

Medical Tourism and Hospitality in Hospital

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Abstract

Medical tourism is a growing phenomenon with policy implications for health systems, particularly of destination countries. Both private sectors and the governments of such destinations are found playing important role for medical tourism promotion and development. This study tries to highlight a conceptual analysis of medical tourism, the targeting of medical tourism flows and major destinations, and the proposed medical tourism development strategies based on the experience of several countries regarding medical facilities. Medical tourism, where patients travel overseas for operations, has grown rapidly in the past decade, especially cosmetic surgery. The review of current literature reveals that no integrated theoretical framework for the holistic study of the medical tourism industry exists. This study examined whether the scholars who studied medical tourism and hospitality in hospitals found interrelationship between those two different sectors. Those who studied medical tourism or healthcare tourism didn't touch on hospitality provided to hospital patients. Likewise, those who studied hospitality in hospitals also ignored the dimension of tourism. In this regard, this study shows the interrelationship between these two entities. i.e medical tourism and hospitality in hospitals which are very important for understanding the concept of medical tourism in better way. Additionally, this study also enters the sphere of cross cultural behavior and intercultural communication between the hosts and the guests.

Keywords: *Medical tourism, hospitality, typology, authenticity, policy implications*

Background

Tourism is one of the leading economic forces. The travel and tourism industry accounts for \$4.4 trillion of economic activity worldwide (World Bank Group, 1998; in Bookman & Bookman, 2007, p.21), leading UNCTAD to call it the world's largest industry (McLeran, 2003; in Bookman & Bookman, 2007, p.21). Lundberg et al. (1995; in Bookman & Bookman, 2007, p.21) claim, "Tourism has become the world's largest business enterprise, overtaking the defense, manufacturing, oil and agriculture industries (Wharton Economic Forecasting Association; in Bookman & Bookman, 2007, p.21). It has grown at twice the rate of world gross national product (GNP) during the 1990s and in 2005, it accounted for over 10 percent of world GDP. As the fastest growing foreign income sector worldwide, tourism accounts for 8 percent of world export earnings and 37 percent of service exports (Benavides & Perer-Ducy, 2001; in Bookman & Bookman, 2007, p.21). While most of the tourist activity that causes this growth tends to be concentrated in Western countries, developing countries are very impressed with its economic potential. They have come to view tourism as a panacea because it increases the flow of foreign currency, contributing directly to the current account of the balance of payments and generating successive rounds of economic activity; leaders are therefore quick to offer their natural resources. As Cynthia Enloe noted, countries are increasingly putting all their development eggs in the tourist basket (Bookman & Bookman, 2007, pp.21-22).

Hospitals are health care institutions that have an organized medical and other professional staff, and inpatient facilities, and deliver medical, nursing and related services 24 hours per day, 7 days per week. Hospitals offer a varying range of acute, convalescent and terminal care using diagnostic and curative services in response to acute and chronic conditions arising from diseases as well as injuries and genetic anomalies. In doing so, they generate essential information for research, education and management. Traditionally oriented on individual care, hospitals are increasingly forging closer links with other parts of the health sector and communities in an effort to optimize the use of resources for the promotion and protection of individual and collective health status (WHO, 2018; in Hussain & Babalghith, 2014, p. 62).

In suggesting that there was a place for hospitality in the hospital setting, Cassee and Reuland (1983) highlighted the challenge of describing the concept of hospitality and in particular its relevance to hospitals. Initially, it seems that there is a good case for seeing hospitality as an important attribute of a satisfactory hospital stay and further that the more at ease people feel, in the hospital situation, the sooner they recover. To assess how applicable the concept of hospitality is to the hospital situation, a closer examination of the concept is required (Hepple, Kipps, & Thompson, 1990, p. 305).

Although the words hospital and hospitality have the same root, some hospitals have been seen as not very hospitable places. During the 1980, when hospitals and other types of health care organisations began to compete for patients, being hospitable was seen as offering a competitive advantage (Super, 1986; in King, 1996, p. 219). In order to improve patient satisfaction and retention, some hospital constituted guest relation programs, in imitation of companies such as Marriott and Disney (Zemke, 1987; Betts & Baum, 1992; in King, 1996, 219). Many of these programs failed to achieve results, and by the late 1980s, guest relations programmes were labeled as fads (Bennett & Tibbits. 1989; Ummel, 1991; in King, 1996, p. 219). One reason for the failure was a narrow focus on training from line employees to be courteous to patients or improving their interpersonal communication and complaint handling skills (Peterson, 1988; in King, 1996, p. 219).

Hepple et al. (1990) reviewed the existing literature for definitions of hospitality, and identified four characteristics of hospitality in its modern sense.

- It is conferred by a host on a guest who is away from home.
- It is interactive, involving the coming together of a provider and receiver.
- It is comprised of a blend of tangible and intangible factors.
- The host provides for the guest's security, psychological and physiological comfort.

They examined the concept of hospitality as applied to hospital patients, and they operationalized the four characteristics as “feeling at home”. Then they identified 10 factors as measures of this feeling in a hospital setting. The factors included friendly staff, admission procedure, information regarding daily routine, plain cooking and menu choice, privacy, comfortable furniture, recreational facilities and attractive décor. Only some of these, such as menu choice, cooking privacy, furniture and décor concern a home-like setting.

Along with the World Trade Organisation (WTO), the United Nations Conference on Trade and Development has been heavily involved in the promotion of trade in the health services sector. The General Agreement on Trade in Services (GATS) (1995), developed by the WTO, provided the legal framework for the liberalisation of the international trade in health services. The GATS defines four trade modes of international trade in health services, as follows (Smith, Blouin, and Drager 2006 ; in (Whittaker, Manderson, & Cartwright, 2010, p.338):

Mode 1, “cross-border supply,” includes services such as telemedicine, teleradiology, or telepathology, involving the international outsourcing of the interpretation of diagnostic images or test results.

Mode 2, “consumption abroad,” is concerned with the movement of patients across international borders.

Mode 3, “commercial presence,” includes health care institutions providing services in locations outside their countries.

Mode 4, “presence of natural persons,” involves the movements of health staff to be employed in other countries’ health systems (Whittaker, et al., 2010, p.338).

The growth in medical and surgical travel includes dentistry, optometry, complementary “alternative” faith-based and traditional therapies, other allied health professional services, and pharmaceutical products, in addition to the kinds of procedures described in this issue. This growth in travel is driven by a number of factors: the changing demographic profile of aging populations in high- and middle-income countries seeking health care, the ease of international travel and global communication, the retreat of neoliberal states from the provision of public services, and the increasing port-ability of health insurance (Whittaker, et al., 2010, p.338).

