical tourism. The majority of them are in Asia and Latin America. Some of the notable Asian countries are China, United Arab Emirates (UAE), India, Israel, Jordan, Malaysia, Philippines, Singapore, Thailand, and Vietnam. Countries in Latin America that promote medical tourism include Brazil, Costa Rica, Cuba, Dominican Republic, Mexico, Panama, and Venezuela. European countries that promote medical tourism include Belgium, Bulgaria, Croatia, Germany, Hungary, Latvia, Poland, and Spain. A few countries in Africa that promote medical tourism are Egypt, Tunisia, and South Africa. Of the countries listed above, a significant majority of them are developing nations.

In 2008, the consulting firm McKinsey and Company conducted a detailed study in over 20 countries for which they interviewed patients, providers, and subsidiaries of medical tourism. They found that 45% of North American patients who travelled abroad for health care travelled to Asian countries and 26% of them travelled to Latin America: seven in ten patients from North America who travelled abroad for health care sought treatment in either an Asian or Latin American country. Among European patients, 39% who sought health care abroad travelled to Asia, 13% to the Middle East, and 5% to Latin America: nearly six in ten European patients who sought health care abroad travelled to a developing country (although not all countries in Asia or Latin America are developing countries, the significant majority of them are). According to Naranong and Naranong, Thailand, India, and Singapore accounted for 90% of medical tourists in Asia in 2008.

Medical tourism destinations promote a plethora of procedures and treatments. Some of the most common and popular include orthopaedic surgery; spinal procedures such as spinal fusion and spinal disc replacement; cardiac procedures such as angioplasty; gynaecological surgery; general surgeries such as vascular surgery, stomach and bowel surgery, kidney and urinary surgery, cataract surgery, and LASIK surgery; hip and knee replacement; hip resurfacing; and dental procedures. Some less common procedures are fertility treatments, bariatric surgery, transplants, sex reassignment, and wellness screenings.

India is a leading destination for medical tourists. According to McKinsey and Company, India's health industry is predicted to grow significantly in the next two decades to a $190 billion industry from its $25 billion industry currently. The Indian government would like for medical tourism to play an important role in this revenue generation. In 2002, 150,000 foreign patients traveled to India for health care. By 2005, that number increased to 500,000 patients. English is widely spoken in India, and several cities have state of the art hospitals that also cater to international patients. Patients from the U.S., U.K., Canada, and Africa are very common in India. A Canadian researcher found that of the 18 medical tourism

companies in Canada that promoted traveling abroad for health care, India was the most commonly promoted destination with eleven companies promoting it. Costa Rica and Thailand were second and third, respectively, with nine and seven companies listing them as medical tourism destinations. Some of the procedures that hospitals in India are known for are bone marrow transplant, cardiac bypass, eye surgery, hip resurfacing, hip replacement, and spinal procedures. Additionally, India is the leading and probably only country that is exclusively known for specific holistic treatments. The ancient Indian treatment of Ayurveda is very popular. Other holistic treatments such as massage therapy, spa treatments, and reflexology are also very popular among medical tourists. Many Indian doctors and nurses practice abroad in Western countries giving them a very good reputation in the health care field. According to Chanda, geography, culture, and language all play a role in making India a top medical tourism destination.

Thailand is another leading destination for medical tourists. According to Gahlinger, "Thailand has become the poster-child for medical tourism". In 2008, medical tourism in Thailand generated approximately $1.6 billion in revenues and it is expected to generate about $13.6 billion in 2024. In 2007, approximately 450,000 medical tourists were treated in Thailand. In 2003, Thailand's Prime Minister Thaksin Shinawatra suggested making Thailand a hub for medical tourism. This would be done through aggressive marketing and easing restrictions on foreign doctors working in Thailand.

Thailand is a leader in medical tourism due to several factors. Many doctors in Thailand who treat foreign patients are U.S. trained. Thailand also has numerous JCI accredited hospitals. Thailand is also a popular tourist destination where crime rates are low and Thai hospitality is second to none. Thailand offers both advanced medical procedures and more holistic treatments. Some of the well-known procedures that medical tourists routinely undertake in Thailand are hip replacement, knee replacement, kidney transplant, dental care, cosmetic surgery, gastric bypass surgery, heart surgery, liposculpture, plastic surgery, traditional Chinese medicine, and acupuncture. Thailand is also one of the few countries that are known for sex reassignment surgery.

Malaysia is a leading medical tourism destination in Southeast Asia. The health care system in Malaysia is public-private. In 2008, Malaysia spent about 4.3% of its GDP on healthcare, and 56% of the healthcare is provided by the private sector (24% in 1983). This increase in private health care expenditure has contributed to the increase in medical tourism. Some common procedures for medical tourists in Malaysia are cardiovascular surgeries, cosmetic surgeries, dental procedures, orthopaedics, fertility/reproductive health, and stem cell treatment.

Several Latin American countries are also known for medical tourism. For dental procedures, Mexico, Costa Rica, Argentina, and Brazil are popular destinations. For cosmetic surgery, Argentina, Brazil, Cuba, Panama, and Venezuela are popular destinations. For many American medical tourists, Mexico is the most popular destination for dental care and cosmetic surgery. Many surgeons and doctors have opened facilities right across the border in

Mexico to make travel fast and convenient for American patients. About 40,000 U.S. patients go to Mexico each year seeking medical treatment. A majority of them visit border towns rather than Mexico City or resort towns due to the proximity of health facilities specifically set up to treat the large number of American patients looking for cheap and quick treatments. Some of the leading border towns in Mexico are Tijuana across from San Diego, California; Ciudad Juarez across from El Paso, Texas; and Nuevo Laredo across from Laredo, Texas. These towns have attracted many leading Mexican dentists and cosmetic surgeons due to their proximity to the U.S., which supplies a large and relatively affluent customer base.

Brazil is a leader in cosmetic surgery. Some of the cosmetic surgery procedures that are popular in Brazil are liposuction, tummy tuck, breast augmentation, rhinoplasty, face lift, and buttock lift. Other procedures that are popular in Brazil are hip resurfacing, spinal fusion, angiogram, and dental procedures. A trip to Brazil for medical treatment can also be combined with a visit to the Amazon rainforests and some popular cities such as Rio de Janeiro.

In Costa Rica, tourism is one of the top revenue generators and nearly 1.5 million foreigners visit the country every year. Costa Rica received 150,000 medical tourists in 2006, primarily for dental procedures and cosmetic surgeries. Costa Rica is known for ecotourism, and medical tourists can recuperate while relaxing among nature.

Egypt and South Africa are two countries in Africa that promote medical tourism. Both Egypt and South Africa are known for cosmetic surgery and dentistry. Some of the common cosmetic surgical procedures are ear repair, breast augmentation, breast lift, face lift, nose surgery, tummy tuck, and Botox. Some of the common dental procedures are crowns, veneers, implants, and bleaching. Many medical tourists who go to Cairo, Egypt, for a procedure combine their stay with a trip to one or more tourist destinations. The pyramids of Giza and the Sphinx statue are top destinations. Some patients also choose to recuperate at one of the modern resorts on the Red Sea or might choose to take a cruise down the Nile River. Medical tourists who go to South Africa for a procedure have the option of combining their trip with a safari in one of several wildlife reserves. Cape Town is also a popular destination for recuperation.

In Eastern Europe, both Hungary and the Czech Republic are popular destinations for affordable dental procedures. Many patients from Western Europe, particularly Germany and Britain, frequent these two countries for top quality but affordable dental procedures such as cosmetic oral surgeries, full mouth restorations, implants, cleaning, and check-ups. Sopron, a town of 20,000 residents in Hungary, has more than 200 dentists and 200 optometrists. Sopron which is only an hour’s drive from Vienna, Austria, caters primarily to Western European medical tourists.

Despite the lack of a shared definition among all concerned researchers, medical tourism is fast becoming a worldwide, multibillion-dollar industry. It has the potential to increase even faster as medical care continues to be further privatized and significant cost differentials remain. Many countries at various levels of economic development have been trying to exploit this rapidly growing industry. Several countries such as Belarus, Costa Rica, Hungary,

Latvia, and Mauritius do not receive a significant number of foreign tourists; yet, these countries are engaged in developing medical tourism.

Medical Tourist Source Countries

Although countries that are medical tourism destinations are easily identifiable, harder to identify are the many source countries of medical tourists. A significant majority of medical tourists are from developed countries such as the U.S., Canada, U.K., Germany, and other Western European countries. Wait times or high cost of treatment are often the drivers. In some cases, certain treatments are unavailable in their country.

In 2006, 500,000 Americans travelled abroad for health care. In 2007, the number increased to 750,000, and by 2012 an estimated six million Americans will be traveling abroad for health care. In 2007, Thailand's Bumrungrad Hospital alone treated 400,000 medical tourists, 80,000 of whom were from the United States. Many Americas are also traveling across the border to Mexico where eye exams, routine check-ups, and stomach surgeries are more affordable. Dental treatments and drugs are also much cheaper in Mexico.

In 2009, about 60,000 medical tourists from the U.K. sought treatment abroad. A little over 40% of them travelled abroad for dental procedures while 30% travelled abroad for cosmetic surgery, and 30% travelled abroad for other surgeries and treatments.

Medical tourists are not always from affluent countries. Medical tourists also travel from developing countries to other developing countries for treatment, often because treatments available in their country are not sufficient or in many cases not available. Medical tourists from several African countries, the Middle East, and South Asian countries like Bangladesh and Nepal frequently travel to India for various treatments. For example, nearly three in four medical tourists from Bangladesh travel to India for treatment. Certain hospitals in India have gained a reputation for exclusively treating medical tourists from other developing countries.

Until recently, most Middle Eastern countries were sources for medical tourists. Many of these nations, such as Bahrain, Jordan, Lebanon, and the United Arab Emirates (UAE), have recently sought to reverse this flow and develop their own medical tourism industry. Saudi Arabia has sought to link medical tourism, especially cosmetic surgery and dentistry, with annual religious pilgrimage visits to the country. Other source countries, such as the United States, have so far done nothing to reduce the flow of medical tourists.

Therapeutic Landscape and Health Care Bypassing

The topic of this dissertation rightly belongs in at least two sub-fields within human geography: geography of tourism and medical/health geography. Tourism is inherently geographic in nature and is a sub-field of human geography that deals with the study of travel and its impact on places. Medical or health geography, on the other hand, employs geographical concepts and techniques to examine issues related to disease and health.

In its early stage of development as a sub-field of human geography in the United States, from the early 1950s and into the 1980s, medical/health geography focused on both infectious and non-infectious diseases and health care delivery as topics and spatial analysis as technique. This led to the development of two major approaches to this sub-field: disease ecology and geography of health care. While disease ecology focuses on various aspects of diseases, such as disease diffusion and disease mapping, health care geography is concerned with the provision of health-care services within and beyond local, regional, national, and international borders. The topic of this dissertation is thus more closely associated with health geography than geography of tourism.

Medical/health geography has undergone a significant transformation since the early 1990s. This transformation was partially the result of a growing recognition of the importance of place and its relationship to health. In a seminal paper, Kearns claimed that medical geography "remains an unnecessarily placeless endeavour". A number of researchers have called for a refocusing of medical geography to reflect spatiality. This has become a core concept of post medical or reformed medical geography as proposed by Kearns. Although Kearns' proposal initiated a lively debate among medical/health geographers, his appeal for a "new" medical and health geography prompted the adoption of a more critical and theoretical approach, as well as postmodern perspectives to health research.

Due to the emergence of post-medical geography, researchers began not only adopting a much broader concept of health, but also focusing on places, and more specifically, a sense of place and attachment to place. These researchers examine how the character of some places is affected by health and healthcare and how, in turn, health and healthcare is affected by the character of particular places. Place is now considered in relation to mental well-being and good health.

During this transformation, Gesler introduced the concept of "therapeutic landscapes" to better understand the dynamics between place and wellness as well as to prompt geographers to adopt a more critical and theoretical approach to medical and health research. "Therapeutic landscapes are places that have achieved lasting reputations for providing physical, mental and spiritual healings". Such reputations may be built on the quality of the physical, psychological, or cultural environments (e.g., national parks or gardens), or they may rest on the qualities of buildings and settings (e.g., temples or hospitals). People seek out such places in order to be "cured" of a chronic disease, or to at least hope for an improvement in their wellbeing. These places are often referred to as the comfort zones people visit for a cure when they are physically or mentally ill. Therapeutic properties of places are culturally or socially constructed. As a result, different people perceive the therapeutic landscape differently. This landscape more strongly defines the relationship between health and place and is closely linked with health, place, and culture.

Since its introduction, several health geographers have expanded the concept of therapeutic landscape by attending more carefully to health seeking behavior at a global scale as well as at a local scale in some developing countries. Although the therapeutic landscape can be studied at different scales, most research has emphasized the local scale. Additionally, an overwhelming majority of the available studies on health and place have been conducted in developed countries, and these studies have neglected the temporal dimension of the therapeutic landscape. Wilson rightly claims that most studies focusing on the therapeutic

landscape have been conducted in developed countries and there exists little dialogue regarding how theoretical arguments might be applied to developing nations.

Although the concept of therapeutic landscape was formally introduced to the field of geography by Gesler in 1992, historically it has existed for centuries. As noted, since ancient times, people have traveled to rivers (e.g., the Nile, Ganges, Yangtze, and Jordan) for physical and spiritual cleansing. Even today, many Hindus bathe in the Ganges River to be eternally cleansed. During the British rule, people from the Ganges delta traveled to mountainous regions (e.g., Darjeeling, India and Kathmandu, Nepal) for a breath of fresh air.

Certain types of health tourism such as massage and yoga therapies and other forms of holistic treatments may have created a sense of place attachment to particular locations among medical tourists. If these specific locations become therapeutic landscapes, it is likely that medical tourists will frequent them. Indian hospitals that cater to foreign patients use this notion of therapeutic landscape within their hospitals. Many of these hospitals have a holistic centre in its premise with more ancient forms of treatments such as yoga and meditation programs, and herbal medicine, naturopathy, homeopathy, and acupuncture departments. The hospitals believe that these alternative forms of treatments can be combined with western treatments to enhance the overall health of the patients.

Health care bypassing emerged as a topic of study at about the same time the concept of therapeutic landscape did; however, health care bypassing has not enjoyed as much attention among medical/health geographers. The term health care bypassing refers to the non-use of proximate health care facilities or personnel in favour of more distant ones. Rediscovery of and a pre-occupation with the importance of place in health care, therapeutic landscapes, and the emergence of medical tourism in recent years likely explain the lack of research on health care bypassing. I argue that international health care bypassing is really a form of the broader definition of medical tourism, traveling across international borders for health care.

