



Medical tourism: A conceptual framework for an innovation in global healthcare provision

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Chapter 9

Medical Tourism: A Conceptual Framework for an Innovation in Global Healthcare Provision

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ABSTRACT

The purpose of this chapter is to establish a conceptual model that can potentially fill research gaps in the literature about medical tourism as an innovative concept in global healthcare provision by developing emerging economies as they are providing low cost alternatives in medical treatment at internationally accredited medical facilities to treat patients from developed countries. Major databases such as Ebscohost and Emerald have been used to search relevant literature. The literature on medical tourism is reviewed so as to understand the key drivers of medical tourism as well as research gaps in the existing literature. Three major drivers of medical tourism have been identified, namely cost, waiting time, and perceived quality. Further empirical research is needed to test the conceptual model in order to better understand what drives a decision to engage in medical tourism. This chapter makes three major contributions; firstly, the identification of the medical tourism literature from the service marketing and management perspectives; secondly, to propose a conceptual model representing innovation in medical tourism for global healthcare by developing emerging economies; thirdly, the identification of research gaps in the medical tourism literature through which future research can further the knowledge of why people travel to developing countries for medical treatment.

INTRODUCTION

There is a growing volume of literature studying the globalisation of healthcare provisions in the world where patients from industrialised advanced countries such as USA, UK, Europe, and Australia are making informed decisions and travelling to developing countries such as India, Thailand, Singapore, Malaysia, Mexico, and Poland for the main purpose of undergoing complex medical procedures, and taking advantage of the reduced health-care costs, less waiting time, and first world quality of treatment, along with enjoying a holiday at an exotic destination (Connell, 2006; Horowitz & Rosensweig, 2007; Bies & Zacharia, 2007; Douglas, 2007; Ye, Yuen, Qiu, & Zhang, 2008; Hopkins, Labonte, Runnels, & Packer, 2010; Lunt, Hardey, & Mannion, 2010; Lunt & Carrera, 2010; Brotman, 2010; Stanley, 2010; Ali, 2012; JCI, 2012; Medhekar, 2011; Taleghani, Chirani, & Shaabani, 2011). According to Asian Medical Tourism Association (2009), medical tourism in Asia is expected to be worth US\$4 billion by 2012 and that an estimated 750,000 American patients are expected to travel abroad for healthcare treatment and this number is expected to increase to six million by the end of 2012 (Baliga, 2006; Deloitte, 2008; AMTA, 2010).

The economic impact of medical tourism in developing countries is significant (Bookman & Bookman, 2007). The health and medical tourism industry is sustained by 617 million individuals, at an annual growth rate of 3.9%, generating revenue of US\$513 billion (Carrera & Bridges, 2006). Various studies have reported that the global medical tourism industry was worth US\$20 Billion in 2005 (RNCOS, 2006; Deloitte, 2008). According to RNCOS (2006) report, the total foreign exchange earned through international medical tourism in 2005 by Thailand was US\$915 million from 1000,000 medical tourists, India US\$333 million from 180,000 medical tourists, Singapore US\$915 million from 350,000 medical tourists and Malaysia 40 million from 400,000

medical tourists. Further, a total of nearly 1.9 million medical tourists visited Asia in 2005 (RNCOS, 2006, pp.13-14). Medical Tourism in Asia is expected to be worth US\$4.4 billion by the end of 2012 (AMTA, 2010), and globally it is worth US\$60 billion annually. The Confederation of Indian Industry (CII) estimates that medical tourism in India in 2005 was worth over US\$310 million, and the market is predicted to grow to US\$2 billion by 2012 (MacReady, 2007).

According to Havighurst (2008), the high cost of health insurance, medical treatment, elective surgery, and long waiting times that affect domestic patients in developed countries like the USA and the UK have spawned a “most startling of sort of innovation in health care service delivery: so called medical tourism: or the taking of serious, potentially high-cost health problems to very low-cost but competent providers in countries as far away as India and Thailand” (Havighurst, 2008, p. 1342). This has thus given birth to creative innovation in health care delivery to international patients who are under-insured, uninsured, and/or cannot wait in the queue for elective surgery, and thus make a decision to travel abroad for treatment in order to reduce pain and improves their quality of life.

Historically, the affluent patients in developing countries travelled abroad to developed countries for complex surgeries, due to non-availability of treatment in their home country, for example from India to USA. However, this situation has now been reversed. Medical patients are now travelling from USA, UK and Canada to the emerging economies of Asia, South America and Eastern Europe for medical treatment. This is somewhat similar to, though not straight analogy, to international trade in goods and services where major manufacturing companies from developed countries have relocated or outsourced production and service maintenance to developing countries, such as China, India, Vietnam, Mexico, Malaysia and Bangladesh, due to the lower cost of production and economies of scale. For example: textile, clothing, footwear, electronic goods, computer

soft-wear and automobile industry, as well as services such as airline maintenance, telecommunication customer service and insurance.

Medical tourism has huge potential economic benefits for developing countries, such as India and Thailand due to internationalisation, globalisation, digitisation and growing international travel and trade in healthcare services (Chanda, 2002; Carrera & Bridges, 2006; Turner, 2007; Healy, 2009; Arunanondchai & Fink, 2007; Davis & Erixon, 2008; Ghose, 2010). Medical tourism is also described as “international economics in action” (Jones & McCullough, 2007, p.1077) as patients seek cheaper and state-of-the-art-technology in medical treatment. According to Feachem (2001) “globalisation is good for your health”, as countries which engage with the world economies through globalisation, trade liberalisation, and privatisation can promote faster economic growth and benefit its population by reducing poverty. Using medical tourism as an export-led growth strategy, many socio-economic challenges and problems faced by developing countries such as India and Thailand can be resolved, particularly where there is decline in traditional industries (Cavaro, 1995; Hinings & Greenwood, 1988; William & Shaw, 1998; Karuppan, 2009). Ghose (2010, p.117) discusses the concept of providing healthcare and medical services to foreign patients by the medical tourism industry as...“a product of the marriage of internationalisation and global digitisation”. Based on number of patients travelling for treatment, as well as the foreign exchange revenue earned by the host country, medical tourism related services have also become an important factor in international trade (Chanda, 2002; Arunanondchai & Fink, 2007; Jones & McCullough, 2007). Medical tourism thus involves international trade between the two major service sectors of the economy namely medicine and tourism (Bookman & Bookman, 2007; Medhekar, 2010).