Adding medicine for foreigners to the mix further expands the economic opportunities of developing countries. Worldwide, health services are estimated to be worth some \$3 trillion, and the health-care sector is among the highest growth sectors in the mid-2000s. Trade in medical services is a small but growing component of overall medical care. As a result, medical tourism has been described as having endless opportunities and benefits for developing countries that manage to break into the market (Bookman & Bookman, 2007, pp. 21-22).

The rapidly growing medical travel industry has implications for the health systems of both sending and receiving countries (Whittaker et al., 2010, p.336). Travel for health purposes is not new. However, the scale, extent of promotion, and organisation of medical services for fee-paying patients, regardless of citizenship status, is new; so too is the ease of travel and the links with global corporate capital and networks (Whittaker, et al., 2010, p.337).

Medical tourism and tourist

Before defining and describing medical tourism, it is very essential to know about the general meaning of ‘hospital’ and ‘medical’. In the past, hospital had been understood as Organised Delivery Systems (ODSs) and later on its understanding has been broadly shifted to Accountable Care Organisations (ACOs). The term hospital also has been defined as a network of organisations which provide or arrange to provide a coordinated continuum of services to a defined population and is willing to be held clinically and fiscally accountable for the outcomes and health status of the population served (Shalowitz, 2013). The term ‘medical’ in its noun form has been defined as ‘an examination to access a person’s state of physical health’. In the course of the development of tourism, medical and tourism were strongly linked to each other.

Medical tourism comprises both medicine and tourism. Although the core product is medical treatment, both attractive hospitality and travel options are also essential. Hence, medical tourism requires good coordination of the healthcare and tourism industries. Realizing the full potential of this sector requires strategic planning and coordination among such key players as hospitals, medical travel agencies, hotels, and the medical tourists themselves.

Medical tourism, according to Connell (2006), is a niche in the sector by the fact that tourist travel from their home for the purposes gaining medical attention. It is like ecotourism, religious tourism, and adventure tourism. Medical tourism refers to a vacation that involves travelling across international borders to obtain a broad range of medical services. It usually includes leisure, fun, and relaxation activities, as well as wellness and health-care service. Patients who seek to reduce their health expenditures travel to medical centres in other countries to obtain dental, medical and surgical services that are less expensive than that at home (Connell, 2006, p.1095). Robinson and Novelli describe tourist niches as depending on the existence of a market as well as an audience for the product. Such tourism does not draw masses but rather it appeals to a select number of people whose demand is big enough to generate sufficient business. Medical tourism, with its component medical and tourist parts, has both a market and an audience. Unlike ecotourism, in which a traveller will choose a destination and then seek an ecological focus, in medical tourism the traveller chooses medical care first, and only then pairs it with a destination and possibly even a vacation tie-in. As all tourism is goal oriented (in the sense that travellers want to see a sight, or experience a tribal encounter, or touch a historical artifact, or simply party), so too medical tourism occurs with a specific goal in mind. The travelling patient aims to purchase a particular service and to achieve a defined health goal. That patient seeks to maximize utility subject to his income constraints. In that calculation, medical services dominate, but nonmedical services, including the accommodations, restaurant meals, excursions, and ground transportation, are not insignificant to the total experience (Bookman & Bookman, 2007, p.41).

Similarly, to typologies created on tourism in general (for example see Cohen, 1984), some authors further divide medical tourism into subcategories, where life-saving procedures are separated from life-enhancing procedures. For Connell (2006b) and Voigt et al. (2010), essential treatments designated to target acute or chronic conditions (such as cancer treatment) are differentiated from non-essential or elective treatments. Connell (2006b; in Cook, 2010, p.140) further suggests that some treatments, such as certain forms of dental treatment, straddle both medical tourism categories.

Within the European context a medical tourist may be categorized in one of two ways. First, there are those citizens who use their European citizenship rights to

access medical care in EU Member States and their national purchaser reimburses the costs of their treatment abroad. This is allowed because European citizens, under specific circumstances, have rights to receive medical care in other EU countries. Such rights have been established by successive rulings of the European Court of Justice on private cases regarding consumption of health care in another EU Member State and reimbursement by the (national) purchasing body in the home country (Bertinato et al., 2005; in Lunt, Smith, Exworthy, Green, Horsfall, & Mannion, n.d.,p.8).

Goodrich and Goodrich (1987) defined health care tourism as “the attempt on the part of a tourist facility or destination to attract tourists by deliberately promoting its health-care service and facilities, in addition to its regular tourist amenities” (p. 217), thus emphasizing the supply side. Van Sliepen (as cited in Hall, 1992) placed stronger emphasis on the demand side and viewed health tourism as comprising three elements: staying away from home, health as the primary motive, and occurring in a leisure setting.

The entrance into medical tourism is an effective healthcare system for tourists. For this purpose, scientific research needs to be done to identify the health service seeking practice and behavior of the tourists. This study therefore provides the basic groundwork for developing effective strategies for tourists’ healthcare. A new niche has emerged in the tourist industry while some writers continue to use the phrase ‘health tourism’ to cover all form of health related tourism (e.g. Harcia-Altes, 2005; in Connell, 2006, p.1094). It seems more useful to distinguish ‘medical tourism ‘ as one involving specific medical intervention (Connell, 2006, p, 1094).

The definitions and classifications of health and wellness tourism vary, as they do for health, medical and wellness tourism. Several scholars do not differentiate between wellness tourism and medical tourism and place wellness-related categories under the general terms of medical tourism. For instance, one typology (Voigt et al, 2010, p.30; in Pirnar, 2012, p. 129) suggests the four medical tourism categories of:

1. Illness: medical check-ups, medical surgery, dental treatment.
2. Wellness: beauty care, spa treatment, yoga, herbal healing.
3. Enhancement: cosmetic surgery
4. Reproduction: fertility treatment and birth tourism.

Many different scholars who studied medical tourism have defined medical tourism in their own way. Unlike other forms of tourism, where tourism is more noticeable, in the health system, identifying tourism functions is more complicated. The nomenclatures used in the literature define medical tourism as international medical travel involving a trip (Fedorov et al., 2009, Cormany & Baloglu, 2010,

Crozier & Baylis, 2010; in Carmen, Iordache, Iuliana, Ciochina, 2014, p. 62), medical services outsourcing across borders (Jones si Keith, 2006; in Carmen et al., 2014, p. 62), medical refugees (Milstein si Smith, 2006; in Carmen, et al., 2014, p. 62) and even biotechnological pilgrims (Song, 2010; in Carmen et al., 2014, p. 62).