Health care bypassing is linked to the concept of therapeutic landscapes because people often bypass the nearest facility in favour of one that promises better health, and a patient's perception of therapeutic landscape relates to his or her perception of better health. Bypassing is generally most evident at the local scale in rural areas of developed countries. However, in developing countries, health care bypassing is evident on different scales: local, regional, and international.

Until the 1990s, national health care bypassing was limited to the rich and wealthy of developing countries. These privileged few traveled to the developed world for better care and also for care unavailable in their own country. Now, irrespective of their socioeconomic conditions, more and more people from developing countries are bypassing their national health care system. On a regional scale, patients from Pakistan, Bangladesh, Sri Lanka, and Nepal are drawn to private Indian hospitals that are comparatively better than ones in their respective countries. For example, in 2007 around 45,000 Bangladeshi patients traveled to India, 15,000 to Thailand, 4,000 to Singapore, and another 5,000 to other countries (e.g., Malaysia, Saudi Arabia, and United States) for medical treatment. In the early 1990s, somewhere between 12,000 and 15,000 patients from Latin America and the Caribbean

bypassed their national health care resources and traveled to Miami and Houston each year for various medical treatments.

As indicated, 65% of all national health care by passers or medical tourists from Bangladesh travel to India, and the remaining 35% seek treatment in other countries. Within these countries, the cities that attract Bangladeshi by passers are Kolkata, Vellore, Chennai, Mumbai, New Delhi, Singapore, Bangkok, Riyadh, and London. The selection of a city is based on reputation, illness type, distance, and socio-economic conditions of a by passer. A host of factors, such as non-availability, poor quality of services, lack of trust in health care providers, lack of modern medical equipment, and high cost of services in the country of origin, are responsible for national health care bypassing.

In recent years, by passers have more likely been patients from wealthy nations traveling to less affluent countries for either urgent or elective medical procedures, such as plastic surgery. For these patients, the therapeutic landscape is a foreign country. Additionally, many recent emigrants to developed countries often prefer traveling to their home countries for health maintenance and elective procedures. These patients, reversal by passers, or medical tourists, including both immigrants and non-immigrants, originate from countries like the United States, Canada, and Great Britain where all modern medical services are available, and they obtain medical, dental, surgical, and other health care in countries such as Cuba, India, Israel, Jordan, Lithuania, Malaysia, Mexico, South Africa, Thailand, and Turkey. Whether all national health care by passers can be considered medical tourists is debated; however, the term may be appropriately used for those who travel often in collaboration with the tourism industry from wealthy countries to relatively poorer countries with the purpose of utilizing “cost effective” private medical care.

As with medical tourism, health care bypassing is motivated by privacy, medical procedures unavailable at home, cost, new technology and skills in destination countries, reduced costs of international travel, the explosion of internet marketing, and favourable currency exchange rates. Another important factor is the wait time for a desired procedure, often termed the “capacity-saturation” of health care.

Within the context of health care bypassing or medical tourism, a strong sense of a therapeutic landscape is evident. For example, the Bangladeshi patients who have decided to go to India for serious kidney problems or kidney transplant will invariably seek treatment in the Christian Medical College Hospital (CMCH) at Vellore, Tamil Nadu instead of Kolkata, Bangalore, or Delhi. Similarly, heart patients from Bangladesh will prefer Kolkata or Delhi over Vellore. From the United States, people often travel to the southern cities of India such as Bangalore for alternative Ayurvedic therapy, yoga, and meditation. Cities of other destination countries, such as South Africa, have obtained a reputation as the place of choice for cosmetic surgery. It is common to fly to South Africa for plastic surgery and at the same time recover while going on animal safaris. For medical tourists, these cities are therapeutic places where they come with the hope of recovering from ill health and disease.

In some cases, like for those going to the hot springs in Bath, England, for treatment, the historical significance of the place attracts patients rather than the price of treatment. Although medical tourism has many definitions, they all have one main theme: tourism with

the intention of having some kind of medical treatment or pursuing better health. As noted, medical tourism has existed for many centuries in many countries of the world. However, medical tourism has never been a major focus of the tourism industry until recently.

Public and private medical tourism companies play the role of travel agent and medical care coordinator by linking patients of developed countries with overseas hospitals for a fee. These companies not only support the needs of health care seekers, they market health care as a commodity to be desired and highlight the specific construction of "place as therapy." At the same time, a place or health facility with perceived therapeutic properties accommodates the needs of prospective foreign visitors.

Clearly, the phenomenon of medical tourism is closely associated with the concept of therapeutic landscape as well as national health care bypassing, and it could be argued that international health care bypassing is indeed medical tourism often using the concept of a therapeutic landscape. While the idea of medical intervention is exclusively inherent in the concept of the therapeutic landscape, it is one of the two important reasons medical tourists travel abroad. Often, deliberate attempts are made by foreign tourism agencies to create therapeutic landscapes within the places that provide health care and well-being. The foregoing analysis suggests a significant overlapping among the concepts of therapeutic landscape, health care bypassing, and medical tourism. This is shown diagrammatically in Figure 2.2 which suggests that place or space provides the hinterland for interactions among the three concepts.

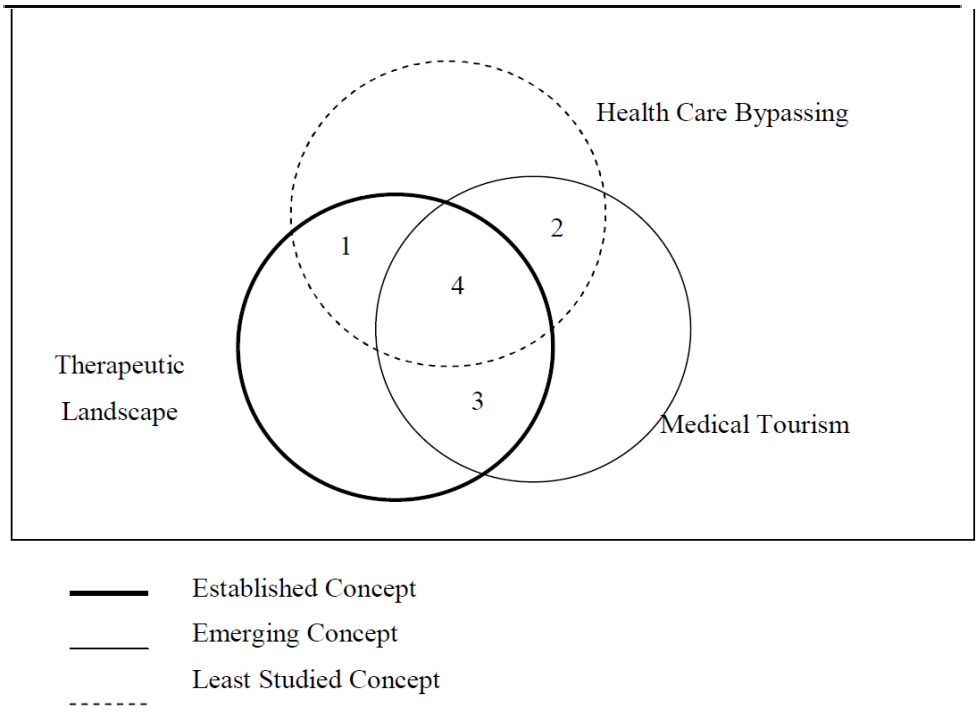


Figure 2.2 Linking medical tourism, health care bypassing, and therapeutic Landscape

Figure 2.2 illustrates four possible interactions among concepts of therapeutic landscape, health care bypassing, and medical tourism. Number 1 shows the interaction between

therapeutic landscape and national health care bypassing. In this case, an individual's decision to bypass national health care resources is driven by the therapeutic reputation of places located outside national boundaries. Number 2 illustrates interaction between national health care bypassing and medical tourism. In this case, an individual or a group crosses a national boundary to seek health care. The major factor influencing the destination choice, however, may be tourism. Cost also plays a role in this decision. This interaction more frequently takes place when non-urgent procedures are sought (e.g., cosmetic surgery or dental care).

Number 3 shows the interaction between the therapeutic landscape and medical tourism. In this case, both the comfort zone and the attraction of the place play a role in the decision-making process to seek health care. Finally, number 4 represents the interaction among the three concepts. This is more of an ideal situation: an individual makes the decision regarding health care on the basis of reputation or comfort, cost, and sightseeing.

Medical tourism has transformed from ancient times to modern times both technologically and geographically. More and more patients from Western countries are traveling to developing countries and medical tourism has become a niche market for people with particular health care needs. As long as health care costs and treatment wait times in some Western countries continue to rise, the potential for medical tourist destinations like India will also continue to rise. Furthermore, the governments of some medical tourist destination countries are combining their resources with the private sector to promote medical tourism. Medical tourism may have potential for significant growth due to many of the trends seen in the industry.

Chapter 3 - Research Methods

Several health theories can help predict and understand the behaviour and attitudes of people seeking medical care abroad. The Health Belief Model is by far the most important and well established health theory in the public health domain. The Social Cognitive Theory is another important theory in health behaviour. A third health theory of note is the Theory of Reasoned Action. A fourth theory is the Theory of Planned Behaviour (TpB), which will be the conceptual framework used for this research.

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Another health behaviour theory is the Social Cognitive Theory. This theory states that a person must have confidence within him/herself so he/she can perform the behaviour under various circumstances. Also, the person should have a benefit to gain by performing the behaviour and the positive benefits should outweigh the negative outcomes.

The Theory of Reasoned Action states that the performance of a behaviour is determined by the person's decision to either perform or not perform the behaviour. The decision to perform the behavior is determined by two factors. The first factor is the individual's attitude toward performing the behavior and is determined by the consequences of performing the behavior.

The second factor is the individual's normative belief that encompasses the opinions of those in close relation to the individual.

The Theory of Planned Behavior (TpB) explains the relationship between attitude and behavior. A person's behavior depends on three variables: behavioural beliefs, normative beliefs, and control beliefs. Various elements of the above mentioned theories and models can be used to explain a medical tourist's behavior. However, this research will primarily use the TpB (Fig. 3.1) to explain the attitudes and behaviours of medical tourists.

Theory of Planned Behavior (TpB)

Icek Ajzen introduced the Theory of Planned Behavior (TpB) in the mid- 1980s. TpB explains that one's actions are influenced by three factors: behavioural beliefs, normative beliefs, and control beliefs.

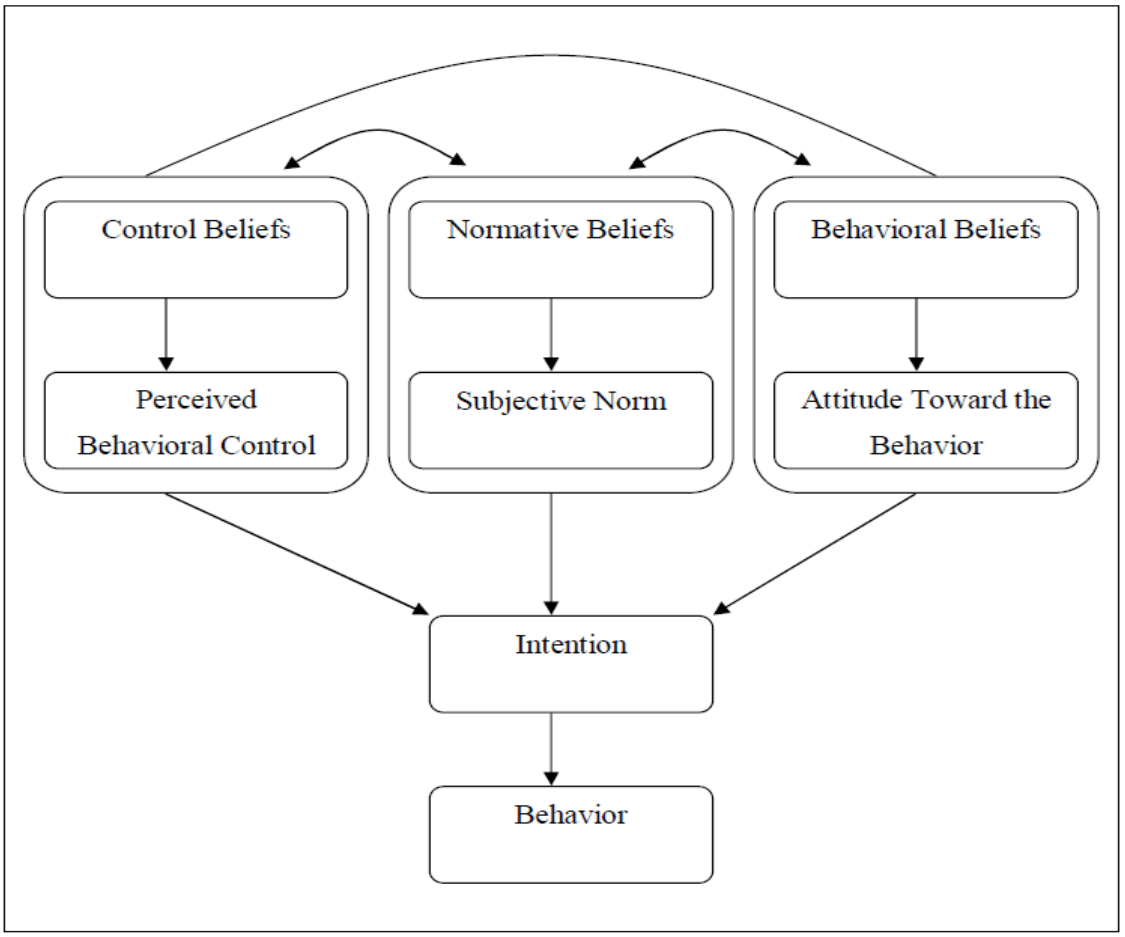


Figure 3.1 Theory of Planned Behavior Framework

Behavioural beliefs reflect the attitude an individual may have towards the final outcome of a particular behavior. For example, an individual may have negative or positive feelings about the perceived outcome of a particular behavior. These feelings will often play a role in whether the individual ultimately partakes in a particular behavior. Normative beliefs reflect the individual's perception of how others (family, friends, and peers) will view a certain behavior. The opinion of others will influence the individual's decision on whether to partake within the behavior. Control beliefs reflect the individual's personal view of the ease or difficulty of partaking in the behavior. The decision will be further influenced by factors that will facilitate or impede the performance of the behavior.

The combination of these three beliefs influences the behavior of an individual. If the behavioural, normative, and control beliefs are favourable, the chances of exhibiting a particular behavior increases. However, no one belief is necessarily superior to another. All three constructs are interrelated. Together these beliefs create an individual's attitude toward a particular behavior and ultimately influence the individual's decision of whether to partake in the behavior.