The word ‘tourism’ is added to ‘medical tourism’ because patients who travel to another country to seek medical treatment are also spending money

on local travel, sightseeing, accommodation, shopping and food in a manner of being on a holiday. ‘Surgery’ (Connell, 2006) can be added to the existing four “Ss” of tourism: sea, sun, sand and sex (Crick, 1989); along with two other niche tourism segments: safari and spirituality (Haq & Jackson, 2009). International healthcare provision, wherein a person from a developed country travels to another developing country and demands complex diagnostic, non-surgical and surgical medical treatment, is considered ‘innovation in international healthcare service delivery’ due to following reasons (i) patients travelling from developed countries to developing countries for medical treatment due to low cost of diagnostic treatment and surgery, (ii) no waiting time, (iii) Joint Commission International accredited quality of medical facilities, professionals and treatment, (iv) availability of state of the art medical technology and latest treatment at super speciality hospitals, (v) non availability of medical treatment due to regulation in developed countries such as: stem-cell research, robotics surgery, organ transplants, reproductive tourism, complex cosmetic surgery, surrogacy for gay couples, hip resurfacing, euthanasia or death tourism and abortion tourism.

Medical tourism is a relatively well-developed global phenomenon. Medical tourism has been widely acknowledged by academic scholars recently (Forgione & Smith, 2007; Horowitz & Rosensweig, 2007; DeArellano, 2007; Hansen, 2008; Healy, 2009; Carruth & Carruth, 2010; Brotman, 2010; Heung, Kucukusta, & Song, 2010; Lunt, Hardey & Mannion, 2010; Cormany & Baloglu, 2011). The growth of ‘Medical Tourism’ industry is due to globalisation (Awadzi & Panda, 2006; Herrick, 2007; Cormany & Baloglu, 2011), international trade in healthcare services (Bookman & Bookman, 2007; Ali, 2012) and the fast development in innovation and adoption of internet technology in marketing and promotion of treatment abroad by the private healthcare providers as well as the government for example

from India and Thailand. The term globalisation is also treated equivalent to internationalisation, liberalisation, universalisation or westernisation (Scholte, 2007). The term globalisation can be defined as a process of moving away from less desirable to more desirable, due to expansion of international trade, international borrowing and lending, foreign direct investment, transfer of technology, movement of labour between countries (McTaggart, Findlay, & Parkin, 2013). In context of medical tourism and globalisation, it is in the self-interest of the consumers who benefit from affordable low cost, less waiting time for surgery, and international quality of health care from developing countries. Comparative advantage thus drives International trade, which is a situation where a country can produce a good or a service at a lower opportunity cost than any other country, for example travelling abroad for healthcare services such as medical treatment or medical tourism. Further, technological change which is also termed as information revolution (McTaggart, Findlay, & Parkin, 2013) and digitisation (Ghose, 2010) has helped in dissemination of web-based health information and promotion of medical tourism destination and specialised surgical treatment to potential medical tourists (Lunt, Hardey, & Mannion, 2010).

Ghose (2010, p.117) argues that, “Following on from the internationalisation of services like education and tourism, this nascent medical industry is a product of the marriage of internationalisation and global digitisation... . The rise of global medical tourism emphasises privatisation of health care, the growing dependence on technology, uneven access to health resources and the accelerated globalisation of both healthcare and tourism”. Increasingly, people from developed countries and affluent individuals from emerging economies are travelling to developing countries for non-surgical, diagnostic and surgical healthcare, and other medical treatment to avoid long waiting times for elective surgery, high healthcare and insurance costs, and the non-availability of certain surgeries and procedures due to regulations

within their home countries. Medical tourism is an emerging niche special interest tourism segment within the overall globalised health industry (Garman, Johnson, & Clap, 2008) and an offshoot of special interest tourism, where people travel to another country with a specific aim of getting highly specialised medical treatment.

The aim of this paper is to develop a conceptual framework for medical tourism industry from the demand side by reviewing the literature on globalisation and internationalisation of healthcare services as an innovative medical tourism phenomenon and an export led strategy adopted by the developing countries for trade in healthcare medical tourism services. This chapter is structured as follows. The introductory section of the chapter provides a background introduction to globalisation of healthcare as an innovative healthcare service industry by developing countries called Medical Tourism. Section two introduces the concept of innovation in context of medical tourism. Section three proposes the conceptual framework for medical tourism from the demand side, focusing on three factors: low cost, waiting time for surgery, and international quality of medical facilities, treatment and professionals. Section four provides managerial and policy implications where globalisation is encouraging entrepreneurial opportunities and innovation in healthcare provisions to provide “first world healthcare at third world prices” (Turner, 2007) to the foreign medical tourists, sometimes at the cost of the health and wellbeing of the millions living in poverty in developing countries of Asia or South America. The final section deals with direction for future research and conclusion.

INNOVATION IN CONTEXT OF MEDICAL TOURISM

Globalisation thus generates innovative economic and entrepreneurial opportunities for the key stakeholders in the business of healthcare provision, which provide highly specialised medical treat-

ment to foreign patients. Business Dictionary (2012), defines innovation as a “process by which an idea or invention is translated into a good or service for which people will pay, or something that results from this process. To be called an innovation, an idea must be replicable at an economical cost and must satisfy a specific need.” There are two categories of Innovation: (i) Evolutionary innovation due to incremental advances in technology and processes of production, within which two types exist, (a) continuous evolutionary innovations that alter the product characteristics, and (b) dynamic continuous evolutionary innovation that requires user-learning, and thus disrupts routine production and may require new behaviour patterns; (ii) Revolutionary innovation, also known as discontinuous innovation, that requires significant user-learning and change in behaviour patterns. A study by Drejer (2003) applied the Schumpeter’s broad definition of innovation, to include innovation in service oriented industries, by examining the emerging literature related to the growth of service industries, where in 2000 nearly 75% of the labour force in USA was employed. According to (Drejer, 2003, p. 552), “The role of the consumer as a co-operating agent in the production process - and therefore also in the innovation process - in service and the labour embodiment of technological change, including the importance of organisational change, thus receives a great deal of attention in service specific studies.”