It is a truism that tourism is supposed to be about relaxation, pleasure and an increase in wellbeing and even health (Connell, 2006, p. 1093). Tourists need not necessarily be hedonists, but they anticipate a beneficial outcome. In the past decade the attempt to achieve better health while on holiday, through relaxation, exercise or visits to spas, has been taken to a new level with the emergence of a new a distinct niche in the tourist industry; medical tourism (Connell, 2006, p. 1093). The tourism industry is continually developing and expanding to meet the needs of changing consumer expectations (Tresidder, 2011, p. 266). Travel for its direct and indirect health benefits has a long history, but healthcare tourism is currently enjoying a new popularity with an increase in the provision of its assorted forms, which range from health surgery to herbal remedies (Henderson, 2004, p. 111). Medical tourism is about to become the new and emerging international business, a growing phenomenon involving both social and economic benefits and risks (Carmen et al., n.d., p. 68). The limited studies on medical and health tourism also tend to focus on a business perspective, and often seek to understand and limit the phenomenon to static, universal definitions (Sobo, 2009; in Cook, 2010,p.136).

Goeldner (1989; in Boga & Weiermair, 2013) and Kasper (1996; in Boga & Weiermair, 2013) health tourism as featuring two determining elements: i) Staying away from home and ii) Health as the most important motive. In addition, Goeldner (1989) adds a third determining element done in a leisure setting. Kasper differentiates the second element further by defining health and tourism as travelling for the maintenance, enhancement or restoration of wellbeing in body, mind and soul. A similar definition can be found in Carrera and Bridges (2006).

Carrera and Bridges (2006; in Pocock & Phua, 2011, pp. 1-2) define medical tourism as “the organized travel outside one’s natural healthcare jurisdiction for the enhancement or restoration of the individual’s health through medical intervention”, using but not limited to invasive technology. The authors define medical tourism as a subset of health tourism, whose broader definition involves “the organized travel outside one’s local environment for the maintenance, enhancement or restoration of the individual’s wellbeing in mind and body”. Medical tourism constitutes an individual solution to what is traditionally considered a public (government) concern, health for its citizen, who at the micro level are responding to market incentives by seeking lower cost and/ or high-quality care overseas that cannot be found at home. Travelling overseas for medical care has historical roots, previously limited to elites from developing countries to developed ones, when health care was inadequate

or unavailable at home. Now however, the direction of medical travel is changing towards developing countries (Carrera & Bridges, 2006; in Pocock & Phua, 2011, pp. 1-2), and globalisation and increasing of health services as a market commodity have led to a new trend; organized medical tourism for fee paying patients, regardless of citizenship, who shop for health services overseas using new information sources, new agents to connect them to providers and inexpensive air travel to reach destination medical (Whittaker, et. al, 2010; in Pocock & Phua, 2011, pp. 1-2).

Medical tourism is categorized as a segment or sub-sector of health tourism defined by Erfurt-Cooper and Cooper's textbook (2009, p.6; in Pirnar, 2012, p. 128). Medical tourists not surprisingly are mainly from rich countries where the costs of medical care may be very high, but where the ability to pay for alternatives is also high. Most are from North America, Western Europe and the Middle East (Connell, 2006, p. 1096).

The objective of studying this subject is to understand tourism as an economic powerhouse which is linked with medical tourism and hospitality. Medical tourism is getting more popular and this has driven developing countries to consider developing medical services for the international patients. Though there is limited research on medical tourism, the researcher made an effort to disseminate the knowledge on medical tourism and hospitality in hospitals. This work will be useful to the students and researchers of medicine, nursing, tourism and hospitality studies/ management including the other areas of academia. It has also been assumed that the review will help many students and researchers. Knowledge production and dissemination will be possible two ways: either through original research work which requires financial support; if not the alternative will be review of secondary sources.

Medical tourism is a growing industry around the world. The trend of patients going abroad for non-emergency treatment is increasing significantly. According to Asia Medical Tourism Analysis and Forecast for 2015, Asia is expected to welcome 10 million medical tourists by 2015 with Thailand, India and Singapore controlling more than 80% market share.

Medical tourism doesn't have a standard definition, but it is a term initially coined by travel agencies and mass media to publicize the new form of medical travel, and now widely used by academic and industry researchers, policy makers, provider and consumers (Samir & Karim, 2011; in Mogaka et al., 2017,p.2).

Glinos et al. (2011) agree medical tourism may have little to do with general tourism (Lunt et al., n.d., p.9). The term emphasizes the commoditisation and commercialisation of health travel. Medical tourism also highlights the role of the

industry, issues of advertising, supplier-induced demand and extends beyond the notion of willingness to travel (Lunt et al., n.d., p.9).

Medical tourism is defined as the sum of all the relationships and phenomena resulting from a journey by people whose primary motive is to treat or cure a medical condition. This includes taking advantage of medical intervention services away from their usual place of residence while typically combining this journey with a vacation or tourism elements in the conventional sense (Voigt et al., 2010: 36, emphasis added in Cook, 2010, p.140).

Medical tourism refers to a vacation that involves travelling across international borders to obtain a broad range of medical services. It usually includes leisure, fun, and relaxation activities, as well as wellness and health-care service. Patients who seek to reduce their health-care expenditures travel to medical centres in other countries to obtain dental, medical, and surgical services that are less expensive than those at home. Medical tourism is now a US\$60 billion global business, with an average annual growth rate of 20% (Macready, 2007; “Medical Tourism, Asia’s Growth Industry,” 2006).

Lunt et al. (n.d.) defines medical tourism as when consumers elect to travel across international borders with the intention of receiving some form of medical treatment. Medical tourism is related to the broader notion of health tourism which, in some countries, has long standing historical antecedents of spa towns and coastal localities, and other therapeutic landscapes. Some commentators have considered health and medical tourism as a combined phenomenon but with different emphases.

Tresidder (2011, p. 268) defines medical tourism as undertaking a medical intervention away from the home country, where the medical element is the central theme of the activity. It has emerged because affordable, accessible transport (e.g. low-cost airlines) has made it easier for people to travel long distances to overseas countries to obtain medical, dental and surgical care while simultaneously being holidaymakers in the conventional sense. In simple words, medical tourism refers to people travelling to a country other than their own to obtain medical treatment. Medical tourism may also refer to those from developed countries who travel to developing countries for lower priced medical treatments. In other words, medical tourism is the travel where the primary purpose is treatment in pursuit of better health. It is identified with general health and wellbeing combining surgical or dental intervention to improve or restore health in the long term.