Many factors can influence the behavior of medical tourists. A medical tourist will have certain behavioural beliefs regarding the possible outcomes of receiving medical treatment in a foreign country. Since one of the primary considerations of a medical tourist is affordability, cost can influence a person's behavior. Curability of the sickness is another important consideration.

Normative beliefs also affect a medical tourist's decision to seek treatment abroad. The tourist's family's and friends' views on medical tourism will either strengthen or weaken the tourist's view. If the tourist's family and friends view medical tourism favourably, the tourist may be more inclined to seek treatment abroad or vice versa.

Finally, control beliefs also influence the medical tourist's decision. Factors such as travel time, cultural barriers, and a new environment can create negative perceptions of medical tourism. For example, an American seeking treatment in India will have a 24-hour flight and will be immersed into a completely different culture and environment. However, the perception that these obstacles can be overcome can positively influence the medical tourist's Behavior.

Description of Study Area

The study site for this research consists of three hospitals and wellness facilities, in the southern Indian city of Hyderabad or Secunderabad

The three hospitals/wellness facilities where the interviews were conducted are:

1) Apollo Hospital
2) KIMS Hospital
3) Continental Hospital

Several hospitals in this city actively promote medical tourism, and a number of these were contacted for permission to interview foreign patients. The three hospitals that were finally chosen are the ones that granted permission. Hyderabad and Secunderabad are considered Information Technology (IT) hubs in India. They have several super specialty/hi-tech hospitals and wellness centres that actively promote medical tourism. They also are near modern international airports, making travel conducive for international patients. English is widely spoken throughout the cities, which further helps tourists. Also, two of the three hospitals where I conducted interviews are Joint Commission International (JCI) accredited, which means that the hospitals meet the strict quality of care guidelines set forth by the commission. Fewer than 40 hospitals in India are JCI accredited.



Figure 3.2 Study Site: Hyderabad

Apollo Hospital, Hyderabad

Hyderabad is the sixth largest city in India and is also served by a brand new international airport. Since the IT revolution of the 1990s, Hyderabad has become a leading IT hub in India. English is widely spoken throughout the city.

Apollo Hospital-Hyderabad is an Apollo Health City, the first of its kind in Asia. The health city contains the hospital, centres for excellence, education, research and information technology, all in one campus. Apollo Hospital- Hyderabad is known for its treatments in heart diseases, joint diseases, cancer, Neurosciences, renal diseases, and eye and cosmetic surgery. Many of its physicians are foreign trained and the hospital proudly displays the

names of its physicians and their country of international training on a giant board in the lobby area. Most international patients that travel to Apollo Hospital-Hyderabad are from surrounding Asian and African countries. However, a few foreign patients from U.S. also came here for treatment.



Figure 3.3 Apollo Hospital, Hyderabad

KIMS Hospital

The oldest hospital from the KIMS Group was founded by Dr B Bhaskar Rao in 2000 in Nellore, India. Shortly after, in 2002, he started another hospital in Rajahmundry India in 2002. In 2004, KIMS group's flagship hospital, KIMS Secunderabad hospital was established, which is now a 1000-bedded hospital. Over the course of the next decade, the group expanded to several other cities in Andhra Pradesh.

KIMS hospital Hyderabad has emerged as a leading multi- super specialty hospital in a short span of time by virtue of its enlightened management and dedicated team of competent medical professionals, working closely in association with each other in a clinically sound and technologically advanced environment conforming to quality in patient care. KIMS Hyderabad is glad to announce its Accreditation by NABH (National Accreditation Board for

Hospitals and Healthcare Providers) and NABL (National Accreditation Board for Testing and Calibration Laboratories) for providing the services in patient care comparable to any international hospital of repute.



Figure 3.4 KIMS Hospital, Hyderabad

Continental Hospitals

Continental Hospital is a NABH and JCI-accredited facility in Hyderabad offering multi-specialty tertiary and quaternary care services. The hospital has a capacity of 750 beds with 250 operational beds currently. The hospital has Green OT, Level 3 NICU and PICU, and it's known for efficient critical care team. The hospital has state-of-the-art facilities and medical equipment, as well as the latest communication and information technology. Key specialties include Cardiac Sciences, Neuro Sciences, Gastroenterology, Obstetrics and Gynaecology, Oncology, Orthopaedics and Emergency Medicine.

Continental Hospitals is a part of IHH Healthcare, a leading premium integrated healthcare provider with a network of 84 hospitals and more than 16,000 licensed beds. It is one of the largest healthcare groups in the world by market capitalisation and is listed in the Main Market of Bursa Malaysia and Main Board of SGX-ST. IHH is a leading player in the home markets of Malaysia, Singapore, Turkey and India, and in their key growth markets of China and Hong Kong.



Figure 3.5 Continental Hospital, Hyderabad

Methodology

This research uses data from both primary and secondary sources. The primary data comes from surveys and interviews (both face-to-face and email) conducted at each of the three study sites. Study participants for the surveys and interviews include medical tourists and several health care management officials such as doctors and support staff. Interviews of the medical tourists sought to understand why and how they chose to attain medical treatment at the study sites. Interviews of health care management officials sought their opinions on medical tourism and information on how they promote their facilities as medical tourist destinations.

The study participants were chosen based on availability at the hospitals and willingness to respond to the researcher's emails. Once permission was granted, participation invitations and official permission letters were provided to all the patients. The survey consisted of a

four-page questionnaire containing questions aligned with the three components (control beliefs, normative beliefs, and behavioural beliefs) of the Theory of Planned Behavior (TpB).

The first two pages contained 7-point Likert-Scale questions. Following are a few of the statements respondents were asked to evaluate: 1) the idea of medical tourism is good or bad; 2) for me to have my medical treatment covered partially is good or bad; and 3) finding a very competent and well-trained doctor in a developing country is unlikely or likely. Several Likert-Scale questions were also asked regarding the following variables in order to determine each variable's significance: idea of medical tourism, saving money, insurance coverage, promptness of treatment, unapproved treatments, privacy, travel and vacation, competence of physicians, quality of facilities, severity of health condition, cost of procedure, family physician's approval, shopping, and travel time. The Likert- Scale questions were analysed using simple descriptive statistics (mean, median, range).

The next two pages gathered specific personal and demographic responses from the patients such as age, sex, cost of treatment, length of stay, treatment sought, health patients' insurance, and knowledge on medical tourism. This section also consisted of several open-ended questions regarding medical tourism and factors impacting the decision to pursue medical tourism. These open-ended questions will be focused on extensively in Chapter 4. Secondary data collection involved a thorough examination of the available literature in medical tourism, as presented in Chapter 2.

Respondent Profiles

Twenty-one patients were interviewed at the three research sites in person or via email. Although 21 might be considered a small sample size for many studies, for this study, it is a sufficient size due to the study's nature and goals. The strength of this sample size is that each interview was in great detail. We were able to spend 2-3 hours with many of the patients knowing that I had a small sample size. Many of the patients were also very eager to talk to the researcher due to the fact that they were in a foreign country and they felt comfortable to speak with someone familiar with their place of origin.

Some quantitative analysis is conducted in this research, however, a significant portion of the analysis and data comes from the qualitative questions. A small sample size enabled the research to conduct in depth interviews to gain a proper understanding of the factors involved in a medical tourist's behavior. In the research limitations sections, we will discuss some of the possible weaknesses of the small sample size.

Of the 21 patients in this research study, all but one patient completed the questionnaire. One patient answered the quantitative portion of the questionnaire but did not attempt the qualitative portion. Of the 21 patients, 11 were male and 10 were female.

Figure 3.6 illustrates the average age of the patients and the average age of patients by gender. The average age of the respondents was 45 years. The average age of the male respondents was 43 years, while the average age of the female respondents was 47 years. On average, females were 4 years older than men.

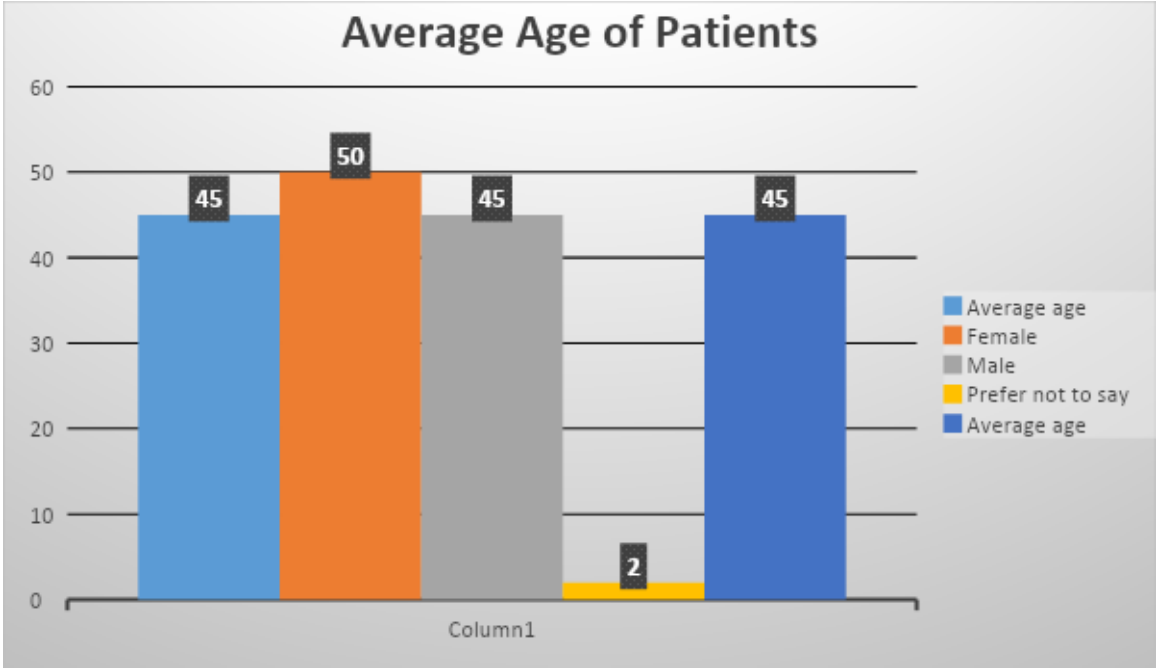


Figure 3.6 Average age of Responders

Figure 3.7 illustrates the source country of the medical tourists. Approximately two-thirds or 7 of the 21 respondents were from the United States. Seven patients each came from the Canada. Two patients each came from Malaysia and Brazil. One patient came from each of the countries of Guam, Ukraine, Bhutan, Nepal, Indonesia, Philippines, South Korea and Russia. Of the 21 patients, only one came from a developing country (Nepal) Based on the particular health care facilities where these Interviews were conducted and the existing medical tourism literature, it may be reasonable to conclude that the majority of foreign patients come from developed countries.

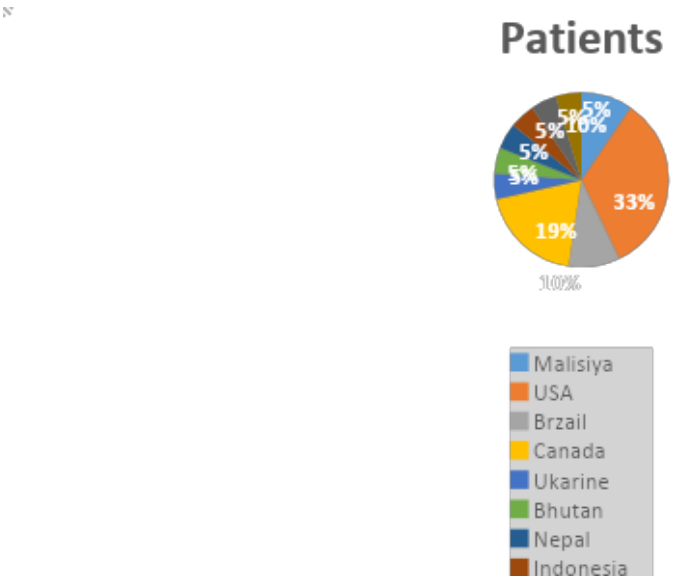


Figure 3.7 Patients Origin

The researcher did not specifically ask any of the patients' questions regarding their race, ethnicity, profession or salary. Although relevant, we wanted to respect their privacy as much as possible. In some cases, the patients themselves revealed their profession, but the other information was never divulged.

Chapter 4 - Data Analysis and Discussion

This chapter analyses and discusses the data gathered to answer the research questions: 1) How do the attitudes and behaviours of patients towards medical tourism influence their decision to become a medical tourist?; 2) Why do medical tourists seek treatment in India?; and 3) What are the issues and challenges they face before coming to India as well as while in India, and what is the patients' level of knowledge on the topic? Data from the interviews, both patient and administrative, also provide a broad overview of medical tourism in general and India in particular.

Patients' Attitudes and Behaviours towards Medical Tourism

The first objective of this dissertation was to explore how the attitudes and behaviours of respondents influenced their decision to become medical tourists. All respondents in this study were medical tourists either during or had been before the time of survey. Respondents were asked a series of questions and their responses were recorded using the Likert Scale with values ranging from 1 to 7. The Theory of Planned Behavior (TpB) (Ajzen, 2006) was then used to predict a medical tourist's future behavior/intention based on three antecedents: direct attitude about becoming a medical tourist (behavioural factors), direct subjective norm or the opinions of people close to the medical tourist (normative factors), and direct perceived control or the medical tourists' perception about being able to partake in the behavior (control factors).

TpB Component	Mean	Std. Deviation
Direct attitude	6.40	.81
Direct subjective norm	5.59	1.76
Direct perceived control	6.68	.80
Intention	6.53	1.18
Indirect attitude	5.46	1.19
Being able to save money	5.82	1.48
Medical treatment covered partially by insurance	3.62	1.47
Getting prompt medical treatment	5.35	1.14
Getting medical treatment not approved in the US	6.11	1.41
Getting private and anonymous medical care	4.00	1.48
Being able to travel and vacation	5.45	1.49
Getting treatment at a high quality facility	6.38	.62
Getting treated by competent and well-trained doctor	6.72	.43

Other attitudes		
Concern over the severity of the health condition	4.97	1.94
Concern over the cost of the procedure	4.71	2.26
Idea of using recovery time to travel after treatment	5.79	1.77
Recommendation from family physician to travel	3.67	2.17
Traveling for pleasure on the same trip	5.24	2.27
Price of the treatment is most important factor	4.32	2.01
Shopping while on the trip	3.18	1.74
Travel abroad over taking a loan in home country	5.30	2.22
Travel for 12-24 hours on a plane to save money	5.09	2.13

Table 4.1 Descriptive Statistics for the Theory of Planned Behavior Components

The descriptive statistics for the different influencing factors are listed in Table 4.1. Intention to pursue medical tourism was measured for each respondent by one opinion-type question: "If the option for me to travel to a developing country to receive a medical treatment were available to me, I would consider it and want to learn more about it." The mean response was a 6.53 with a standard deviation of 1.18 (1 = strongly disagree, 7 = strongly agree). With 4 being the mid-point, a 6.53 is very near the "strongly agree" end. Therefore, most patients were strongly in favour of considering and learning about treatment abroad if it were available to them.