Various studies have shown significant growth in the service sector industries around the world, with 50% to 60% of the world economy’s GDP growth coming from the service sector (OECD, 2008). Examples of trade liberalisation in services such as banking, insurance, tourism, healthcare services, and medical tourism can not only improve economic performance, but also provide new export opportunities in the cases of developing emerging economies such as India, Thailand and Brazil. Schumpeter (1934, p.66) has classified five types of innovation in an economy: (i) product innovation - the introduction of new good or a

new quality of a good, (ii) process innovation - the introduction of a new method of production, including a new way of handling a commodity commercially, (iii) market innovation - the opening of a new market, (iv) input innovation - the conquest of a new source of supply of raw material or intermediate input, (v) organisational innovation - the carrying out of a new organisation of industry.

Drejer (2003, p.557) argues that “the understanding of innovation in services has suffered from the popular notion that since many services are performed with a particular customer in mind, and sometimes in a close interplay with the customer, every service delivery is unique. This has led to the confusion regarding whether all services or no services represent the creation of something new. The notion of standardised services has relieved at least part of the services from this uniqueness- characterisation, but even customer-fitted services consist of combinations of well-defined elements which can remain unchanged or which can be subject to development and thus innovation”.

Medical tourism, is a growing global healthcare service industry in developing countries of Asia, and involved in providing international quality of healthcare services to foreign medical tourists at low cost and no waiting period, is an innovation in itself where new niche markets are emerging as “clusters of innovation,” (Schumpeter, 1934) as it caters to the healthcare needs of foreign individual patients, each of them suffering from and requiring particular medical treatment or surgery such as: cardiac, cancer, dental, cosmetic, eye, or organ transplant in medical tourism destinations such as Thailand, India and Malaysia. The key supply side stakeholders, such as private medical hospitals, tourism and the hospitality industry, along with the government, are promoting the development and growth of this industry as an innovative concept to foreign patients and capitalising on the competitive and comparative advantages over tourists’ home countries.

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Medical Tourism thus falls under Revolutionary Innovation, as it involves significant user-learning (medical tourists and medical tourism service providers/medical tourism industry) and changes in behaviour in adapting to a new system where the medical tourists (demand side) on one hand have to adapt to Internet searches and get used to the idea of travelling abroad for medical surgery to take advantage of affordable low cost and quality of care with shorter waiting periods, due to high health and insurance costs and long waiting periods in the patients' home countries.

On the other hand, the medical tourism industry (supply side) is required to provide low cost, efficient, effective, up-to-date medical treatment and surgery with world standard qualified medical professionals in state-of-the-art medical facilities which are JCI accredited in partnership with various supply side stake holders such as the medical industry, accrediting bodies, pharmaceutical companies, tourism industry, transportation facilities, and governments. Thus, on supply side, innovation comes into play in terms of joint collaborative efforts of different stakeholders. For example in case of India, it is the government at all levels, private hospitals, allied healthcare providers, ambulatory care, pharmaceutical industry, on-line healthcare promotion and literacy, interpreting services, medical travel agents, national and international accrediting bodies for medical facilities and healthcare professionals, hospitality and accommodation, local transport, airlines, food and beverage industry; all these stakeholders are linked through medical tourism supply chain to provide best quality of health care to international medical patients (Medhekar, 2010; Medhekar & Ferrer, 2012).

The medical tourism industry and the governments of the destination countries that introduce this new method of treating foreign patients in their country for complex diagnostic and medical surgeries are taking a great risk by creating a new market and treating foreign patients with latest medical technology and expertise, as well as treatments not available in patients' home countries,

due to various possible reasons as stated. Thailand and India are examples of revolutionary innovators of the medical tourism healthcare service industry in the 21st century. These developing and emerging economies that enter the medical tourism market are establishing their own niche as particular specialists for certain treatments. For example, Thailand, Poland, and the Philippines specialise in dental surgery. India and Singapore specialise in high-end complex surgeries like hip and knee replacement, cardiac, organ transplants, surrogacy, and cataracts. Therefore, not all the countries that are emerging markets in medical tourism business can provide super-speciality treatments in super-speciality hospitals, like those found in India and Thailand, given the expensive medical technology, medical infrastructure facilities, and human resource issues of shortage of specialist surgeons.

According to Gopalakrishnan and Damanpour (1997, p.15), "...innovation facilitates the process of adaptation to many of these changes. Consequently, innovation plays a role in nurturing the economy, in enhancing and sustaining the high performance of firms, in building industrial competitiveness, in improving the standard of living, and in creating a better quality of life". Therefore, the medical tourism phenomenon is an example of innovation in the global healthcare service industry, playing a role in the development and growth of the emerging economies, enhancing and sustaining medical hospitals as large 'corporate healthcare service firms', performing healthcare provision of an international quality, and building industry competitiveness in terms of affordable cost and efficient process for treatment meeting international standards and quality of health care. The goal is not only to provide foreign patients with state of the art medical treatment, technology and facilities, but also to improve the standard of living by providing better quality of life, latest healthcare facilities, and treatment to the local domestic population of developing emerging economies.

LITERATURE REVIEW

Medical tourism also known as, wellness tourism; and travel abroad for healthcare and medical treatment is not a new phenomenon. Literature on travelling abroad for medical treatment or medical tourism can be reviewed from various perspectives such as; cardiac surgeries, dental tourism, surrogacy, cosmetic, reproductive, legal, ethical, social, equity, health insurance, economic development, international trade in services, health policy, and environmental issues. We are going to broadly review the various models of medical tourism developed from different perspective. The main purpose of a potential medical patient is to travel abroad for diagnostic and complex invasive surgeries and medical treatment. Bookman and Bookman (2007, p. 1) have defined medical tourism, “as travel with the aim of improving one’s health, medical tourism is an economic activity that entails trade in services and represents the splicing of at least two sectors: medicine and tourism”.