Medical tourism continues with the patient and their body, it travels with them, regardless of location and time. According to Goodrich and Goodrich (1987, pp. 217- 222), medical tourism focuses on travel for more serious treatments usually primarily on the grounds of cost or availability.

Ultimately 'tourism' is rather more than just a cosmetic noun for an activity that otherwise has little to do with conventional notions of tourism, since most visitors and certainly those who accompany them, find some time for tourism. Moreover, at the same time, the whole infrastructure of tourist industry (travel agents, airlines, hotels, taxis etc.) all benefit considerably from this new niche. Indeed, since for a significant proportion of patients there may be a lengthy period of recuperation, the rewards to the tourist industry, and especially the hotel sector, are considerable. Such benefits are presently unquantifiable though one estimate is that medical tourism in Thailand was worth US\$1.6 billion in 2003 (Taffel, 2004; in Connell, 2006, p. 1098), while medical tourists in South Africa were estimated to have spent between US\$30-40 million in the same year (Connell, 2006, p. 1098).

Medical tourism, as Cook (2005, p. 4) describes, is the idea of combining medical treatment with holiday- is one which is becoming increasingly fuzzy, precisely because medical treatment is merging into the tourist experience, and because it is sometimes hard to see the boundaries between body modification and medical treatment.

Many countries have recognized the business opportunity that medical travel, particularly when combined with tourism, represents. In 2005, for example, India, Malaysia, Singapore, and Thailand attracted more than 2.5 million medical travellers (United Nations Economic and Social Commission for Asia and the Pacific [UNESCAP], 2008); and Singapore, India, Thailand, Brunei, Cuba, Hong Kong, Hungary, Israel, Jordan, Lithuania, Malaysia, the Philippines, and the United Arab Emirates are now emerging as major health-care destinations. Many other countries, including Colombia, Argentina, Bolivia, Brazil, Costa Rica, Mexico, and Turkey are also in the process of making themselves attractive health-care destinations, particularly for cosmetic surgery (Singh, 2008). At present, however, Asia remains the main region for medical tourism (Connell, 2006).

Gupta (2004) has stated that, medical tourism is the provision of cost-effective medical care to patients in collaboration with the tourism industry. This process is usually facilitated by the private medical sector, whereas both the private and public sectors are involved in the tourism industry. By travelling abroad to have surgery or other medical treatment, medical tourists also take advantage of the opportunity to visit a popular travel destination, thus combining health care with a vacation.

Incidental medical tourists

Some eight percent of travellers to developing countries require medical care while on their trip (or immediately after). Usually it is for the treatment of diarrhoea, although for travellers to Africa, the primary reason is malaria. These are not illnesses tourists plan for, and therefore, their treatment is also unplanned. Foreigners who require incidental medical care in developing countries can be divided into two

categories according to the duration of their visit. Long-term stayers include students pursuing training or degree courses that require residence of several months or years. Another group of long-term stayers are foreign workers. They are migrants or expatriates working in multinational or national enterprises (in countries such as Chile, many expatriates came with the spread of multinationals in the 1980s and 1990s) (Bookman & Bookman, 2007, p.46).

The second category of incidental medical tourists consists of ordinary tourists who travel for a short period of time to enjoy beaches, jungles, and historical sites. Globally, such tourists made 700 million international trips in 2000, up from 25 million in 1950. It is no surprise that some of them got sick while on their trip. These are usually emergency care services, since routine care or minor health concerns will be shelved until a traveller's return home. The chances of healthy people becoming ill while travelling is higher than if they stayed at home, given freely floating respiratory illnesses in airplane cabins as well as exposure to digestive and other illnesses that may not exist in one's home environment. Moreover, some types of tourist activities are more likely to result in accidents that require care (for example, mountain climbing, skiing, scuba diving, or hurricane chasing).

Review of literature

This paper reviewed the secondary sources such as books, research articles and the research notes. The scholars in their previous works have made attempts to highlight the significance of medical tourism in relation with health, hospital, healing, medicine, cost and benefit, marketing, policies, economic development, human capital expertise, tourist and the destinations. Though there are various approaches of reviewing the literature, the author followed textual narrative approach instead of following narratives synthesis (in-depth approach) which is drawn from a number of studies, both qualitative and quantitative. According to May et al.(2005; in Mair, Ritchie, & Walter, 2014, p.4), narrative reviews may include thematic analysis.

In the academic literature, conceptual analysis of medical tourism has emerged from a tourism management perspective, analyzing supply and demand factors (Connell, 2006; Garcia, 2005; Henderson, 2004; Heung, 2010; in Pocock & Phua, 2011, p. 3) and as a node in the trade in health perspective (Smith, 2009; in Pocock & Phua, 2011, p. 3). Legal literature is beginning to cover patient liability issues when surgery is carried out overseas (Cohen, 2010; in Pocock & Phua, 2011, p. 3).

It is Cook (2010) who analyzed medical tourism by following sociological theory i.e. authenticity. Cook's (2010, p.136) concentration is how the medical tourism industry constructs itself and its patients and how medical tourists are the impetus and embodiment with these practices. This is achieved through an interactions

framework of authenticity. The performances of places, spaces, practices, objects and bodies which constitutes the significant social phenomena.

Recent work has begun to analyze medical tourism and its potential impacts on health systems in specific countries (Chee, 2010; in Pockock & Phua, 2011; Fergione, 2006). Yet not all health systems functions are analyzed in these accounts. A core concern is whether medical tourism diverts resources from public components of health systems in destination countries (Pennings, 2010; in Pockock & Phua, 2011). Furthermore, conceptual framework in the health systems literature focus on the impact of targeted vertical interventions in health system (Atun, De Jongh, Secci, Ohri & Adei, 2010; in Pockock & Phua, 2011). But medical tourism is a phenomenon rather than an intervention; its policy implications have yet to be considered within the context of the health system.

This paper presents a conceptual framework of medical tourism and policy implications as developed by previous researchers. It provides a basis for more detailed country specific studies on the benefits and disadvantages of medical tourism, of special relevance for policymakers and industry practitioners. Bridging the social science discipline, the public policy approach to research is a pragmatic one, with the end goal of translating research into useful policy recommendations, in this instance, those that optimize the benefits of medical tourism for both foreign and local consumers and mitigate the risks.