First, a direct attitude score was calculated using the mean of three responses to one question. Here, one question contains three possible responses with different word choices in order to get a more accurate response: "For me, traveling to a developing country to receive medical treatment is" (1 = harmful, 7 = beneficial; 1 = unpleasant, 7 = pleasant; 1 = bad, 7 = good). The mean response was a 6.4 with a standard deviation of .81. With 4 being the midpoint, a 6.4 is much closer to the positive side of the response. Therefore, most patients regarded traveling to a developing country to receive medical treatment as beneficial/pleasant/good.

Second, a direct subjective norm was analysed with the question: "Most people who are important to me would (1 = disapprove, 7 = approve) of my traveling to a developing country to receive medical treatment." The mean was 5.59 with a standard deviation of 1.76. With 4 being the mid-point, a 5.59 is nearer to approval. Therefore, it is the patients' beliefs that most people who are important to them will approve of them receiving medical treatment in a developing country.

Third, direct perceived control was measured with the question: “If I wanted to travel to a developing country to receive medical treatment, I would be able to do it” (1 = definitely false, 7 = definitely true). The mean was a 6.68 with a standard deviation of .8. With 4 being the mid-point, a 6.68 is very near the “definitely true” response; therefore, the perception of the patients is that if they wanted to travel to a developing country to receive medical treatment, they would be able to do it.

These results show that all three TpB antecedents (direct attitude about becoming a medical tourist, direct subjective norm or the opinions of people close to the medical tourist, and direct perceived control or the medical tourists’ perception about being able to partake in the behavior) factor into the decision making process of a medical tourist. The most important factor was the direct perceived control with a mean of 6.68. The patients felt strongly that if they wanted to travel to a developing country for medical treatment, they could. The second most important antecedent was direct attitude with a mean of 6.40. They also felt that getting medical treatment in a developing country would be beneficial, pleasant, and good. The third most important antecedent was direct subjective norm with a mean of 5.59. Most people who are important to the patients would approve of them traveling to a developing country for treatment; however, the approval would not be very strong. This is expected because people from developed countries might view the economic and physical conditions of developing countries to be poor. So, they might not be as supportive to approve of a family member traveling to a developing country for treatment. Finally, the intention to learn more about and pursue medical treatment abroad if available to them had a mean of 6.53. With such high means for two of the antecedents (direct perceived control and direct attitude), positive support for the third antecedent (direct subjective norm), and a high mean for intention, we can confidently state that these patients might actively pursue medical treatment abroad if the need or opportunity arises.

Next, the patients were provided with several two-part items addressing their indirect attitudes toward more specific aspects medical tourism. Each item had two questions: the first dealt with a behavioural belief (an estimation of a specific outcome’s possibility) and the second asked for an outcome evaluation (an assessment of that particular outcome’s positivity or negativity). The items that were tested were: saving money, medical treatment partially covered by insurance, getting prompt medical treatment, getting medical treatment not approved in the U.S., getting private and anonymous medical care, being able to travel and vacation, getting treatment at a high quality facility, and getting treated by a competent and well trained doctor.

Item one was about saving money. When asked, “Traveling to a developing country to receive medical treatment saves money compared to getting the same treatment in the U.S.” (1 = extremely unlikely, 7 = extremely likely), the mean was a 6.12 with a standard deviation of 1.51. A 6.12 is close to the “extremely likely” response, which means that patients believe that they can save money by traveling abroad for a similar treatment at home. The second question of the item asked for patients’ assessment of the outcome of saving money: “For me

to save money is" (1 = extremely bad, 7 = extremely good). The mean was a 5.52 with a standard deviation of 1.82, which indicates that saving money is somewhat important for the patients in this case. One would expect that saving money might be most important; however, these particular patients had dealt unsuccessfully with their ailments for a long time, and their primary goal was finding a successful treatment rather than finding an inexpensive one. This might suggest that, although money matters, saving it might not be the single biggest factor in a medical tourist's decision making process. Overall, the mean for the questions related to "saving money" was 5.82 with a standard deviation of 1.48, which suggests that it is an important factor in the decision making process of a medical tourist.

Item two concerned medical insurance. When asked, "My insurance company paying for my traveling to a developing country to receive medical treatment is" (1 = extremely unlikely, 7 = extremely likely), the mean response was a 1.58 with a standard deviation of 1.17, which means that very few of the patients expected any financial assistance from their insurance companies. The second question of the item was: "For me to have my medical treatment covered partially by my insurance is" (1 = extremely bad, 7 = extremely good). The mean response was a 5.39 and the standard deviation was a 2.15, which suggests that patients would like to be covered by their insurance but they did not necessarily feel very strongly about this. One would expect that everyone would assess insurance coverage extremely positively, but, again, the responses given might have been impacted by the patients' conditions. If their conditions were severe and treatment costs were not covered in the U.S., they might have lost any hope they might have had for insurance coverage. Overall, the mean for the questions related to "insurance coverage" was 3.62 with a standard deviation of 1.47, which suggests that the patients were not dependent on their insurance to have any positive or negative impact on the overall costs of their medical treatment.

The next item dealt with the promptness of treatment. The first question asked: "Traveling to a developing country to receive medical treatment sometimes allows a person to receive faster medical treatment than getting the treatment in the U.S." (1 = extremely unlikely, 7 = extreme likely). The mean response was a 5.42 with a standard deviation of 2.04. With 4 being the midway point, a 5.42 suggests that the patients believe that sometimes it is somewhat likely that they could receive treatment faster in a developing country than in their home country. One might reasonably assume that in most cases, a person would receive medical treatment faster in a developed country than in a developing country. However, this would also depend on the patients' ailment and whether their home country offers any treatments for that particular ailment. The second question of this item asked: "My ability to get prompt medical treatment when I want or need it is" (1 = extremely bad, 7 = extremely good). The mean response was a 5.18 with a standard deviation of 2.03. This implies that many of these foreign patients seeking treatment abroad believe that their ability to receive prompt treatment in their home country is somewhat good but not necessarily exceptional. One might assume that people in a developed country receive very prompt treatment. That could again depend on the ailment and the specific health care system in that country. For example, some nonessential treatments in some western European countries where they have socialized medicine have long wait times. Therefore, some patients from those countries

might choose to go abroad to have that ailment treated immediately rather than wait in their home country. Overall, the combined mean for promptness of treatment was a 5.35 with a standard deviation of 1.14. This suggests that these patients believe that most people in developed countries will receive prompt treatment; however, there will be a few people who will not receive treatment in a reasonable amount of time.

The next item asked about treatments that were not approved in their home countries. The first question asked: "Being able to get a medical treatment that hasn't been approved in the U.S. by going to a developing country is" (1 = extremely unlikely, 7 = extremely likely). A mean of 5.94 with a standard deviation of 1.55 suggests that the patients feel that it is likely that they could get procedures done in a developing country even if it was not approved in their home country. The second question asked patients: "For me to be able to get a medical treatment that hasn't been approved in the U.S. if I want it is:" (1 = extremely unimportant, 7 = extremely important). The mean was 6.33 and the standard deviation was 1.45. A mean of 6.33 is very near to the extremely important end. Therefore, the idea of getting treatment abroad even it is not approved in the patient's home country is for the most part extremely important. Overall, the combined mean for getting treatment in a developing country for an unapproved procedure in their home country was a 6.11 with a standard deviation of 1.41. This suggests that the patients are willing to go to a developing country to receive treatment for a procedure that is not approved in their home country. If patients are willing to take certain risks to do it, it speaks to the severity of their ailments and also their risk taking as a last resort.

The next question pair dealt with the issue of privacy. The patients were asked: "Getting private and anonymous medical treatment in a developing country is" (1 = extremely unlikely, 7 = extremely likely). The mean response was a 5.41 with a standard deviation of 2.19. A mean of 5.41 suggests that it was somewhat likely that they would receive private and anonymous medical treatment in a developing country. Being thousands of miles away from their home country definitely enables patients to keep their medical treatment anonymous from most people they might regularly associate with at home. The outcome evaluation question asked the patients: "For me to be able to get medical treatment privately and anonymously (without people knowing what procedure or treatment I had) is" (1 = extremely unimportant, 7 = extremely important). The mean response was a 2.59 with a standard deviation of 2.24. With 4 being the mid-point, a 2.59 suggest that receiving private and anonymous treatment is unimportant to most of these patients. This may be because most of the people familiar with them might already be aware of their ailments. Also, most of the treatments that these patients are receiving do not suffer from societal judgment. Overall, with a mean of 4 and a standard deviation of 1.4, the idea of receiving private and anonymous treatment in a developing country does not seem to carry much weight for these patients.

The next question pair asked the patients about the idea of vacationing during their medical trip. The first asked: "Being able to vacation and see a developing country while I am there to receive a medical treatment is" (1 = extremely unlikely, 2 = extremely likely). The mean response was a 4.62 with a standard deviation of 2.43. A mean of 4.62 suggests that the

patients thought that it was slightly more likely to vacation on their trip while also receiving treatment. However, the mean is very close to the mid-point, which also suggests that many of them thought that vacationing during their trip might not be likely. When asked: “For me to be able to travel and have the opportunity to vacation and see a developing country is” (1 = extremely bad, 7 = extremely good), the mean response was a 6.29 with a standard deviation of 1.08. The high mean suggests that having the opportunity to vacation during the trip was very good regardless of its possibility. Overall, the mean was a 5.45 with a standard deviation of 1.49, which suggests that patients wanted to travel and vacation on their trip, but did not necessarily feel strongly about it (Table 4.1).

The next question pair addressed quality of the medical facility. The first asked: “Finding a high quality private medical facility in a developing country is” (1 = extremely unlikely, 7 = extremely likely). The mean response was a 6.85 with a standard deviation of .35. The high mean suggests that the patients felt that it was extremely likely that they could find high quality private medical facilities in developing countries. The second question asked: “For me to get medical treatment at a facility that is of high quality is” (1 = extremely unimportant, 7 = extremely important). The mean was a 6.27 with a standard deviation of 1.09. A 6.27 is a high enough mean to suggest that most patients feel that receiving medical treatment at a high quality facility is quite important to them. Overall, when it comes to quality of the treatment facility, the mean was a 6.57 with a standard deviation of .62, which suggests that it is an important factor.

The last item dealt with the quality of the doctor. The first question was: “Finding a very competent and well-trained doctor in a developing country is” (1 = extremely unlikely, 7 = extremely likely). The mean response was a 6.5 with a standard deviation of .88. A 6.5 is again a high mean, which suggests that the patients thought it was extremely likely that they could find a doctor of high quality in a developing country. The second question asked: “For me to have a very competent and well-trained doctor is” (1 = extremely unimportant, 7 = extremely important). The mean was a 6.94 with a standard deviation of 1.09. Again, the mean is on the higher end, which suggests that it is important for the patients to have a high quality doctor. Overall, regarding the quality of the doctor, the average mean was a 6.72 with a standard deviation of .43, which suggests that most of the patients felt strongly that they needed to and could find a competent and well-trained doctor in a developing country (Table 4.1).

Among the patients’ more specific beliefs about medical tourism, two factors were rated very high. Being treated by a competent and well trained doctor was the most important factor (mean = 6.72). The next most important factor was being treated at a high quality facility (mean = 6.38). The third most important factor that also rated high was getting treatments that were not approved in their home countries. After the top three factors, being able to save money (mean = 5.82) was important but not very important. Being able to travel and vacation during the same trip (mean = 5.45) and getting prompt medical treatment (mean = 5.35) were also important factors. Finally, getting private and anonymous medical care (mean = 4.0) was

not an important factor, and having that treatment at least partially covered by their insurance (mean = 3.62) was also not an important factor.

Several additional questions were asked to assess other important factors that might influence the patients' decision to pursue medical tourism. These factors are: the severity of the health condition cost of the procedure, recovery time to travel after treatment, family physician's recommendation, traveling for pleasure, price being the most important factor, shopping, travel abroad versus taking a loan in their home country, and long travel time in order to save money.

The first question asked: "To what extent would the nature/severity of the health condition/medical procedure influence whether you were willing to consider traveling to a developing country to have it performed?" The mean was 4.97 with a standard deviation of 1.94 (1 = not at all, 7 = completely) which shows that the nature/severity of the health condition/medical procedure is somewhat of an important factor in a medical tourist's decision making process. This can be partly supported by some of the qualitative responses of the patients. Six of the 32 respondents (19%) listed the severity of the condition as one of three important factors that helped them consider pursuing medical treatment abroad.

The second question asked: "To what extent would the cost of the procedure influence whether you were willing to consider traveling to a developing country to have it performed (if cheaper in a developing country)?" The mean was 4.71 with a standard deviation of 2.3 (1 = not at all, 7 = completely). With 4 being the midpoint, a mean of 4.71 shows that the cost of the procedure is somewhat of an important factor in a medical tourist's decision making process. Nineteen of the 32 respondents (59%) mentioned lower cost of treatment as one of three important factors that helped them consider pursuing traveling to a developing country for treatment.

The next question asked: "The idea of using some recovery time after my treatment to travel within that country is" (1 = extremely unappealing, 7 = extremely appealing). The mean score was a 5.79 with a standard deviation of 1.77. A mean of 5.79 suggests that traveling after their treatment to explore the country is a very appealing idea. The literature review also shows that the medical tourism industry promotes the idea of traveling within a country after getting treated. However, most patients in this particular study were unable to travel in India after their treatment due to the nature of their ailments. Eleven of the 21 patients said that they had traveled or were planning to travel within the city, while only 10 of the 21 patients said that they had traveled or were planning to travel beyond the city. Most of these patients had to stay in their hospital rooms to recover from their surgeries/treatments, so tourism was not a major priority for them.