Bookman and Bookman (2007) have provided a conceptual economic base for the emerging global medical tourism industry in developing countries in their book called ‘Medical Tourism in Developing Countries’, and have identified three forms of medical tourism: invasive, diagnostic, and lifestyle. Invasive treatments involve high-tech procedures performed by a medical specialist; diagnostic procedures encompass several types of tests such as blood screening and lipid analysis; and lifestyle includes wellness or recuperation treatments. Medical tourism can be viewed as a phenomenon where a patient travels with or without a companion outside his/her country of residence, to another country for medical treatment which could be risky, invasive, and involve complex surgical procedures with the use of highly specialised medical equipment, technology, and experienced surgeons, for the improvement of overall physical health and quality of life, combined with a vacation at an exotic destination (Medhekar, 2010). Similar to other tourism products, medical tourism potential can

be realised by developing countries as a means to promote economic growth and development (Bookman & Bookman 2007).

Various models of medical tourism from the demand side as well as from the supply side are proposed by academics from different disciplines in recent literature. Smith and Forgione (2007) have identified the factors influencing the patient’s choice of a specific destination country (economic, political, and regulatory) and that choice of international medical facility is impacted by costs, quality of care, physicians training, and accreditation in their two-stage model. Smith and Forgione (2007) model does not consider the demand and supply side factors affecting the medical tourism industry as a whole. Caballero-Danell and Mugomba (2007) broadly described a distribution channel model for medical tourism along with a model for the marketing of medical tourism, in terms of first collecting the sources of medical tourism information from print and online databases such as newspapers, magazines, periodicals, academic papers, and electronic media, and went on to describe the medical tourism industry by identifying the key stakeholders. Their model identified nine factors including: social issues, communication channels, product, target market, infrastructure, legal framework, branding, operators, and customer benefit. Ye, Yuen, Qiu, and Zhang (2008) developed a model of analytical framework of Hong Kong medical tourist motivations. After conducting an extensive critical review of current literature on medical tourism models Heung, Kucukusta, and Song (2010) found that “no integrated conceptual framework for the holistic study of the medical tourism industry exists” and they proposed an integrated demand and supply model of medical tourism. Heung, Kucukusta, and Song (2011) have tested the supply side of their model for Hong Kong medical tourism industry and argue that the current existing conceptual models have limitations and shortcomings, and do not fully capture the growing medical tourism sector.

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Lunt, Hardey and Mannion (2010), have provided a conceptual framework to understand the role of Internet advertising for outsourcing medical tourism and making it a global phenomenon. Lunt, Hardey, and Mannion (2010, p.1) argue that, “A key driver in the medical tourism phenomenon is the platform provided by the Internet for gaining access to healthcare information and advertising”. For medical tourism purposes, patients search for potential medical tourism destinations, undertake a cost comparison between countries for the type of medical services they desire, read other patients testimonials, look at accreditation, and investigate aspects related to travel such as accommodations. Karuppan (2009) argues that the USA is in a healthcare crisis and mass media ICT has played a role in disseminating information, leading many under-insured and uninsured medical patients to seek travelling to developing countries for get timely, quality treatment at a fraction of the cost, along with a vacation. However, not all are taking advantage of information technology to purchase medical treatment from abroad, and a large market is left untapped due to missing information regarding certain types of costs and several dimensions of quality exacerbates the perception of risk associated with travelling abroad for surgical procedures (Karuppan, 2009, p. 32).

Medhekar and Haq (2010) have proposed a Culturally Sensitive Muslim Typology to market Indian medical tourism to Muslim patients in an Islamic way, in other words Halal medical tourism. India has many Muslim patients travelling from neighbouring countries in South Asia, Africa and the Middle East for medical treatment and faces competition for halal medical treatment from Malaysia, Singapore and Dubai. The first Halal Friendly Medical Tourism Hospital jointly certified by Halal India and International Halal Integrity Alliance, Malaysia which is a partner of Islamic Chamber of Commerce and Industry Saudi-Arabia was established in India-Chennai Global Health City in 2012, to cater to niche markets by providing customised halal medical

treatment to foreign Muslim patients along with halal certified medicine, food, Friday prayer, and Arabic TV channels.

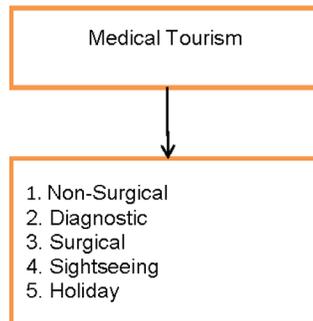
Medhekar and Newby (2012) have proposed an Information Search Model of Medical Treatment Abroad wherein potential medical tourists search for internal (personal experience) and external (internet, print, media, family, friends, doctor, medical tours operator, health insurance provider) information before making the decision to travel abroad for treatment. Medhekar and Ferdous (2012) have developed a conceptual model for the medical tourism Industry based on culturally competent health literacy for medical tourists and medical tourism service providers and. Given the globalisation of healthcare services, medical tourism service providers need to have health literacy for medical tourists with respect to visual literacy to understand and interpret visual information related to medical data, reports and graphs; information literacy so that the service providers and medical patients are able to use, evaluate and apply health information from the internet; computer literacy to be able to operate, and research for relevant information on the search engines; and numerical literacy to be able to calculate and understand data related to medical tourists health reports.

Based on the literature review and exploration of medical tourism associations and hospital websites the medical tourism typology is developed. Figure 1 depicts a medical tourism typology that combines medical (diagnostic, surgical and non-surgical) and tourism (sightseeing and holiday).