In course of studying medical tourism, Whittaker et al. (2010) have shed light on the political economy of medical tourism industry and the potential opportunities and disadvantages it poses for access, equity and the right to health. Bookman and Bookman in their book *Medical Tourism* (2007) discuss on the economic and health resources implication, demand and supply of the trade, the involvement of the state, and the advantages of its promotion and its role in economic development. As Sobo (2009; in Whittaker et al., 2010, p. 340) noted, anthropology has an important role to play in generating detailed data from specific locales that can be used by program planners and policy makers as they design programs to take advantage of the benefits of medical travel as they address the disadvantages created by this same activity. Lunt et al. (n.d.) have identified the key emerging policy issues relating to the rise of medical tourism with the concentration of medical tourists' flow between countries and discussed on the interaction of the demand for, and supply of, medical tourism services (p. 2).

It is Henderson (2004) who studied on healthcare tourism in Southeast Asian destinations. He concentrates on the sector's development and marketing in which the selected countries are assessed, revealing problems and opportunities with special focus on demand and supply. There is another work on medical tourism carried out

by Heung, Kucukusta & Song (2010) who have developed integrated model which has been suggested that this model will be useful not only as implications for future research but also it will be impetus for practitioners in the field of medical tourism industry. Besides they have also focused on demand and supply side. As Connell (2006) writes, the rise of medical tourism emphasizes the privatisation of health care, the growing dependence on technology, uneven access to health resources and accelerates globalisation of both health care and tourism. The author sees it as a new niche that has emerged in the tourist industry (p.1094). Carmen, Iordache, Juliana, and Ciochin (2014) in their study have shown how medical tourism is economically viable. Besides this, they have critically analyzed two areas of social life: Travel and Hospitalisation. As they write, "while tourism is associated with relaxation and leisure, development and fun, hospital is evoking images of constraints, suffering and feelings of helplessness" (p. 62). Mogaka, Masamba-Thompson, Tsoka-Gwegwen, and Mupara (2017) have also carried out a study on medical tourism on health systems in Africa, where they used a systems-based approach.

Within studies of tourism, it is possible to identify instances whereby each of the three approaches has significant analytical potential (Coles et al., 2006: 309312), for example, with respect to medical tourism. Health and medical reasons have long been identified as motives for travel, with early visitors to spas and resorts travelling to enjoy their recuperative properties. The current multibillion-dollar global medical tourism sector has emerged over time on the basis of much wider demand for medical treatment (TRAM, 2006; in Hannam, 2009, pp.91-92). Where once this might have been for spa treatments or climatic conditions for respiratory complaints, now this ranges from standard procedures for routine complaints such as hip replacements, cataract removals, dentistry and cosmetic enhancements to more intricate and involved courses of treatment on cancers, HIV-AIDS, fertilisation and xeno-transplantation the transplantation of nonhuman cells and tissue into humans (Coles, 2007b). Standard approaches to tourism (through 'business post-disciplinary tourism' and 'interdisciplinarity' see in detail Kunwar, 2018) enable to the researchers to identify the considerable volume and value in medical tourism flows and their importance to host destinations and state economies. Without embracing insights from medical sciences, bioethics and political science, we would not be able to develop as full an understanding of these visitor flows in terms of issues such as citizenship, health provision and bioregulation as key push-pull factors (Hall, 2007; Coles, 2007b; Hannam, 2009, p.92).

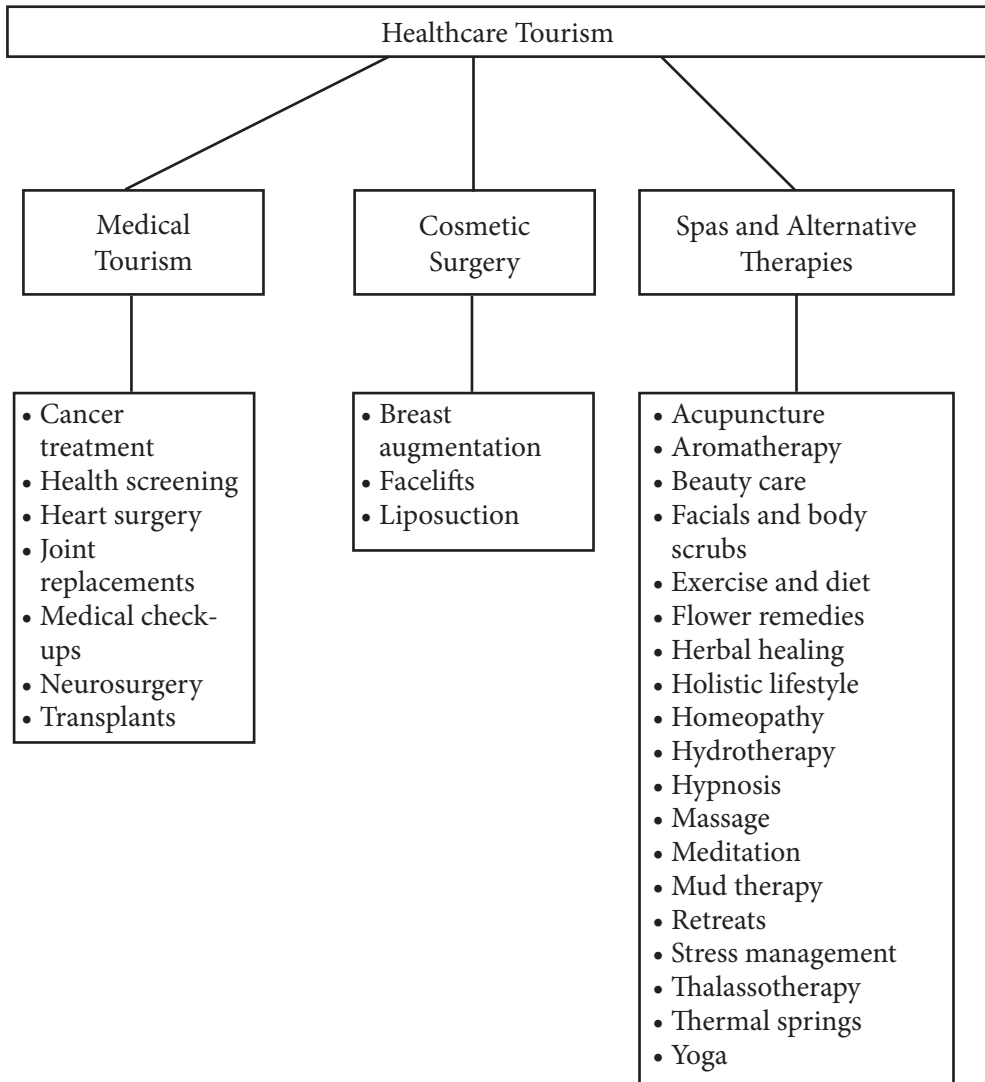
There is considerable controversy between health tourism and medical tourism advocating supremacy of one's own field or studied area. Medical tourism can be distinguished as a specific type that incorporates health screening, hospitalisation, and surgical operations, in contrast to nonessential cosmetic surgery and the often