Another question asked: "A recommendation from my family physician to go abroad for treatment is" (1 = extremely unimportant, 7 = extremely important). The mean score was a 3.67 with a standard deviation of 2.17. Since a mean of 3.67 is very near the mid-point of 4, it can be concluded that the patients did not particularly care about what their family physician

thought about medical tourism. As per the literature review, many U.S. physicians are hesitant to recommend medical tourism to their patients due to perceived threats, both legal and economic. It is estimated that U.S. physicians might lose $162 billion due to Americans taking their health care needs abroad. It is not surprising that these patients who sought treatment abroad were not particularly interested in their family physician's opinion regarding treatment abroad.

The next question asked: "Besides medical treatment, traveling for pleasure on the same trip to me is (1 = extremely unappealing, 7 = extremely appealing). A mean of 5.24 with a standard deviation of 2.27 suggests that traveling for pleasure on the same trip is somewhat appealing to these patients.

Another question asked: "The price of the medical treatment is the most important factor for my treatment" (1 = definitely false, 7 = definitely true). The mean response was a 4.32 with a standard deviation of 2.01. A mean of 4.32 suggests that the price of the medical treatment is not the most important factor for their treatments. This probably has to do with the fact that most of these patients either had no insurance or the procedures were not covered abroad if they had insurance. Also, the cost of the treatments in India is significantly less than in their home countries. Therefore, the cost of the treatment was not the most important factor.

The next questions asked: "If I travel abroad for medical treatment, shopping in that country for me is" (1 = extremely unimportant, 7 = extremely important). The mean response was a 3.18 with a standard deviation of 1.74. A 3.18 mean is below the mid-point of 4, which suggests that shopping is not important for these patients while they are in India for treatment.

Another question asked: "If I cannot afford a particular type of treatment that is life threatening in my home country, would I rather take out a loan and have the treatment done in my home country, or will I go abroad to a developing country for treatment if it is affordable" (1 = extremely unlikely, 7 = extremely likely). The mean response was a 5.3 with a standard deviation of 2.22. A mean of 5.3 suggests that it is likely that these patients will go abroad to a developing country for treatment rather than take out a loan for an expensive surgery in their home country. Again, this shows that if the cost of the treatment in their home country is too expensive, then cost becomes a factor. However, if it is less expensive in a developing country, even if still relatively expensive, these patients are willing to spend the money.

The last question in the Likert Scale section asked: "I would travel abroad on a plane for 12-24 hrs to attain medical treatment if I can save a few thousand dollars" (1 = extremely unlikely, 7 = extremely likely). The mean response was a 5.09 with a standard deviation of 2.13. A mean of 5.09, which is past the midpoint of 4, suggests that it is likely that the patients are willing to travel for long times in order to save money. However, it is not significantly past the mid-point of 4, which suggests that saving money in these specific cases is important but not necessarily extremely important.

Of these additional factors, the idea of using recovery time to travel after treatment (mean = 5.79) was quite appealing. Next, it was likely that the patients would rather travel abroad for affordable treatment instead of taking out a loan in their home country (mean = 5.3). Traveling for pleasure on the same trip was also somewhat appealing (mean = 5.24). Traveling on a long flight to save a few thousand dollars was also somewhat likely (mean = 5.09). Concern over the severity of the condition was also somewhat of an important factor when deciding whether to travel abroad for treatment (mean = 4.97). Cost was also somewhat important (mean = 4.71). However, cost of the treatment was not the most important factor (mean = 4.32). Recommendation from a family physician (mean = 3.67) and shopping while on the trip (mean = 3.18) were not important factors in the decision making process of these medical tourists.

For the first objective in this study, discovering how the attitudes and behaviours of patients towards the concept of medical tourism influence their decision to become a medical tourist, all three TpB antecedents (direct attitude, subjective norm, and perceived control) had means closer to the positive end, which means that these medical tourists are likely to partake in medical tourism in the future if the need or opportunity arises.

Based on the means of the patients' responses, the most important factor was direct perceived control with a mean of 6.68. The patients felt strongly that if they wanted to travel to a developing country for medical treatment, they could. The second most important factor was direct attitude with a mean of 6.40. Their feelings about getting medical treatment in a developing country were beneficial, pleasant, and good. The third most important factor was the direct subjective norm with a mean of 5.59. Most people who were important to the patients would approve of them traveling to a developing country for treatment. Finally, intention to consider medical tourism had a mean of 6.53. Patients were very interested in learning more about and pursuing medical treatment abroad if available to them. With such high means for two of the antecedents (direct perceived control and direct attitude), positive support for the third antecedent direct subjective norm), and a high mean for intention, we can confidently state that these patients might actively pursue medical treatment abroad if the need arises.

Data from the questions about patients' indirect attitudes regarding specific beliefs and medical tourism showed the most significant one was "getting treated by competent and well-trained doctor," with a mean of 6.72. The second most important factor was "getting treatment at a high quality facility" with a mean of 6.38. The third most important factor was "getting medical treatment not approved in the US" with a mean of 6.11. The fourth most important factor was "being able to save money" with a mean of 5.82. The fifth most important factor was "being able to travel and vacation" with a mean of 5.45. The sixth most important factor was "getting prompt medical treatment" with a mean of 5.35. "Getting private and anonymous medical care" received a neutral mean score of 4. "Medical treatment covered partially by insurance" received a mean of 3.62 which means that patients did not expect to be covered by their insurance plans.

Several additional questions assessed other important factors that might influence the patients' decision to pursue medical tourism. Listed in the order of importance based on mean responses are: recovery time to travel after treatment (5.79), travel abroad versus taking a loan in their home country (5.30), traveling for pleasure (5.24), long travel time in order to save money (5.09), concern over the severity of the health condition (4.97), cost of the procedure (4.71), price being the most important factor (4.32). Other factors that received negative responses were: family physician's recommendation (3.67), and shopping (3.18).

Why Medical Tourists Seek Treatment in India

The second half of the survey contained several qualitative and open-ended questions that addressed the second research question: Why do medical tourists seek treatment in India? What are the issues and challenges they face before coming to India as well as while in India and what is the patients' level of knowledge on the topic? Open-ended questions asked the patients to more extensively share their opinions and thoughts on various issues regarding medical tourism, allowing the respondents to go beyond numeric answers. We asked the patients to list the three primary reasons (from most important to least important) they chose India for medical treatment (Table 4.2). Most patients provided three reasons, but a few gave only one reason and two gave no reasons.

Reason for going to India for treatment	1st most importance	2nd most importance	3rd most importance	Total
High quality of doctors and facilities	12	7	3	22
Cost	6	10	3	19
Availability of specific treatments	6	4	5	15
Pain alleviation	3	1	2	6
Superior customer service	1	2	3	6

Personal recommendations	2	0	1	3
Family presence in India 0 3 0 3	0	3	0	3
Online research	1	1	1	3

Table 4.2 Top three reasons listed by patients for their travel to India for Treatment

High quality of doctors and facilities

Twelve out of the 21 respondents said that the most important factor was the expertise of the doctor and the medical facilities in India. They believed that they were going to see the best doctor, in the best facilities. Another seven patients listed the above reason as the second most important reason while three patients listed it as the third most important reason for their decision. Overall, 9 patients listed the competence of the doctor and the superiority of the facilities as one of three reasons that helped them make up their mind to come to India for treatment.

Many patients were extremely positive about the health care personnel (physicians, nurses, administrators, and other people) they met in India while seeking treatment there. One patient said, “Treatment here is professional, honourable, very much from the heart.” Added another patient, “The doctors were amazing, the hospital clean, and the staff talented and friendly.” Another patient discussed how wonderful the entire staff was and how kind and attentive they were.

Another patient said,

Dr. X in India performed my surgeries. He was an amazing surgeon and a wonderful human being. I went alone to India, not knowing anyone, and not knowing anything about where I was going. From the moment I was met at the airport until the time I left India, 27 days later, I was treated amazingly well by everyone I met – at the hospital, at the resort I recovered at and above all, by Dr. X and his staff – and meeting and having dinner with him and his family at their home was the highlight of my trip.

Some patients’ treatments in India were life changing. One patient said, “I am forever grateful to Dr. X for giving me back a functional life without pain. I lived in hell for 12.5 years with my condition before I went to India.” Another patient who used to have a very active life style before his ailment boasted he can once again snowboard, ski, surf, run, and hike regularly. Another patient said, “I feel that the treatment I received in India will allow me to lead a much fuller life than I would have been able to had I gotten an FDA approved

device in the US." One patient was extremely pleased about his physician. He said, "Dr. X and his staff gave me my life back."

All patients of the holistic health centre were primarily there for preventative medicine. Ailments they presented included diabetes, depression, being overweight; some were there just to promote their general well-being. The health centre's holistic treatments such as Ayurveda and homeopathy was the primary draw for medical tourists. Many of the patients interviewed here felt that modern medicine alone did not satisfy their health needs. One patient said she was "completely stuck in her body and couldn't help herself anymore." She felt that something had to be done outside traditional western medicine, which is what brought her to the holistic health centre. The use of both nature and holistic medicine in the setting forms the therapeutic landscape basis for treatment.

Another patient said:
My surgeon took a lot of time with me before I ever decided to travel to have the work done, he was incredibly responsive, easy going, and had a command of the procedure and the ability to explain it in a way that not only could I as a PhD understand, but that my girlfriend who has less education could understand as well. I immediately felt at ease and knew I made the right decision when I sat down in his office.

Cost

Six respondents listed cost as the most important reason they chose India for treatment. Ten patients listed cost as the second most important reason for their decision, and three patients listed it as the third most important reason. Overall, 19 patients listed cost as one of three reasons they chose India for medical treatment.

The first question about cost asked the patients about the total cost of their treatment and stay. As Figure 4.1 illustrates, the minimum cost was $300 and the maximum was $16,000. The average cost for treatment and stay was $6,071. The patients who paid only $300 dental procedures.

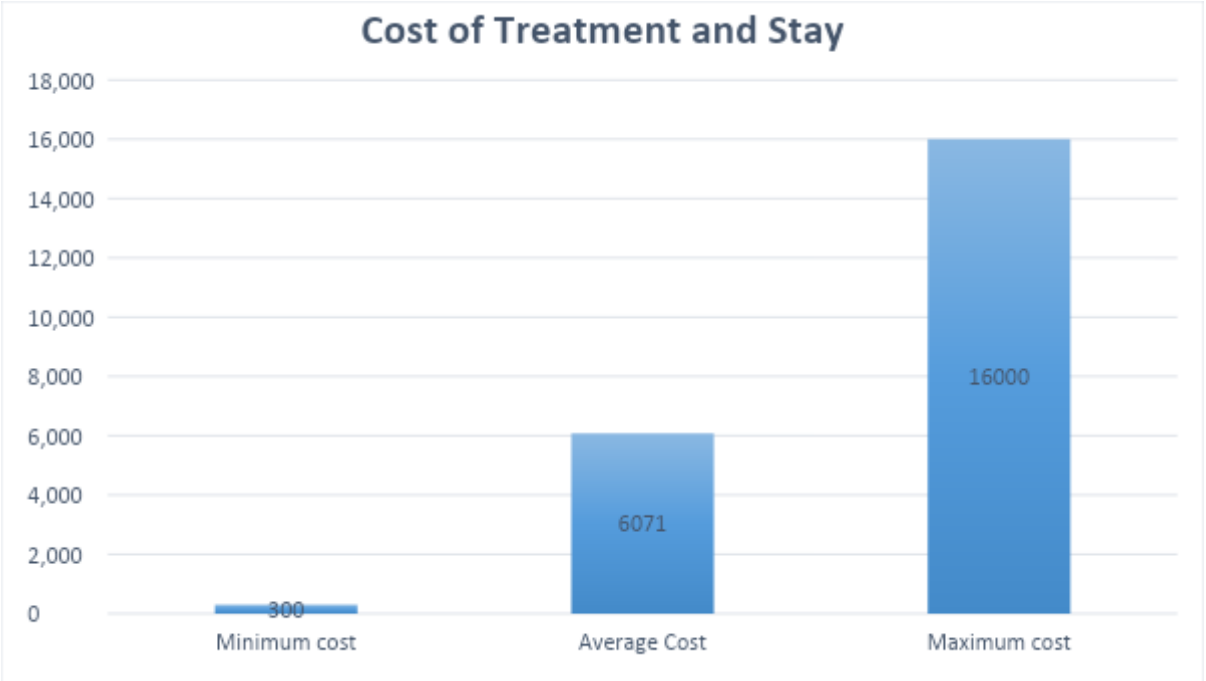


Figure 4.1 Cost of treatment and stay in India

As illustrated by Figure 4.2, total cost of the entire trip, including treatment, stay, airfare, and any other activities such as tourism and shopping, was an average of $9,376. The minimum cost was $1,700, and the maximum cost was about $18,600. A complete medical trip to India for under $10,000 is inexpensive relative to cost of the procedures in the U.S.

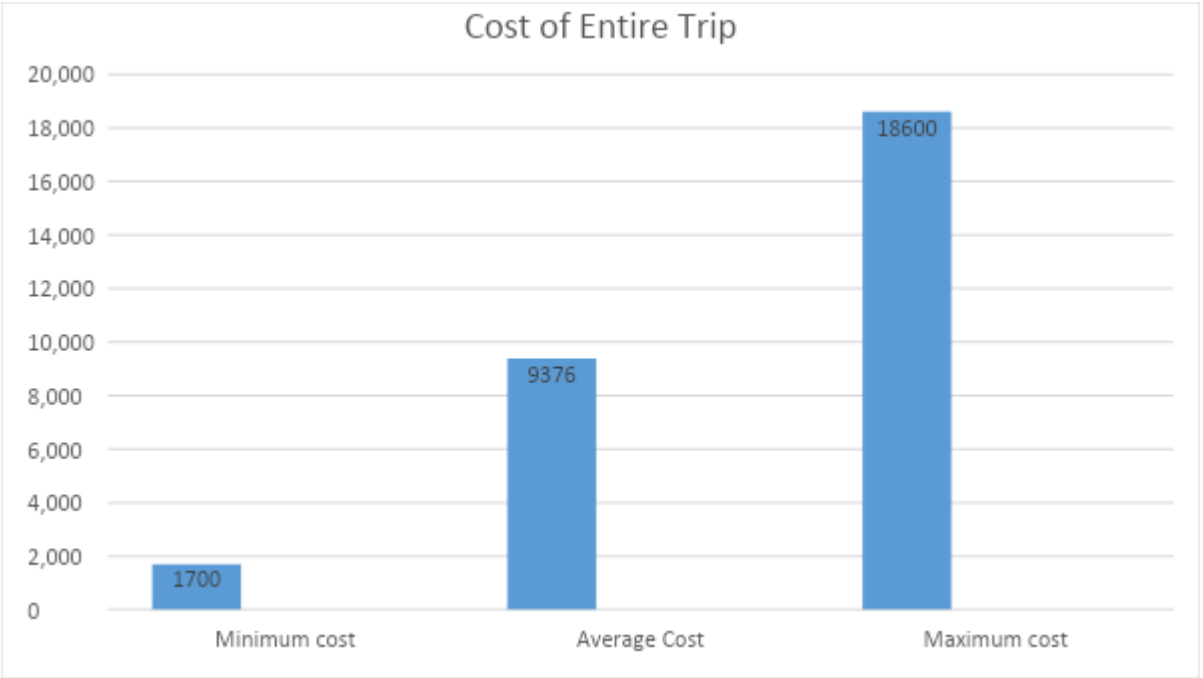


Figure 4.2 Cost of entire trip to India

Availability of specific treatments

Six respondents listed the availability of a particular treatment in India as the most important reason they chose India for treatment. Four patients listed availability as the second most important reason, and five patients listed it as the third most important reason. Overall, 15 patients listed the availability of a treatment as one of three reasons they chose India for medical treatment.