CONCEPTUAL FRAMEWORK FOR MEDICAL TOURISM

Based on the literature review on various models of medical tourism, a conceptual model with regard to the demand for medical tourism focussing on key drivers can be proposed. The conceptual model is formed from the perspective of disruptive innovation. The notion of disruptive innovation

Figure 1. Medical tourism typology



by Hwang and Christensen (2008) describes a technology, process, or business model that introduces a product or a service which is affordable and simpler to use. This notion of innovation can be applied to medical tourism as “healthcare service delivery to foreign patients that is simpler in quality, more convenient, and more affordable.” Havinghurst (2008, p.1341) explains the concept of disruptive innovation as “low cost alternatives in medical treatment while maintaining or improving quality”. Medical tourism is the result of demand by patients from developed or developing countries, where the government has failed to provide access to affordable healthcare services in a timely manner. Patients may choose to pay their own health cost when they have high-deductible health coverage or are uninsured and seek “values for money” in healthcare service delivery. The global change caused by medical tourism as an innovation is so huge that it disrupts the current healthcare service provision to domestic patients who instead travel abroad for medical treatment and elective surgery. The emerging economies and popular medical tourism destinations of India and Thailand are providing medical treatment that foreign patients want and choose as a second best alternative for medical surgery. Thus, delivery of recognised, affordable health services with shorter waiting time and international quality are the key reasons to consider medical tourism as an innovative entrepreneurial healthcare business of the emerging economies, which has led

to the development of the export led growth of the health sector to the developed countries in the twenty first century.

Cost: Cost is one of the key factors responsible for the growth of the global healthcare medical tourism industry in developing emerging economies (Milstein & Smith, 2006; Little, 2010; Deloitte, 2011; Ali, 2012; JCI 2012). Comparing the cost of medical treatment and surgery is essential if competitive healthcare services are to be provided to foreign patients. Most of the developed countries’ medical tourists select a developing country for treatment based on its first-world health infrastructure and specialist surgeons, accredited quality, advantage of English language, availability of alternative therapies like Ayurvedic spas and treatment, lower cost, and shorter waiting period (Bookman & Bookman, 2007; Medhekar, 2010). Medical tourists compare costs of same medical treatment/surgeries in different countries before making the decision to travel. As can be seen from Table 1 there are significant differences among the costs of selected surgeries in USA compared to Thailand, Singapore and India - the popular and leading medical tourism destinations.

In India, a heart bypass surgery can cost between \$9,000 and \$10,000. A hip-replacement costing US\$43,000 or more in America can cost US\$7,000 in India including return airfare and a holiday package (AMA, 2008). According to Thakkar (2010), many Americans are traveling abroad for medical treatment as they are either under insured or have no medical health insurance coverage. Many expatriates from Malaysia and India choose to obtain medical treatment in their country of birth so as to enjoy the additional benefit of meeting family members. Given the cost comparisons of medical surgery between countries, as well as the increasingly available information regarding accreditation of medical facilities, it is becoming easy and affordable for patients from developed countries such as USA and Australia to compare the standards of medical care and cost, and make decisions about travelling abroad to developing countries for medical treat-

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Table 1. Cost comparison for selected surgeries

Countries	Heart By Pass	Hip Replace	Knee Replace	Hysterectomy
Australia	\$33,340	\$23,800	\$20,089	\$7,113
USA (US\$)	\$130,000	\$43,000	\$40,000	\$20,000
India (US\$)	\$9,300	\$7,100	\$8,500	\$6,000
Thailand (US\$)	\$11,000	\$12,000	\$10,000	\$4,500
Singapore	\$16,500	\$9,200	\$11,100	\$6,000
Korea (US\$)	\$34,150	\$11,400	\$24,100	\$12,700

Source: American Medical Association (2008); American Medical Association and Medi-bank Private (figures from 2007 financial year prices)

ment. For example, In Australia, a heart bypass surgery can cost up to AUS\$33,340, which is covered by private health insurance when the surgery is undergone in Australian hospitals. However, private health funds in Australia do not cover overseas medical cost. Thus, many medical tourists from developed countries travel abroad for more affordable elective medical treatment as it has come to offer “first world healthcare at third world prices” (Turner, 2007). Table 2 shows the cost of selected cosmetic surgeries in USA compared to top three medical tourism destinations.

Waiting Time: Availability of medical treatment and elective surgery in a timely manner in public hospitals is critical for many patients (Hurst & Siciliani, 2003; Eggertson, 2006; MacReady, 2007). According to the OECD report by Hurst and Siciliani (2003), waiting time for elective surgery may vary from country to country in terms

of the definition of waiting period and aggregation method. For their study they have defined waiting time in two ways: (1) the waiting time between specialist assessment and the time the patient is admitted for surgery (inpatient waiting time) and (2) waiting time at the time of admission for treatment. Waiting time, as determined by the Department of Health in South Australia, is the time a doctor refers a patient to a specialist, who then refers the patient on an elective surgery waiting list depending on the patient’s condition (Government of South Australia, 2012). This waiting time does not include the time taken to receive a General Practitioners (GP) appointment and then GP referral to a Hospital for a surgical assessment. Waiting time includes, waiting time to admissions for elective surgery: by public hospital, speciality of surgeons and by medical procedure (Australian Government Institute of Health and Welfare,

Table 2. Comparative country costs of cosmetic surgery

Procedure	USA (\$)	Thailand (\$)	Singapore (\$)	India (\$)
Face-Lift	\$20,000	\$4,800	\$6,250	\$3,100
Breast Augmentation	\$10,000	\$3,150	\$8,000	\$2,200
Breast Reduction	\$10,000	\$3,900	\$8,000	\$3,000
Eyelid Surgery	\$7,000	\$14,00	\$3,750	\$2,200
Liposuction	\$10,000	\$2,100	\$5,000	\$2,500
Nose Surgery	\$7,300	\$3,850	\$4,400	\$1,800
Tummy Tuck	\$8,500	\$4,050	\$6,250	\$3,400

Source: Medical Tourism in India: Cost Comparisons of Medical treatments: India vs. the World selected Surgeries. Retrieved 10 May 2013, <http://www.indiaprofile.com/medical-tourism/cost-comparison.html>

2012). In Australia, “The median waiting time for surgery (or 50th percentile) has been used as an indicator for waiting time. The Australian government is trying to make sure that patients have timely access to diagnostic treatment and elective surgery by taking measures to reduce waiting time. Australia wide in 2011-12, total knee replacement had the longest median waiting time (184 days) and coronary artery bypass graft had the shortest median waiting time (16 days). By specialist surgeon, longest median waiting time is for ophthalmology (74 days), and it took nearly 335 days to treat 90% of the patients followed by ENT with a medium waiting time of 66 days. According to Australian Government Institute of Health and Welfare (2012), in Australian hospitals in 2010-11, nearly 50% of patients waited for 36 days or more for elective surgery, an increase of 4 days from 2006-07. Nearly 2.9% of patients waited for more than a year for elective surgery.