more hedonistic indulgences of spas and alternative therapies (Henderson, 2004, p. 113). This differs from other forms of health-based tourism by the fact that the trip or vacation involves some form of medical intervention, which may vary from simple plastic surgery to liver or kidney transplants. The expanded options are also signified by a new term, medical tourism.

Though there are many problems of defining medical tourism, Connell sees medical tourism as an industry in its own right (Connell, 2006b; in Cook, 2010, p.136). Yet, in spite of the economic, geographical, social and political significance of medical tourism, it has received scant academic attention. Sobo (2009; in Cook, 2010, p.136) suggests that this has been due to the traditional lack of human movement for medical services, and the traditional flow of patients from poor health facilities in less developed countries to higher quality facilities in developed countries.

In this regard, Heung et al., (2010, p. 237) focused on health tourism rather than focusing on medical tourism because they consider that health tourism is broader phenomenon because it encompasses both wellness tourism and medical tourism. Although some scholars sometimes differentiated health tourism with medical tourism, there are some scholars who have maintained neutrality and came up with the conclusion that there are no striking differences between both phrases. Those who advocate the importance of health tourism within the framework of medical tourism, Carrera & Bridges (2006, p.447; in Lunt et al., n.d., p.7) define health tourism as the organized travel outside one's local environment for the maintenance, enhancement or restoration of an individual's well-being in mind and body. This definition encompasses medical tourism which is delimited to organized travel outside one's natural health care jurisdiction for the enhancement or restoration of the individual's health through medical intervention (Lunt et al., n.d. p.7).

There is found considerable differences between medical tourism and health tourism as that has been showed by Henderson (2011) which he developed a model showed in the following table.

Figure: The spectrum of healthcare tourism

Source: Henderson (2004, p. 113)

It is Connell (2006a; in Cook, 2010, p. 140) who replicates wellness features of health tourism but separates medical tourism, defining it as the movement of people who, in addition to holidaying as tourist, undergo medical, dental and surgical intervention that might be for serious life-threatening conditions (Whittaker, 2008). In addition, Carrera and Bridges (2006: 447, 449) believe medical tourism to be subset of health

tourism, as ‘the organized travel outside of one’s natural healthcare jurisdiction for the enhancement or restoration of the individual’s health through medical intervention’. Many of the elements commonly identified as medical tourism are encompassed in this recent definition:

In the literature, the connections between tourism and health have been referred to variously, including health tourism, healthcare tourism, global healthcare and medical tourism. As will be explored below, some authors believe that these terms are transposable while others assert that they are different and therefore need to be distinguished. The majority of existing definitions of health and medical tourism focus on the perceived desires or motivations of the consumer. Pollock and Williams (2000), Laws (1996, in Henderson, 2004) and Schofield (2004) separate health tourism from the everyday world of work and home, emphasizing that it involves ‘leisure, recreational and educational activities’ (Pollock & Williams, 2000: 165; in Cook, 2010, p.139) that are concerned with an improvement of ‘physical, mental and social wellbeing’ (Schofield, 2004: 137; in Cook, 2010, p.139). Similarly Bennett et al., (2004: 123; in Cook, 2010, p.139), liberally define health tourism as ‘any pleasure-orientated tourism which involves an element of stress relief’, but highlight a more comprehensive definition encompassing health-related pilgrimages, climatotherapy, cruises with health treatments, government promotion of health services to international tourists (a supply angle), thalassotherapy, sanitourism for the ill and their families, and health resorts.

Tourism typologies

The important thing in the study of medical tourism is that the researcher must be familiar with various typologies of medical tourism. In this regard, the literature shows different concepts and understanding of different scholars in the field of medical tourism. For example, Goodrich and Goodrich, as cited by Bookman and Bookman (2007, p.43) have coined the term health-care tourism instead of medical tourism. Likewise, Henderson (2004; in Bookman & Bookman, 2007, p.43) divided health-care tourism into three categories: spas and alternative therapies (massage, yoga, beauty care, etc.), cosmetic surgery and medical tourism. Unlike this, Hunter-Jones, in her study of the role of holidays in managing cancer, distinguished between health tourism, spa tourism, health-care tourism, and wellness tourism but Bookman and Bookman (2007, p.43) is in favour of addressing medical tourism which includes the entire industry.

The term typology refers to classification of any given entity. Different scholars have opined on the concept of tourism into different forms such as wellness tourism and xenotourism. Though medical tourism and wellness tourism are not completely interdependent with each other, they complement one another. So, it is necessary

to mention what wellness tourism is about. Along with medical tourism, the health and wellness industry has also been recognized as the fastest-growing tourism niche markets (Yeoman, 2008; Voigt & Pforr, 2014; in Hull, 2015, p.26). Wellness tourism is differentiated from medical and health tourism and is defined by Smith and Puczkó (2014, p.25; in Hull, 2015, p.26) as ‘trips aiming at a state of health where the main domains of wellness (body, mind, spirit) are harmonized or balanced. There is emphasis on prevention rather than care, but some medical treatment may be used to lifestyle based therapies’. The Global Spa Summit (2011; in Hull, 2015) also adds that wellness tourism involves people who are maintaining or enhancing their personal health and wellbeing and who are seeking unique, authentic, location-based experiences. Wellness is described as including the following dimensions: multi-dimensional, holistic, changing over time, personal influenced by the environment and encouraging self-responsibility (GSS, 2010; in Hull, 2015, p. 27).

The study of Khanal (2018) shows that Nepal has a huge potential in the field of natural healing systems like Ayurveda, Yoga, Meditation, Naturopathy, Homeopathy and Tibetan medicine.

Medical tourism is distinguished from health tourism by virtue of the differences with regard to the types of intervention, setting and inputs.