Among the study participants for whom availability was a primary factor for choosing India, most came for the Birmingham Hip Resurfacing procedure. This procedure was not FDA approved in the U.S. until 2006. Even after approval, many people still traveled to India for the procedure because the doctors in India had much more experience performing the procedure than their US counterparts. The second most common procedure linked to availability was treatment for repetitive strain injuries. The patients who came to India to be treated for this ailment mentioned that certain forms of these injuries were not even recognized as an ailment in the UK; hence, treatment there was unavailable. An administrator said that many of their patients came to their hospital with very severe problems – usually as a last resort. “We had a guitarist who couldn’t play any longer. We practice wellness treatment and preventative medicine which is not promoted in the US with these particular ailments.”

Pain Alleviation

Three respondents discussed their inability to perform daily activities comfortably due to their pain and their need to get it treated immediately, which they felt confident could be done in India. One patient listed the above reason as the second most important reason and two patients said it was the third most important reason. Overall, six patients listed too much pain as one of three reasons that helped them choose India for medical treatment.

Customer service

One respondent listed superior customer service as the most important reason for choosing India. Two patients listed it as the second most important reason and three patients listed it as the third most important reason. Overall, six patients listed superior customer service as one of three reasons that helped them choose India for medical treatment. Words used by the patients to describe the customer service include professionalism, human compassion, and fast response. Two patients mentioned that the doctors/facilities responded to their emails immediately and had everything set up within two days.

Customer care is one of the more important priorities of Indian facilities promoting medical tourism. Having doctors and nurses constantly available for foreign patients is very important. In the U.S., patients in many hospitals have only brief contact with doctors and nurses. By contrast, doctors in Indian hospitals that promote medical tourism make several

rounds in a day to check up on foreign patients. Nurses are also constantly available for the patients, often responding to room calls in less than a minute. This constant personalized care makes the patient feel comfortable and important. All hospitals we visited had this trait, and the respondents specifically mentioned how different it was from the U.S. One patient said, "Service in India was so over the top, very diligent, doctors do rounds every day, never frustrated in India because of how good they are. In the beginning, overly helpful – too much staff – too often – a little annoying but they took my feedback and now its better."

One hospital administrator said that satisfying one patient brings in more patients. He said, "Many times, we attract more patients by word of mouth. It is like a truck right now. It's hard to get it moving at first, but once it picks up a bit of speed, it gets really good."

Another administrator explained that customer service begins not in the hospital but upon initial contact, which is often an email from prospective patients. Immediately, the administrator sends as much information as possible in order to clear up any misconceptions and to provide a holistic image of their choices. This administrator said, "Everything we do is to satisfy the patient." They cannot control reality on the outside – slums, traffic, etc. However, once patients are inside the hospital, the administrator can control the patients' surroundings. Administrators must take into consideration cultural differences when thinking about meeting the needs of foreign patients.

One administrator mentioned that although many of their patients prefer to make their own flight arrangements, the hospitals also offer to make these arrangements. As soon as a treatment date is set, the hospital can book the best available flight for the patient. They also send out information regarding how to prepare for the long trip. Once the patients arrive in the India, the hospital has a representative waiting to greet the patient in the international arrivals area of the airport. The patient is quickly taken in an air conditioned car to the hospital. Once in the hospital, the patient gets regular attention from the doctors and nurses. If the patient wants to travel locally, the hospital usually makes all the arrangements. If the patient wants to travel within India, the hospital puts the patients in touch with a tour company that can make all the arrangements. All this of course is done prior to the patient arriving in India.

One patient reflected on this excellent service she received upon landing in India. She was greeted and picked up at the airport by a pre-arranged hospital car, taken to her hotel for the night, and then taken to the hospital the very next day for her initial consultation with the doctor. She also said, "I had such a positive experience with Dr. X and his staff – the entire staff was so humble and kind. They exuded a passion for their work, from the doctors and nurses, to the dietitians and PT's." After her surgery, she was given the telephone number for the surgeon and was advised to call him at any time if she had any problems whatsoever.

Personal recommendations, family support, and research

Two respondents listed personal recommendations as the most important reason they chose India for treatment. No one listed the above reason as the second most important reason while one respondent listed it as the third most important reason. One patient specifically said, "Almost five years after my surgery, I still get calls from people about information and my experience in India." Overall, three patients listed personal recommendation as one of three reasons that helped them choose India for treatment. One respondent each listed online research about their ailment as the first, second, and third most important reason that helped them choose India for treatment.

Examining the concept of therapeutic landscape in medical tourism

When asked the question "What did you like about coming to India," the patients provided many different answers. The most common response was the amicable nature of the people in India, the medical staff and locals alike. Words used to describe the people included compassion, nice, friendly, loving, gracious, warm, and welcoming. The second most commonly cited response was the value and quality of the treatment, both medically and professionally. Several patients mentioned how nice the doctors, nurses, and medical staff were and also how good the hospital facilities were. Some of them mentioned that the hospital rooms were very large and clean and felt like an upscale hotel room.

In examining the concept of therapeutic landscape in relation to medical tourism, and India's medical tourism in particular, it is important to note that many of the hospitals/wellness centres took great pride in the physical appearance of the rooms and facilities. A therapeutic setting, whether inside or outside the patient's room, may speed up the recuperation process. A calm, inviting, and comfortable place may put a patient at ease and make the process of recovering a bit less stressful.

The difference in environment between an international ward where most foreign patients were and a local ward was pronounced. The local wards were readily accessible, but the international wards were restricted. The hallways in the international ward seemed larger and were well decorated. By contrast, the local wards were congested. Rooms were much closer to each other in the local wards and more people were both in the hallways and the rooms. Although the local wards did have some single rooms, the majority were small with two patients sharing the room. The rooms in the international ward contained one bed per room. Some rooms contained two beds, but one was for a significant other, not a fellow patient.

The larger rooms in the international wards were also well decorated. All of the rooms contained large televisions and several paintings and ornamental plants. The rooms appeared more like a hotel room than a hospital room. The rooms were spacious, clean, and inviting. Describing his room, one patient said, "My room was very clean, well-lit and comfortable. I also had a computer and a little kitchenette." Several patients expressed surprise at how nice the rooms were. They felt very comfortable with the accommodations they had. Making a room inviting and therapeutic rather than sterile and cold may make a difference in the mind-set of a recovering patient. Hospital administrators mentioned the importance of an

inviting and upscale setting for these foreign patients. Since many of them are from developed countries, the administrators believed that the patients would feel very comfortable in a setting they were familiar with. One administrator mentioned, “We try to have fresh cut flowers in their rooms as frequently as possible.”

At one hospital, patients often recovered in resorts on the beach after their surgeries. One patient said, “The stay at the resort was like being in paradise – I had a great room a few hundred yards from the beach, wonderful vegetarian food and again, a very friendly staff that spoiled me.” She had her surgery at the hospital, and then was transferred to the beach resort for 10 days. She had to then go back to the hospital for a three-day follow up treatment and was again brought back to the resort for the final week of her stay in India.

The concept of a therapeutic landscape is important to some aspects of medical tourism. Hospitals that promote medical tourism strive to make their facilities world-class and as inviting as possible for foreign patients. Creating therapeutic landscapes for patients may help in their overall health and recovery.

Another common response to the question “What did you like about coming to India” was the value of the trip and products in India. Patients said that their food and services were cheap. Several patients also cited the rich history and culture of India as a rewarding experience.

U.S. vs. India in health care

Yet another reason these patients chose India for their health care needs may be negative experiences with or perceptions of the U.S. health care system. Although the patients had some complaints about their trips to India, they had significantly more complaints about the U.S. health care system. One patient said, “Medical care in U.S. is sub-standard and the FDA is a “for profit” government entity that does not serve the people that pay taxes to have it exist. The government is a business...and a fraudulent one at that!”

Another patient also had a bleak assessment of the health care system in the U.S.

> I had insurance but they refused to pay for anything and I went against my doctor's recommendation. I was paying $900 per month for family coverage at that time but I cancelled it immediately upon my successful surgery in India. I have been uninsured since my return from India because I have lost all faith and confidence in our health care system.

Another patient was extremely impressed by what she experienced in India as opposed to her experiences in the U.S. She said:

> I am a nurse and I have to say that patients get much better treatment in Indian hospitals than in any U.S. hospital I've seen. The nurse to patient ratio is 1 to 3, an RN slept in my room on a fold out bed the first night. If I made the slightest noise she was on her feet at my bedside immediately. The nurses were extremely well trained and

> competent. Because their patient load was manageable, they weren't stressed out. They spoke of nursing as a profession and a vocation rather than a job – they had a quality of devotion that they brought to their practice. I still reflect on their care as a model in my own practice.

Another patient said this:

> India has the medical business figured out and offers service on the professional and staff levels that is impossibly good. I believe that the availability of very, very skilled physicians with great bedside manners is a huge thing. Today in the U.S., physicians are distracted, often not as skilled, and not as good at explaining what the procedure is, what the advantages and disadvantages are and so on.

Another patient also showed their displeasure with the U.S. health care system, saying that the U.S. was not always the leader in new medical technologies. She also said, “Medicine is a business: don't always assume the advice you get is in your best interest (it may be in the doctor’s or the hospital’s best interest).” This patient also felt that treatment received in the U.S. would have been far inferior to what she received in India. She said that, “Wonderful people and medical services await you in India. One must travel with an open mind and it pays to do lots of research up front, and speak with others who have made the journey before.”

One patient talked about the price difference for treatments between the U.S. and India, saying, “I don't understand some things like dental being very costly. The same can be obtained for not more than a couple of hundred dollars in India. I definitely encourage people looking into medical tourism.” Although cost of the treatment might not be a very important factor in choosing medical tourism for everyone, it is for some.

Another patient thought that the same treatment in India was better than what he might have received in the U.S. He said, “I'm lucky to not have insurance because I would have been fused in the U.S. which would not have been very flexible.”

Some patients brought up the issue of follow up care. One of the possible disadvantages of having treatment abroad is complications upon returning to their home countries. Many U.S. physicians and hospitals will be hesitant to treat patients who have had foreign treatment due to fear of lawsuits if further complications arise. However, one patient said that she was so pleased with her treatment in India that even if a complication arises once she is back in the U.S., she will travel back to India if needed.

Overall patient satisfaction

When asked if they had any regrets about coming to India for medical treatment, two out of 21 patients said yes. One patient did not elaborate and the other patient reported food poisoning on multiple occasions. Nineteen of the 21 patients were either satisfied or happy

with their decision to travel to India for health care. When asked if they would recommend medical tourism to a friend or family member, again, two out of 21 patients said no, the same two patients who had regretted coming to India for medical treatment. Nineteen of the 21 patients would recommend or strongly recommend medical tourism to a friend or family member based on their experiences in India.

Overall, medical tourists decided to come to India for treatment for several reasons. The high quality of doctors and facilities was the most important reason followed by the overall cost of treatment. The third most important reason was that they could receive specific treatments in India that might not be available in their home countries. Other reasons for patients choosing India as their medical tourism destination were: excellent customer service, support from their families to travel to India, and also having some negative experiences and opinions of the U.S. health care system.

Issues and challenges before and after coming to India

Medical tourists face numerous issues and challenges before traveling abroad for treatment. First and foremost, they have to check with their insurance companies to see if their treatments will be covered abroad. Although a few U.S. insurances will cover partial costs of treatments abroad, the overwhelming majority does not. Next, the patients have to be in regular communication with their facility/doctor in India in order to plan their trip. Often times, this can be stressful because most of these patients have never been to India before. The patients have to also figure out how long they are willing to spend in India based on the doctor's recommendation.

Once the patients are in India, although most issues have been taken care of, the patients have to deal with different cultural norms, different settings and generally a completely different atmosphere than what they are probably accustomed to. Upon arriving at the hospital, they have to mentally prepare for their treatments, often times a surgery. After the surgery, some patients might have the option of visiting the city or beyond the city, which they have to plan with the facility. This section looks at some of the issues and challenges that the patients faced before and after coming to India.

Planning and preparing for a trip to India

One of the questions in the survey asked patients, "How much of a problem was it for you to come to India for medical treatment?" Seventeen of the 21 patients said that they did not have many problems. Most of them cited the fact that the hospitals took care of most of the bookings for accommodations, food, and other services, which made their planning fairly simple. A few patients did mention that although the hospitals took care of most of the planning, it was nonetheless a stressful experience. Two patients also mentioned the fear of coming to a developing country for medical treatment.

Another question asked patients, “Who made all the arrangements for you to come to India?” Eighteen of the 21 patients made the arrangements themselves and/or with the help of the hospitals. Since the majority of patients did not have many problems coming to India as noted in their responses to the prior question, the hospitals must have been helpful indeed in making arrangements with and for the patients. In two cases, medical consulting companies that promoted medical tourism made all the arrangements for the patients.

Figure 4.3 illustrates the average amount of time patients spent in India. Patients spent between two to twenty weeks for their treatment; however, the average length of stay was approximately four and a half weeks long. Thirteen of the 21 respondents stayed between two to four weeks for treatment and only two patients stayed for longer than 10 weeks. Therefore, it could be said that most of the respondents had a short stay in India.