According to Medhekar and Ferrer (2012, p.208) “Value, in the context of health service supply chain, can be defined as something that the customer is willing to pay for. Value-adding activities transform materials and information into something a customer wants. Non-value-adding activities consume resources and do not directly contribute to the end result desired by the customer. Long waiting periods, therefore, is defined as anything that does not add value from the customer’s perspective.” Seddon et al. (1999) study found that waiting time for coronary artery bypass surgery was longer in New Zealand than in Ontario Canada due to funding constraints. Thus, waiting time from point of appointment with the general practitioner (GP), and then the actual referral to the specialist surgeon, diagnosis, and then appointment for complex surgeries in a developed country is very critical from a patient’s perspective in terms of health and well-being, and quality of life.

Various studies on waiting time for different types of surgeries in different countries confirm

that waiting time is a matter of concern. A study by Carroll, Horn, Soderfeldt, James, and Malmberg (1995), found that the longest waiting times for all cardiovascular procedures were reported in the United Kingdom, Sweden and Canada, with some waiting times for elective procedures > 9 months. In an empirical study by Clover, Dobbins, Smyth, and Samson-Fisher (1998), where 691 US patients’ data was obtained from a computerized booking system shows that four factors were significantly associated with waiting time (i) type of surgical speciality, (ii) urgency rating, (iii) employment status, and (iv) the status of patient’s health insurance. Other factors such as age, gender, country of birth, hospital, education, marital status, and health-care card were not significantly associated with waiting time for elective surgery. Dexter, Macario, Traub, Hopwood, and Lubarsky (1999) study concluded that 367 patients in the USA wanted to wait for 2 weeks (median) longest time as acceptable for an elective surgery. Dunn, Black, Alonso, Norregaard, and Anderson (1997) conducted a study where patients over the age of 50, accepted 3 months or less waiting and 6 months or more was unacceptable for cataract surgery in all three countries Canada, Denmark and Spain, and their dissatisfaction increased with the increase in the duration of waiting time. The study of Coyte et al. (1994) also concluded that patients preferred less waiting time in Ontario (Canada) for knee replacement surgery from the time of initial consultation with an orthopaedic to knee replacement surgery. A New Zealand study on waiting time for elective surgery for hip and knee joint replacement conducted by Derrett, Paul, and Morris (1999) concluded that “people with more severe symptoms desire surgery more quickly than people with less severe symptoms” as it reduced their health related quality of life. Another study on UK patients also concluded that with increasing waiting time for emergency hip-surgery in elderly patients significantly increases rehabilitation process and hospital stay (Thomas, Ord, & Pailthorpe, 2001).

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Pell, Pell, Norrie, Ford, and Cobbe (2000), studied whether waiting time for cardiac surgery of 26,642 patients in Scotland was effected by their socioeconomic status based on urgency, age, gender and type of operation. They concluded that patients with low socioeconomic status were more likely to develop coronary heart surgery and were disadvantaged as they were on low priority list and so had to wait longer for elective surgery or less likely to be investigated for surgery. This means that few of these patients are most likely to travel abroad for treatment. Given the key economic problem of scarcity of resources, demand for elective surgery is greater than the supply in developed countries. A study by Mayo et al. (2001) of 29,606 women diagnosed with breast cancer concluded that the waiting time for breast cancer surgery from diagnosis to surgery in Quebec has increased between 1992-1998 due to increased demand, decreased resources, and changes in the pattern of care. Further impact of waiting time for total hip-anthroplasty surgery led to significant "loss of quality adjusted life years...and patients experience weeks and months of rapidly reversible pain and disability" (Ostendorf et al., 2004, p. 308), resulting in deteriorating health. Another study by Löfvendahl et al. (2005, p. 133) on waiting time for orthopaedic surgery in Sweden also found that "patients' value short waiting times and the possibility of influencing the date of surgery".

A study by Crawford, Davis, Siddiqui, de Caestecker, and Gills (2002), found that delays in treatment for women with endometrial cancer in Scotland resulted in high survival rate, which is contrary to other studies. They calculated waiting time from the dates of GP appointment and referral letter, clinical appointments, investigations, and operation. VanBerkel and Blake (2007) studied Canadian patients and concluded that, with the given resources, allocated expected waiting time for general surgery was 100 days in 2007. They have suggested more efficient and economical use of resources, beds and time to avoid this problem. Chen, King, Pearcey, Kerba, and MacKillop (2008)

also suggested that the risk of local recurrence of cancer increases with increasing waiting time for radio therapy (RT), and decreases the survival rate. Waiting time for RT should be as short as possible to improve the survival rate and quality of life. In another study, cataract patients from Canada and Spain were willing to pay for surgery in a private hospital in Denmark, if anticipated waiting time for cataract surgery increased more than one month. Willingness to pay was more for patients who were educated and had severe vision problems (Anderson et al., 1997; Bishai & Lang, 2000).

From the above studies, it can be concluded that a long waiting list has resulted from an increase in demand for elective surgery due to an ageing population in developed countries, increased expectations from patients, new medical technology, insufficient supply of healthcare services resulting in shortage of resources such as specialist surgeons, beds, hospitals and time to treat patients in a timely manner, and government failure in managing and providing timely access to healthcare. Waiting time for elective surgery in most of the developed countries, such as USA, UK, Europe, and Australia, drives patients to travel abroad for medical treatment.

Accreditation: International patients from developed country are not only seeking low cost and no waiting period for elective surgery, but also first world quality of national and international accreditation of medical facilities, treatment, and professionals in the overall healthcare service delivery. The Joint Commission International (JCI), launched in 1999, is the global arm of the US-based Joint Commission on the Accreditation of Healthcare Organizations (JCAHO). JCI has certified over 18,000 hospitals in the United States and 17 in India (JCI, 2012). The growing demand for medical tourism has led JCI to accredit hospitals in Europe, Asia, Africa, and the Middle East, and to effectively evaluate and guarantee the quality and safety of medical tourism product and service providers. Key barriers to overcome in

medical tourism within developing countries are the perceptions among potential medical tourists of inadequate standards and quality of medical treatment, non-availability of latest technology, and absence of accreditation from internationally recognised accrediting bodies. Since 1999, JCI has accredited 186 medical facilities and 359 hospitals in 51 countries, with a total of 545 as of October 2012 (see Table 3). JCI-accredited hospitals have to renew their accreditation every three years, and must collect and report data on services provided and quality indicators (Mattoo & Rathindran, 2006).