A good example is health and wellness tourism which can be broken down into at least six micro-niches:

Health and Wellness Tourism Micro-Niches	Typical Activities	Typical Visitors
Spa tourism	Healing with medical or mineral waters	Elderly visitors with health problems
Holistic tourism	Body, mind, spirit treatments in a retreat	Middle-aged professionals/executive
Spiritual tourism	Pilgrimages, ashrams, meditation retreats	Mainly over-30s, some backpackers
Yoga tourism	Asanas and meditation in retreats	Mainly professional women over 40
Medical tourism	Operations, plastic surgery	Primarily Western women over 40 women
Beauty tourism	Massage, facial treatments in a spa or hotel	Women over 25, professionals or executives

Source: Smith, MacLeod & Hart Robertson (2010, p. 1)

According to Cook (2005, p. 5), medical tourism is similar to xenotourism. Xenotourism is a contemporary development in medical tourism. It is connected to and derives from medical procedures around xenotransplantation. Xenotransplantation involves the transplantation of living animal cells, tissues or organs into a human recipient. The possibility of xenotransplantation becoming available to international patients has recently raised some concerns. While this 'xenotourism' possesses obvious similarities to transplant tourism, xenotourism raises far more dangerous for the international community. One of these dangerous is trans-species viral infection. The new intimacies created by xenotransplantation could mean viruses not previously capable of infecting humans would become infectious and create new diseases capable of generating human epidemics. According to Hall (2013, pp. 61-75), xenotransplantation poses the risk of unknown infections crossing the species barrier. As in the case of other human infectious of animal origin (for example, severe acute respiratory syndrome (SARS) and human immunodeficiency virus (HIV)), viruses are not constrained by geopolitical borders, meaning xenotransplantation produces local, national and global angst. Consequently, this globalisation of infectious disease risk highlights a need to consider xenotourism in regulatory frameworks, as evidenced in the New Zealand community.

Medicity

For the first time, when Fitz (2010) wrote an article on medicity, it played important role for making medical tourism more popular. Later on, this became part of medical tourism marketing for organisations.

Medical cities have been designed to be comprehensive in scope and incorporate advanced technologies and medical practices. These services are comprehensive of most, if not all, clinical service lines and include the full spectrum of diagnostics and therapeutic treatments. The scale and scope of medical cities usually demands an advanced level of care – both in technology and approaches – to create an attractive destination for care. This attractiveness is necessary to ensure the high level of patient volumes required to support such a large operation (Fitz, 2010, p.82).

Often, medical cities will also incorporate substantial non-medical services to support the staff, patients and visitors. These include retail, hotel and transportation systems. More often than not, medical cities also include academic and research activities that draw upon the large numbers of patients, the mix of learning opportunities and the access to high-tech facilities (Fitz, 2010, p.82).

“Medical cities will always require a significant amount of patient volume from the local population in addition to needing the human resources and community infrastructure that a city setting provides.”

Specifically related to medical tourism, medical cities offer several attractive attributes in support of attracting foreign or 'non-local' patients. First, they have the ability to support advanced medicine and high technology services. As medical cities are of a larger scale and better represent the full continuum of care, they have the ability to support services that are highly specialized – services that often struggle to see sufficient volume to support a business case. These can be sub specialized services within larger services lines, such as heart transplants or highly focused technology items such as robotic surgery systems or image guidance in the operating room. These advanced services in term provide excellent marketing support for those organisations looking to capitalize on patients seeking this type of care (Fitz, 2010, p.83).

The second area where medical cities can strongly support a medical tourism initiative is in the ability to create a true destination healthcare experience. Family accommodations, more expansive retail services and convenient pre- and post-acute care resources create an environment where the patient and the family needs can be fully met – especially for services that might normally be more involved and time consuming, such as cancer care or operations with long recovery periods. Beyond the scope of services and access to advanced care, medical cities might offer additional medical tourism benefits in the increased research opportunities and the ability to support information technology investment for the provision of virtual services such as telemedicine (Fitz, 2010, pp.83-84).

Medicity target the perceived desires of medical tourists by clustering medical and non-medical care with research and training facilities, rehabilitation centres and commercial facilities such as retail and accommodation (Fitz, 2010, pp. 82-84). Various governments are also encouraging and supporting medical tourism by providing medical tourists and their companions with medical visas (see Chinai and Groswami 2007; in Cook, 2010, p.141) and some US employers are paying for their employees to travel abroad for medical treatments rather than provide expensive health insurance or treatment in the US (Konard 2007; in Cook, 2010, p.141).

Medical tourism and economy

Loosely defined 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. According to the World Health Organisation (WHO), it is a growing trend with enormous economic implications (Woodward et al., 2002; in Bookman & Bookman 2007,p.2,186). As early as 1989, an Organisation for Economic Cooperation and Development (OECD) report noted that trade in health services provided developing countries with a competitive opportunity in this arena, given their abundance of labour and availability of capital and skills in medicine (Bookman & Bookman, 2007, pp.1- 2).

Medical tourism entails the splicing of two sectors, medicine and tourism. Both are service industries that face a high-income elasticity of demand. Both are labour intensive, and both rely heavily on the Internet to spread information. However, medicine is more high tech than tourism and has higher barriers to entry while tourism has higher price elasticity of demand. One is precise and involves rational decision making, and the other ephemeral, resting on imagination and the exotic and the transport into something outside of one's own culture. Medical tourism thus walks on two legs. Each leg is necessary but neither is strong enough on its own to drive the creation of a successful medical tourism sector. On their own, both tourism and medicine are high-growth industries in many parts of the world (Bookman & Bookman, 2007, pp. 21-22).

The multifaceted aspect of medicine and tourism both in linear graph (medicine and tourism only) and nonlinear graph (medicine, tourism and other complimentary sectors) attract larger intersection of economic activity. This aspect is shown by countries like Thailand, India, Singapore and many other countries. They share significant, if not, not a small section in GDP contribution to states' economy with statistics showing the industry worldwide to generate about US\$60 billion annually. Medical tourism in Malaysia, Thailand, Singapore, and India alone is projected to generate more than US\$4.4 billion per year by 2012 (Singh, 2008). The sector proceeds in India are estimated to reach as much as US\$2.2 billion a year by 2012 (Smith et al., 2009; Bookman & Bookman, 2007). Singapore has set itself the target of attracting 1 million foreign patients annually by that year which would push the sector's GDP contribution to the city state to more than US\$1.6 billion, whereas neighbouring Malaysia expects medical tourism income to reach around US\$590 million per year in 5 years' time ("Medical Tourism, Asia's Growth Industry," 2006). In Thailand and South Korea, this industry is confidently set to exceed US\$4 billion annually by 2012 ("Medical Tourism, Asia's Growth Industry").