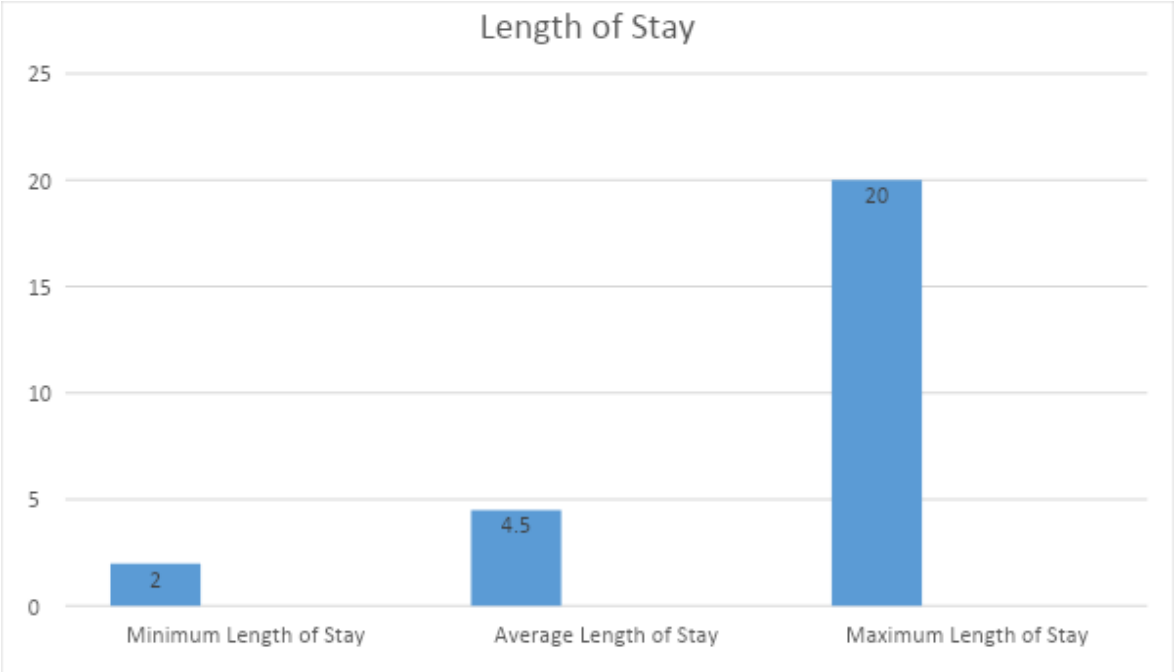


Figure 4.3 Length of stay in India (Weeks)

Health insurance and medical tourism

Figure 4.4 illustrates the number of patients that had health insurance in their country. Out of the 21 patients, 12 had health insurance coverage and 9 had none. One might expect to see mostly patients without health insurance traveling abroad for treatment since medical tourism literature cites a lack of health insurance as a primary motivator. Of the 12 patients who had health insurance, one patient had his entire trip (treatment, stay, flight) covered. Another patient had up to 70% of his expenses covered. Both these patients were from the U.S. A few insurance companies in the U.S. have started to cover treatments for patients who travel abroad. In some cases, a few insurance companies will even incentivize medical tourism by paying the patient an extra amount on top of all the expenses related to traveling because

treatment abroad is sometimes cheaper for the insurance company than what it would cost in the U.S.

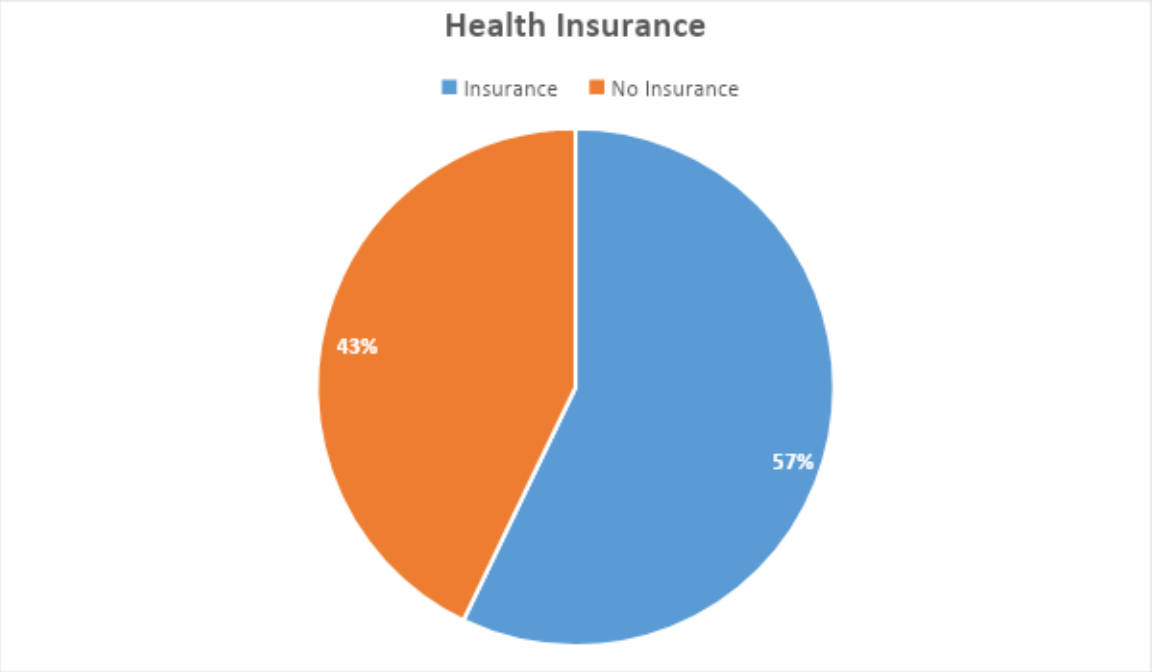


Figure 4.4 Fraction of patients with and without health insurance

The next question asked patients "if they would have been able to come to India without health insurance." All but one patient answered that they would have been able to come to India even if their health insurance would not have covered their trip. There could be several explanations for this. One reason could be that the patients were so desperate to get treatment that they would have come to India no matter what. Another possible reason could be that the procedures were elective and therefore not eligible for insurance coverage anyway. Another reason may be that patients were seeking non-FDA approved procedures, again not eligible for insurance coverage. Some patients choose to go to India even for an FDA-approved procedure because doctors in India might be more experienced with the procedure.

"Tourism" in medical tourism

Medical tourism is promoted in the media as traveling not just as a patient, but also as a tourist. When asked the question, "are you planning to do some tourism in India?" most patients said they were not. Ten of the 21 patients said that they might travel locally since they were already in the city. However, they mentioned that they were in no condition to do any serious traveling due to their recovery period. Eleven of the 21 patients said that they planned on traveling beyond the city where they received their treatments. However, for the majority of the patients, traveling was not an important aspect of medical tourism. This conclusion is further strengthened by their responses to the next question that asked patients if they came to India for medical treatment and/or to travel as well. 11 of the 21 patients said that they came to India primarily for treatment. Any sort of travel in India was not part of

their agenda at the time of planning. Ten of the 21 patients said that they had also planned on doing some travel while they were in India.

During the administrative interviews, one administrator mentioned that patients from developed countries started coming to India only in the last decade. With the medical tourism boom that was mainly media driven came more and more foreign patients from developed countries such as the U.S. and U.K. However, very few of these patients do any sort of serious tourism when visiting India as supported by the patient responses discussed above.

No respondent listed being able to visit and see India and its culture as the most important reason for choosing India for treatment. One patient listed the above reason as the second most important reason, and five patients listed it as the third most important reason. Overall, six patients listed being able to visit and see India and its culture as one of three reasons that helped them make up their mind to come to India for treatment.

Dislikes of coming to India for treatment

When patients were asked, “What do you not like about coming to India,” the traffic was the most common response. The roads had heavy traffic with a lot of noise and pollution. One patient said, “I'm walking down the street, crossing the street and wondering 'wow', I'm here for my health.” The streets were heavily crowded and dirty. One patient said, “it’s even a problem for an ambulance to get through the traffic which might be life threatening for the person in dire need of medical treatment.” In some cases, the streets were extremely unsanitary. Another dislike cited by the patients was poverty. Poverty could be seen everywhere and it was disheartening for some of the patients to see so many poor people on the street. A few patients complained about the food and having to deal with diarrhoea. A few patients mentioned that they did not like the fact that they had to travel half way around the world for medical treatment. The nearly 24 hours of flight time was extremely tiresome for some of the patients. One patient did worry about the possibility of complications arising upon returning home.

Several patients also complained about some of the personnel and facilities. One patient had a long list of complaints about one facility’s lack of organization. He felt that the facility needed to westernize and publicize its facility. The walls and cubicles were dirty. Also, he said that their facility needed a good PR agency to help promote them more clearly. However, the patient did say that once he got used to the “differences,” it was not so bad. Another patient complained about a facility’s lack of privacy. This patient felt that the facility, since it promoted medical tourism, should be more aware of the different cultures of their patients, which would enable them to meet the specific needs of their patients.

One patient complained about the lack of a treatment schedule saying she was not given any structure for her treatments and the facility’s concept of time was very fluid. Another patient

discussed arriving in India not knowing anything because the facility had not provided proper instructions. Upon landing, he did not have clear cut instructions on how to get to the facility. After finally reaching the facility, uncertainties regarding his treatment schedule remained. The patient suggested that the facility have an orientation for its foreign patients – where to buy food, basic necessities, etc. One patient also complained that his internet and electricity did not work at times, which was extremely frustrating. Some patients complained about their journey to India being both physically and mentally hard. It felt very lonely at times being away from family in an unfamiliar setting. Although the patients reported some negative issues related to medical tourism, nearly all patients were more than happy with the treatment they received and all but one of them would recommend medical tourism to a friend or family member.

Medical tourists' knowledge of medical tourism

Some of the survey's questions tried to gain an understanding of how much medical tourists knew about the overall concept of medical tourism. One of the questions asked where they thought most medical tourists travel to for medical treatment. Most respondents listed several countries as medical tourist destinations (Table 4.3). Of the 15 destinations listed by the respondents, seven were Asian countries and primarily in South/Southeast Asia. Three destinations were in Europe, three in North America and one in South America. Of the 21 respondents, 6 selected India as a medical tourism destination.

Destinations	# of Respondents
India	6
Philippines	1
European Countries	1
Srilanka	3
Romania	1
USA	1
Canada	1
South Korea	1
Singapore	1
China	2
Israel	1
France	1
Mexico	1
Brazil	1
Japan	1

Table 4.3 Patients' perceptions on medical tourism destinations

Medical tourism, internet and the media

The question "How did you hear about medical tourism?" garnered several different responses. Thirteen of the 21 respondents learned about medical tourism via the internet. According to medical tourism literature, one of the most common ways of promoting the industry is through websites. Three patients heard about medical tourism on the American television news magazine show *60 Minutes*. One patient heard about medical tourism on a Repetitive Strain Injury (RSI) website in the U.K. One respondent read about medical tourism in *Time* magazine. One patient heard about it when attending a support group in London. Other sources of information were friends, yoga teacher, medicine magazine, *Ayurveda* magazine, newspaper, family member, and television.

Since medical tourism has received a lot of media attention in the last decade, the administrators are well prepared for interviews. One administrator from a major hospital said that he had been either mentioned or directly interviewed by CBS's *60 Minutes* show and ABC's *20/20* show, and that FOX channel was also planning on interviewing him. Several of the patients that were interviewed mentioned that they found out first about medical tourism

from one of these news shows. The administrators also mentioned that many testimonials and interviews about their hospitals existed on YouTube and other video sharing websites. Web enabled marketing, one to one marketing, seminars, and trade shows were all being used to promote their hospital and medical tourism. According to Hopkins the internet has helped the medical tourism industry to grow. The internet has connected patients with hospitals where patients are able to schedule services, contact their doctors, and make travel arrangements and gather more information about the facilities.

Administrators' thoughts on medical tourism

Many administrators provided useful information on medical tourism. They discussed their opinions on the medical tourism industry, marketing, patient demographics, the process of setting up a medical tourist visit from the initial contact to the final step, and media coverage.

One administrator thought that although medical tourism is the name used to promote the phenomenon, there were more appropriate terms. One administrator said that rather than calling it medical tourism, he thought it should be simply "patients with passports." These patients did not care about shopping, visiting places, or touring the country. They came for treatment as the sole purpose of their visit. He thought that India should not be marketed as a destination for medical tourism, since tourism was not a priority of the patients they received.

The other administrator shared similar sentiments. He thought that many medical tourists who traveled to Thailand were medical tourists but not the patients that traveled to India. As a catch phrase, "medical tourism" was being used by everyone to promote the industry. In reality, the phrase only applied to specific countries with specific treatments.

Summary

The data presented several important factors for choosing medical tourism in India. Cost was not the most important reason, though it is advertised as such in the media; rather, the competency of the doctor and the quality of the care and hospital were more important reasons. Also, customer service was very important. The lower cost of treatments when compared to the cost in developed countries and specific treatments that are not approved in the U.S. were also important in attracting medical tourists to India.

Chapter 5 – Conclusion

This chapter summarizes the research findings, discusses the limitations, and examines the future of medical tourism. This study had three primary research objectives. First, it sought to understand how patients' attitudes and behaviours towards the concept of medical tourism influenced their decision to become a medical tourist. Second, it aimed to understand why medical tourists seek treatment in India; and third, what issues and challenges they face before coming to India as well as while in India; and the level of patients' knowledge regarding medical tourism? The Theory of Planned Behavior was used as the conceptual framework in answering the first objective.

A total of 21 patients were interviewed in person or via email at three hospitals/health care centres located in the south Indian city Hyderabad. A four-page questionnaire survey was administered to the 21 patients. The first two pages of the questionnaire survey consisted of Likert Scale questions with a scale of 1 to 7. The last two pages of the questionnaire survey consisted of short answer/open ended questions. Several hospital administrators were also interviewed to gain a better understanding of how they managed medical tourism at their facilities and their general opinions on the issue.

Summary

According to the TpB, human actions can be predicted based on three antecedents: behavioural beliefs, normative beliefs, and control beliefs. Behavioural beliefs reflect an individual's attitude towards the final outcome of traveling and receiving treatment abroad. Normative beliefs reflect the individual's perception of how others (family, friends, and peers) will view the idea of traveling abroad for health care. Control beliefs reflect the individual's personal view of the ease or difficulty of traveling abroad for health care. These three antecedents predict a patient's intention to partake in medical tourism in the future.

Based on the means of the patients' responses, the most important factor was the direct perceived control with a mean of 6.68 on a scale of 1 to 7. The patients felt strongly that if they wanted to travel to a developing country for medical treatment, they could. The second most important factor was direct attitude with a mean of 6.40. They considered getting medical treatment in a developing country to be beneficial, pleasant, and good. The third most important factor was the direct subjective norm with a mean of 5.59. Most people who were important to the patients would approve of them traveling to a developing country for treatment. Finally, intention to consider medical tourism had a mean of 6.53. Patients were very interested in learning more about and pursuing medical treatment abroad if available to them. With such high means for two of the antecedents (direct perceived control and direct attitude), positive support for the third antecedent (direct subjective norm), and a high mean for intention, we can confidently state that these patients might actively pursue medical treatment abroad if the need arises.