Other organizations that provide information on certain standards regarding the quality of hospitals, health care, and medical ethics include the International Society for Quality in Health Care (ISQUA), the National Committee for Quality Assurance (NCQA), the European Society for Quality in Healthcare (ESQH), and the International Standards Organization (ISO). From Table 3 we can see that Saudi-Arabia, followed by UAE,

Brazil, Thailand, Turkey, and India out of their total JCI accredited medical facilities, have the highest number of medical hospitals (h), accredited by JCI.

Certification and accreditation by international accrediting bodies guarantees and determines the quality of care, the reputation of the medical institution and their medical professionals, along with the demand for accredited hospitals by the patients. JCI's standards and qualifications are derived from an international consensus of achievable expectations for structures, outcomes, and processes for medical facilities. JCI works closely with private and public hospitals, government agencies, health care providers, health insurance companies, patients, legal experts, medical consultants, and other major players in the larger health care industry to ensure the consistency and reliability of its accreditation process. JCI approval is not the only accreditation available for medical tourism facilities. However, it is the most widely accepted medical tourism industry benchmark, and

Table 3. Number of JCI accredited medical facilities & hospitals

Asia & China	South Asia & West Asia	Middle East & Africa	Latin America & The Caribbean	Europe
20-China-16h	Bangladesh-1h	Egypt-3h	Barbados-1h	4-Austria- 2h
Indonesia-5h	20-India-17h	Ethiopia-1h	Bahamas-1h	Belgium-1h
4-Japan-3h	Pakistan-1h	8-Israel-7h	Bermuda-1h	Slovenia-2h
33-SouthKorea-13h	Kazakhstan-1h	11-Jordan-9h	42-Brazil- 23h	4-Czech Rep-1h
9-Malaysia-7h	Russia-1h	Lebanon-2h	Chile-2h	15-Denmark-13h
Philippines-4h		10-Qatar-5h	Columbia-2h	Germany-3h
21-Singapore-14h		50-SaudiArabia-42h	Costa Rica-3h	Greece-1h
35-Thailand-18h		57-UAE-38h	Equador-1h	22-Ireland-16h
21-Taiwan-11h		Kuwait-2h	10-Mexico-8h	21-Italy-14h
Vietnam-1h		Yemen-1h	Nicaragua-1h	12-Portugal-8h
		Bahrain-1h	Panama-2h	21-Spain-7h
		Nigeria-1h		46-Turkey-18h
		Oman-2h		
Total = 153	Total = 24	Total = 149,	Total = 66	Total = 153

Source: Compiled from Joint Commission International (5-10-2012) (h = hospitals). Key format (For example): India has a total of 20 medical facilities accredited by JCI, out of which 17 are hospitals. Likewise, Thailand has 35 total medical facilities accredited by JCI, out of which 18 are hospitals.

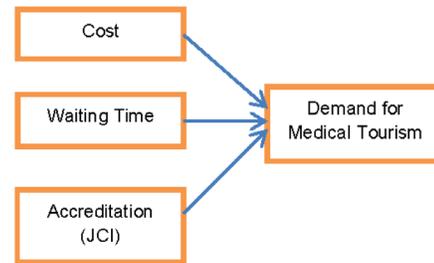
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followed by the Confederation of Indian industries (CII) accreditation for hospitals and India British Standards Institute (IBSI). Accreditation is essential for assessing levels of patient information, rights of the patient and their families, quality of surgical service, and protection from infection in the medical tourism industry so as to gain a credible reputation due to the increased demand for medical tourism (JCI, 2012).

Brenzel (2004) has also argued that it is crucial for health-care providers to be accredited and be a part of international referral networks, so that they can be rated for risks and quality by JCI and other accrediting bodies, which will also make health insurance more portable from one country to another in the global medical tourism industry. In other words, accreditation is crucial because it overcomes the barriers to medical tourism and builds confidence among actual and potential medical tourists with regards to the quality of health care and in making a decision to travel to a developing country. This confidence increases when accreditation is accompanied by affiliations with prestigious hospitals or health care systems in developed countries (Mattoo & Rathindran, 2006). Some examples of these associations include the Harvard Medicine School partnering with the Dubai Healthcare City in launching the University Hospital, and the Johns Hopkins Hospital having ties with well-known hospitals in Japan, Singapore, India, UAE, Canada, Lebanon, Turkey, Ireland, Portugal, Chile, & Panama (Deloitte, 2008).

Based on the above review, the developed conceptual model shown in Figure 2 comprises the three key demand factors of medical tourism that drive the innovation in terms of providing affordable choices of destinations for medical treatment which is of first world quality and less or no waiting period by emerging economies to foreign patients. Thus three drivers of demand for medical tourism are also the cause of disruptive innovation for the healthcare industry.

Figure 2. Key drivers of demand in medical tourism



In the public health hospital system of the developed countries, full capacity has been met because of the shortage of resources in terms of specialist medical staff and beds, and there is a non-price waiting list for elective surgery in the absence of private health insurance (Medhekar, 2010). Patients have no choice but to wait in the queue if they cannot afford private health insurance or do not have money to travel abroad for treatment. However, in the private system the market forces of supply and demand work in favour of patients, allowing them to jump the queue with their private health insurance and ability to pay. The emerging economies of developing countries such as India, Thailand, and Brazil are providing first world medical treatment at third world prices, with no waiting time, state of the art technology, sufficient supply of medical professionals, and JCI accreditation of healthcare facilities and treatment to foreign patients at the cost of access to primary, secondary, and tertiary health care to millions living in poverty.