Next, patients were asked several other questions to test some of their indirect attitudes regarding specific beliefs about medical tourism. Of these beliefs, the most significant one was "getting treated by competent and well-trained doctor" with a mean of 6.72. The second most important factor was "getting treatment at a high quality facility" with a mean of 6.38. The third most important factor was "getting medical treatment not approved in the US" with a mean of 6.11. The fourth most important factor was "being able to save money" with a mean of 5.82. The fifth most important factor was "being able to travel and vacation" with a mean of 5.45. The sixth most important factor was "getting prompt medical treatment" with a mean of 5.35. "Getting private and anonymous medical care" received a neutral mean score of 4. "Medical treatment covered partially by insurance" received a mean of 3.62, which means that patients did not expect to be covered by their insurance plans.

Additional questions assessed other important factors that might influence the patients' decision to pursue medical tourism. Listed in order of importance based on mean responses, they are: recovery time to travel after treatment (5.79); travel abroad versus taking a loan in their home country (5.30); traveling for pleasure (5.24); long travel time in order to save money (5.09); concern over the severity of the health condition (4.97); cost of the procedure (4.71); price being the most important factor (4.32). Factors that received negative responses were: family physician's recommendation (3.67), and shopping (3.18).

The Likert Scale responses clearly show that getting treatment from well trained and competent doctors at a high quality facility were the most important factors rather than cost of the treatment. Although cost of the treatment was important, it was not the most important factor despite the media's proposal that it often is. Overall, these patients had very positive attitudes towards medical tourism and would partake in the behavior in the future.

The second research objective was to understand why these patients chose India as their choice of destination for their treatments; some of their concerns and limitations before and after their trips to India; and finally, the patients' knowledge level about medical tourism. Overall, the patients had several reasons for choosing India as their treatment destination. The high quality of doctors and facilities was the most important reason followed by the overall cost of treatment. The third most important reason was that they could receive specific treatments in India that might not be available in their home countries. Other reasons for choosing India as their medical tourism destination were: excellent customer service, support from their families to travel to India, and also having some negative experiences and opinions of the U.S. health care system.

Finally, medical tourists also faced some challenges in preparing to come to India for treatment. Once they figured out their insurance coverage, they had to work with the hospital in India to plan their trip. They had to also mentally prepare themselves to travel to a country that is completely different from what they are used to – different culture, norms, people,

setting, food, etc. They probably also had to encounter new sights and sounds such as poverty in India that they are not used to in their country.

Overall, most of the patients who came to India for treatment had researched the topic of medical tourism thoroughly. They were well aware of many of the countries that promoted medical tourism and were also well aware of many of the source countries.

Research Limitations

Several limitations impeded the progress of this research, including: few hospitals granting permission to conduct interviews, getting permission to interview enough patients in the hospitals that did grant permission, apathy from some patients towards the interview process, and small sample size for the overall research. Due to these challenges, we were able to interview only a total of 21 patients.

Although several hospitals/wellness facilities promoted medical tourism in the city, very few of the administrators were enthusiastic about granting permission to interview their patients for this research. Permission requests were made for over five hospitals/wellness facilities, but in the end, only three granted permission for interviews. In some hospitals, we tried to go directly to the administrator. In most cases, the administrator of first contact was the director or the lead person in charge of international patient services. In other cases, we had to use personal networking to gain access in hopes of receiving a more desirable answer towards interviewing patients. Several of the facilities took several weeks to review the application for permission, but ultimately chose not to grant permission. Their simple reason was, “at this time, we are unable to accommodate your request.” Several of the facilities did not even entertain the idea of interviewing their patients. For nearly every single rejection, we had to follow up with the administrators on multiple occasions.

There were also several challenges associated with the hospitals that granted permission. Some facilities spoke highly of their high demand for medical tourism. One administrator specifically mentioned that they received approximately 50-60 foreign patients every month from all around the world. However, when we asked to interview a few of their patients, the administrator was noncommittal. We were told to call the administrator on a given day to see if any patients were available for interviewing, but when we called, the administrator asked me to call back another day. When we called again, the administrator had a reason for not allowing any interviews, or in some cases allowed us to interview only one or two patients at most. It was frustrating to hear the administrator discuss the high number of medical tourists visiting their hospital but then being denied access to interview them.

Administrators may have been hesitant to grant interviews because of privacy concerns of both the hospitals and patients, a lack of trust about the researcher, a general apathy towards my research, or improper information regarding the number of medical tourists that actually came to their hospitals for treatment.

Although privacy laws for patients in Indian hospitals are not as strict as they are in Western countries, it seemed that most of the hospitals that we conducted our research in had high standards for their western patients. On multiple occasions, the administrators mentioned that protecting the privacy of their patients was very important. Several administrators also mentioned that many of their patients had not yet recovered enough from their surgeries/treatments in order for them to be disturbed for this research.

Administrators also wanted privacy for the hospital. They may have been worried about being cast in a negative light, though we specifically told all of the hospital administrators all data collected would not be associated with any particular hospital but would rather be presented as a whole. Still, one administrator specifically mentioned that he had allowed a researcher to conduct a study on medical tourists in their hospital but later found out that the research was somewhat critical of their facility, which the administrator deemed inappropriate. The administrator mentioned that anything perceived as negative regarding their hospital might have an impact on attracting foreign patients, which was already challenging enough. We also had the impression that some of these places were wary of being research guinea pigs, although we once again assured anonymity for both the facilities and the patients.

Finally, it may also be possible that some of the administrators were not providing the correct data. It may be possible that only a few patients travel to these hospitals for treatments, but in order to promote the business, the administrators gave me highly inflated numbers. None of the administrators would grant me permission to examine hospital records in terms of the number of patients that traveled to their hospitals and other demographic data.

Apathy among some of the patients also hindered this research, though to a lesser degree. A few of the patients seemed lethargic during the interview process. This was understandable, though, due to the fact that many of them were in their recovery period from invasive procedures. After being in a foreign country for several weeks, home sickness sets in and many of the patients specifically mentioned wanting to go back home.

A hindrance in this research may be the small sample size. Our initial goal was to interview about 100 patients; however, due to all the challenges faced acquiring interviews, the final sample size ended up being only 21, which is not large enough to warrant any firm generalizations about medical tourism as a whole. Nonetheless, certain observations may still provide meaningful insights into the thought processes of a certain segment of medical tourists.

Recommendations and Future Direction of Research

Academic articles based on interviews of medical tourists are extremely limited. Most of the information on medical tourism comes from tourism and consulting companies and hospitals that promote medical tourism. Their information is valuable, but these efforts need to be

combined with those of academic researchers to gain a better understanding of the medical tourism industry.

An aspect that needs much more exploration is the economic impact of medical tourism for the destination countries as well as the origin countries. Medical tourism brings in millions of dollars to countries that promote it. Most of this money goes to hospitals and facilities that treat the patients. What needs to be examined is the economic impact of medical tourism on the rest of a country's economy. Many more entities and people benefit from medical tourism, including tourism companies, consulting companies, tourism dependent economies such as beach resorts, and all the people associated with them. Also, is medical tourism having an impact on the patients' home countries?

Another important aspect of medical tourism that needs to be further explored is patients' post care/complications upon returning home. Many doctors in their home country may not want to see them if complications arise for fear of being sued if something goes wrong. However, patients might not want to travel back to their treatment destination for basic follow up care; it is both expensive and time consuming, not to mention mentally and physically stressful. Also, detailed surveys of physicians and medical personnel in the developed countries need to be carried out to get a sense of what they think of medical tourism. We have read a few articles about American doctors not liking the idea of medical tourism, but further research on this issue is needed.

Future studies on medical tourism must also include interviews of people involved in the health care industry in Western countries such as physicians, insurance companies, health care officials, hospitals and tours companies. From the literature review, a few American physicians have stated that they are hesitant to treat patients who have gone abroad for medical tourism. Interviewing Western physicians will give us a better understanding of their personal opinions on the issue. Interviewing insurance companies will also give us an idea on how they approach the issue of medical tourism. Tour companies can be interviewed to see if any of them cater to medical tourists and if so how they go about doing that.

Another aspect that needs further research is the logistics behind a health insurance company that actually promotes medical tourism. Currently, very few insurance companies promote medical tourism; however, it is conceivable that insurance companies may be able to cut down costs of treatments if they outsourced patients to a country such India where treatment is generally cheaper than in the U.S. The impact this outsourcing of health care might have on countries such as the U.S. or U.K. could be interesting. For example, if a treatment is considered non-essential or non-life threatening, patients in the U.K. will find long waiting times in their government funded health care system. How would it impact the U.K.'s health care system if this patient went abroad for treatment rather than getting it in the U.K.?

Finally, are these patients really medical tourists or are they just patients with passports? During the interview, one administrator specifically stated that he thought that these patients were here just for treatment and not tourism. However, even the hospital that he worked in

promoted these patients as medical tourists. ‘Medical Tourism’ is a catch phrase that attracts much media attention. Even if the term ‘patients with passports’ seems more appropriate in some circumstances, this industry has been promoted as ‘medical tourism.’ Personally, based on our study, we think ‘patients with passports’ or ‘medical travellers’ might be more appropriate terms for people seeking treatment abroad.

In conclusion, medical tourism, although a fairly new phenomenon in its current form, has grown robustly both in terms of the revenue it generates and the geography of its distribution. It is expected that **global medical tourism market** size expected to reach USD 207.9 billion by 2027, expanding at a CAGR of 21.1%, according to a new report by Grand View Research, Inc. Medical tourism generates direct foreign exchange income and contributes to the overall development of any economy. More than 50 countries are involved in promoting medical tourism with many governments actively participating in promoting their countries as medical tourism destinations. As medical tourism grows, more and more people will have access to it in this globalized world where health care has become a very important issue.

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Appendix A. Medical Tourism Questionnaire
Medical Tourism Participant Survey

(You do not have to answer any questions you choose to)

To what extent would the nature/severity of the health condition/medical procedure influence whether you were willing to consider traveling to a developing country to have it performed?

not at all 1 2 3 4 5 6 7 completely

To what extent would the cost of the procedure influence whether you were willing to consider traveling to a developing country to have it performed (if cheaper in a developing country)?

not at all 1 2 3 4 5 6 7 completely

The idea of medical tourism is

extremely bad 1 2 3 4 5 6 7extremely good

For me to get affordable health care is:

extremely bad 1 2 3 4 5 6 7extremely good

For me to save money is:

extremely bad 1 2 3 4 5 6 7extremely good

Traveling to a developing country to receive medical treatment saves money compared to getting the same treatment in the U.S.:

extremely unlikely 1 2 3 4 5 6 7extremely likely

For me to have my medical treatment covered partially by my insurance is:

extremely bad 1 2 3 4 5 6 7extremely good

My insurance company paying for my traveling to a developing country to receive medical treatment is:

extremely unlikely 1 2 3 4 5 6 7extremely likely

My ability to get prompt medical treatment when I want or need it is:

extremely bad 1 2 3 4 5 6 7extremely good

Traveling to a developing country to receive medical treatment sometimes allows a person to receive faster medical treatment than getting the treatment in the U.S.:

extremely unlikely 1 2 3 4 5 6 7 extremely likely

For me to be able to get a medical treatment that hasn't been approved in the U.S. if I want it is:

extremely unimportant 1 2 3 4 5 6 7extremely important

Being able to get a medical treatment that hasn't been approved in the U.S. by going to a developing country is:

extremely unlikely 1 2 3 4 5 6 7extremely likely

I was aware of Medical Tourism when my health issue first arose:

extremely aware 1 2 3 4 5 6 7extremely unaware

For me to be able to get medical treatment privately and anonymously (without people knowing what procedure or treatment I had) is:

extremely unimportant 1 2 3 4 5 6 7extremely important

Getting private and anonymous medical treatment in a developing country is:

extremely unlikely 1 2 3 4 5 6 7 extremely likely

For me to be able to travel and have the opportunity to vacation and see a developing country is:

extremely bad 1 2 3 4 5 6 7extremely good

Being able to vacation and see a developing country while I am there to receive a medical treatment is:

extremely unlikely 1 2 3 4 5 6 7extremely likely

For me to get medical treatment at a facility that is of high quality is:

extremely unimportant 1 2 3 4 5 6 7extremely important

Finding a high quality private medical facility in a developing country is:

extremely unlikely 1 2 3 4 5 6 7extremely likely

For me to have a very competent and well-trained doctor is:

extremely unimportant 1 2 3 4 5 6 7extremely important

Finding a very competent and well-trained doctor in a developing country is:

extremely unlikely 1 2 3 4 5 6 7extremely likely

If the option for me to travel to a developing country to receive a medical treatment were available to me, I would consider it and want to learn more about it:

strong disagree 1 2 3 4 5 6 7 strongly agree

For me, traveling to a developing country to receive medical treatment is:

harmful 1 2 3 4 5 6 7beneficial

Most people who are important to me would of my traveling to a developing country to receive medical treatment

approve 1 2 3 4 5 6 7disapprove

If I wanted to travel to a developing country to receive medical treatment, I would be able to do it:

definitely false 1 2 3 4 5 6 7definitely true

The idea of using some recovery time after my treatment to travel within that country is:

extremely unappealing 1 2 3 4 5 6 7 extremely appealing

A recommendation from my family physician to go abroad for treatment is:

extremely unimportant 1 2 3 4 5 6 7extremely important

Besides medical treatment, traveling for pleasure on the same trip to me is

extremely unappealing 1 2 3 4 5 6 7 extremely appealing

The price of the medical treatment is the most important factor for my treatment:

definitely false 1 2 3 4 5 6 7 definitely true

If I travel abroad for medical treatment, shopping in that country for me is:

extremely unimportant 1 2 3 4 5 6 7 extremely important

If I cannot afford a particular type of treatment that is life threatening in my home country, would I rather take out a loan and have the treatment done in my home country, or will I go abroad to a developing country for treatment if it is affordable:

extremely unlikely 1 2 3 4 5 6 7 extremely likely

I would travel abroad on a plane for 12-24 hrs to attain medical treatment if I can save a few thousand dollars:

extremely unlikely 1 2 3 4 5 6 7 extremely likely

Other Questions

What are some of the countries that Medical Tourists travel to for treatments?
What are some of the countries that Medical Tourists come from?
What country did you come from?
Your age and sex?
Your profession?