MANAGERIAL AND POLICY IMPLICATIONS: RECOMMENDATIONS

Low cost of surgery and shorter waiting time for complex medical treatment and surgeries, and JCI quality of health care facilities and treatment, are significant in maintaining sustainable growth and development of a global healthcare industry for

the emerging economies of Thailand, India, and Malaysia. There are significant managerial and policy implications for private sector healthcare providers, public sector hospitals, and government involvement in formulating health policies; these include:

1. Clearly defined international law and ethics related to medical tourism are necessary for the safety and security of the foreign medical tourist, as well as domestic medical patients.
2. Maintaining international accreditation, continuous upgrades of medical infrastructure facilities and state-of-the-art medical technology are necessary to avoid excessive waiting periods and to be competitive in these emerging markets.
3. Private corporate hospitals, as well as the enforcement of government ethical policy and regulations, must make sure that correct information is provided to foreign patients on the hospital websites in regards to cost comparisons between countries for different types of specialist surgery, waiting time, JCI accreditation of medical facilities, availability of both innovative state-of-the-art medical treatment/surgery with latest medical technology and qualified physicians or teams of surgeons.
4. A training program for culturally competent medical health literacy for medical tourism staff should be put in place to ensure that they remain sensitive to patients from different cultural, religious, and ethnic backgrounds.
5. It is important to have a supply side policy in place to increase the capacity and supply of specialist surgeons and physicians, along with accredited quality of medical facilities and sufficient number of beds, in prudent consideration of the growing global demand for medical tourism and healthcare services, so as to reduce the cost and waiting time.
6. Governments of developing emerging economies promoting trade in medical

tourism healthcare services and desiring to be competitive in maintaining sustainable development and growth of their medical tourism industry, and thus attract foreign medical patients from developed countries, have to provide clean, green, and hygienic local environments such as Singapore and other developed countries, along with world standard country infrastructure, tourism and sightseeing facilities.

FUTURE RESEARCH DIRECTIONS

The health and medical tourism Industry is driven by international patients, who are not insured or are underinsured and cannot afford to pay high prices for elective surgery after waiting in a long queue within their home countries. When informed patients looking for better alternatives make the choice to travel abroad for treatment, they frequently seek out the developing emerging economies of Asia, Eastern Europe, and South America, regions where the healthcare treatment is at affordable third world prices, there is little waiting time, and first world quality healthcare is readily available. Health or medical tourism is a very complex and wide field of study. It cannot be viewed in isolation or as existing within the context of one discipline alone. It has many dimensions and issues that researchers should consider. There are various perspectives among different areas within the medical tourism industry that can be explored and researched, such as: healthcare economies' supply versus demand, globalisation of healthcare service delivery, global supply chains in medical tourism, tourism economics, international trade in healthcare services, impacts of medical tourism service quality on other industries, health public policy and regulation issues, healthcare financing, legal issues, ethical issues, global health insurance transferability, ageing population, and human resource studies.

CONCLUSION

This chapter provides insight into the factors that lead medical tourists from advanced industrialized countries such as USA, UK, Europe, and Australia to travel abroad to have surgeries in developing countries such as India, Thailand, and Mexico. Medical tourism is a new and innovative concept in terms of international travel and trade in health care services. This chapter, based on the existing literature, has developed a conceptual model that includes the three demand drivers of medical tourism, namely: cost, waiting time, and JCI accredited quality of medical facilities and treatment. Chapter also justifies the conceptual framework of medical tourism as an innovation in global healthcare provision by emerging economies who have realised the healthcare crisis, escalating cost, long waiting time, non-availability of treatment due to regulation in developed countries and seen this as an entrepreneurial opportunity for developing and marketing their private healthcare sector to the industrialised world, in providing affordable alternatives with no waiting time and JCI first world quality of treatment as well as those treatments not available by regulation in developed countries' such as surrogacy, gender change, cosmetic surgeries, stem cell research and state-of-the-art medical technology and treatment.

With the increasing number of patients traveling to emerging economies, governments in these countries have to play a key role in regulating the industry, in relating to ethical issues, in ensuring and monitoring hygiene, health, and safety of the medical facilities, and in safeguarding medical tourists from any mishaps or virus infections. Economic development and growth among emerging economies not only provide entrepreneurial opportunities in the global healthcare industry, but also offer opportunities for innovation in the health sector and its related industries.

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KEY TERMS AND DEFINITIONS

Domestic Medical Tourism: A phenomenon where a person travels from remote rural or regional area due to non-availability of medical treatment, to a capital city for diagnostic, non-surgical or surgical treatment.

Globalisation of Healthcare Services: Is a phenomenon where increasing number of patients from developed countries are now travelling to developing countries for health tourism that is also called as either wellness tourism or medical tourism. This has given rise to growth and development of trade in healthcare services by many developing countries in Asia, South America and Eastern Europe providing alternative choices of first world quality of health care at affordable cost, where world is becoming our hospital.

Innovation in Context of Medical Travel Overseas: Medical tourism, where patients from developed or developing countries make alternative informed decision and choose to travel to another country for medical treatment due to low cost, no waiting time for elective surgery and world class innovative methods of medical treatment.

Medical Tourism: A phenomenon when a person travels across border to another country mainly for diagnostic, non-surgical or surgical treatment because of low cost, no waiting time, quality of care and availability of treatment and may be having a holiday.

Quality of Health Care: Organizations that provide information on certain standards regarding the quality of medical facilities, ambulatory care, care continuum, clinical care program certification, clinical laboratory, hospital, medical transport and primary care health care and medical ethics such as: Joint Commission International (JCI), the International Society for Quality in Health Care (ISQUA), the National Committee for Quality Assurance (NCQA), the European Society for Quality in Healthcare (ESQH) and the International Standards Organization (ISO).

Waiting Time: It is the time a doctor (GP) refers a patient to a specialist surgeon, who then refers the patient on an elective surgery waiting list depending on the patient's condition. In Australia, waiting time does not include the time taken to receive a General Practitioner's (GP) appointment and then GP referral to a hospital specialist for a surgical assessment.

ENDNOTES

- Asian Medical Tourism Association (AMTA)
- Confederation of Indian Industries (CII)
- European Society for Quality in Healthcare (ESQH)
- Government of India (GOI)
- Gross Domestic Product (GDP)
- International Standard Organisation (ISO)
- International Society for Quality in Healthcare (ISQUA)
- Joint Commission International (JCI)
- National Committee for Quality Assurance (NCQA)