Economics effectively calibrates the rise of medical tourism. Price differentials between most Asian states and more developed countries are considerable and are presently diverging even further. This may be accentuated or influenced by long waiting lists. For complex surgery the differences are considerable. In 2003 a small child in the United States with a hole in her heart was faced with a bill of around \$70,000 there, but the operation was carried out in Bangalore, India at a cost of \$4400 (Neelankantan, 2003; Connell, 2006, p. 1097). Open heart surgery may cost about \$70,000 in Britain and up to \$150,000 in the United States but in India's best hospitals it costs between \$3000 and \$10,000 depending on how complicated it is. Dental, eye and cosmetic surgery costs about a quarter of that in western countries (Neelankantan, 2003; Connell, 2006, p. 1097).

Thailand is also one of the crucial destinations of medical tourism in Asia. Where in 2004 some 247,238 Japanese, 118,701 American, 95,941 UK and 35,092 Australian patients were reported treating in Thai hospitals, though this includes locally based expatriates and other injured and sick tourists (Levett, 2005; in Connell, 2006, p. 1096). If there is an apex in the hierarchy of hospital services in Asia, it is Bumrungrad hospital in Bangkok. Aiming at what John D. Rockefeller Jr. called “catalytic bigness,” this 554-bed facility with a staff of 2600 has spent the past decade striving to be the biggest and best in its class (De Arellano, 2007, p. 195). In 2003, Bumrungrad treated one million patients. In 2005, it treated 55,000 American patients, three-quarters of whom flew directly from the United States (De Arellano, 2007, p. 195).

It is Henderson (2004) who has presented estimated earnings, number of foreign patients, country’s origin and specialty of health services which are given below:

Export of health services

	Estimated Earnings	No. of foreign patients	Origin of patients (in order of volume)	Specialty
Thailand (2006)	Baht 36 billion (US\$ 1.1 billion)	1.4 million	Japan, USA, South Asia, UK, Middle East, ASEAN countries	Cosmetic and sex change surgery
Singapore (2007)	S\$ 1.7 billion (US\$ 1.2 billion)	571 000	Indonesia, Malaysia, Middle East	Cardiac and neuro surgery, joint replacements, liver transplants
Malaysia (2007)	253.84 million MYR (US\$ 78 million)	341 288	Indonesia, Singapore, Japan, India, Europe	Cardiac and cosmetic surgery

Source: Henderson (2004, p. 113)

Since the costs of different surgeries may not be stable, the AMA-OMSS Governing Council Report B presented the costs for the United States, India, Thailand and Singapore (see in detail in the given table below).

Comparative costs of medical procedures by country

Procedure	U.S.	India	Thailand	Singapore
Heart bypass	\$ 130,000	\$ 10,000	\$ 11,000	\$ 18,500
Heart valve replacement	\$ 160,000	\$ 9,000	\$ 10,000	\$ 12,500
Angioplasty	\$ 57,000	\$ 11,000	\$ 13,000	\$ 13,000
Hip replacement	\$ 43,000	\$ 9,000	\$ 12,000	\$ 12,000
Hysterectomy	\$ 20,000	\$ 3,000	\$ 4,500	\$ 6,000
Knee replacement	\$ 40,000	\$ 8,500	\$ 10,000	\$ 13,000
Spinal fusion	\$ 62,000	\$ 5,500	\$ 7,000	\$ 9,000

Source: AMA-OMSS Governing Council Report B June 2007- Appendix A.

Follow-up care once the patient returns home can also be a problem. Mary Percak Dennett said: "When I returned and went to see my doctor, he was furious. He said no American doctor would treat someone who had surgery overseas. However, he looked at my knee and my x-rays and concluded they had done an excellent job." He noted they had left my knee cap in place and that was good because the knee would heal much faster (York, 2008, p. 101).

Medical tourism and hospitality

A medical tourism product is a medical service with a leisure component. Although coordinating the resources and services of the health-care and tourism sectors is a challenge, strategically such coordination is often carried out at the governmental level. Once an individual decides to have a medical procedure performed in a foreign country, he or she requires both health-care and tourism services. Detailed travel arrangements must be made (including obtaining visas, airline tickets, etc.), the availability of a doctor must be ascertained, and other medical arrangements, including recuperation services, must be planned. All of these services require cooperation between the two sectors (Chacko, 2006); in Heung et al., 2010, p.238).

As the popularity and reputation of medical tourism continue to grow, so too will the opportunities for both hospitality and health care industries (Hume & DeMicco, 2007; in Heung et al., 2010, p.238). It is noteworthy to highlight the concept of hospitality and its historical development for its broad understanding.

The historical development of hospitality has been summarized by Borer (1972), Taylor and Bush (1974) and Taylor (1977) for the United Kingdom and by White (1968) for the United States. What emerges from the literature has been summarized by Christian (1979) in his statement, 'Hospitality throughout history has been centred on security, physical comfort and psychological comfort (provided) to others by a host

(Nailon, 1982, p. 137). Deeply imbedded in the tradition of hospitality management is the concept of service (Nailon, 1982).

Hospitals are health care institutions that have an organized medical and other professional staff, and inpatient facilities, and deliver services 24 hours per day, 7 days per week. They offer a varying range of acute, convalescent and terminal care using diagnostic and curative services. According to the WHO (2018), hospitals should be organized around people's needs, working closely with other health and social care services and contributing to strengthening primary health care (PHC) and public health services, to substantially contribute to Universally Health Coverage (UHC) (WHO, 2018). Like any institution, hospitals need to survive...if everyone comes in with medical issues but no input (money) is provided to compensate for the services, and the needs of the patient come first (according to WHO) then the hospital will treat people until they go broke and must shut down. So more realistically, the hospital must find equilibrium with its current resources for long term survival and the immediate needs of the patients.

The trade press has noted the phenomenal growth in medical tourism over the past few years. The media have documented the fact that many medical destinations are making significant commitments to improve their facilities. Many offshore hospitals are either making major improvements or building new facilities that will cater to medical tourists. It is not uncommon to find hospitals abroad with "tourism wings", with English speaking personnel and special services tailored for Americans. New destinations are also springing up monthly. For example, Stephano points out that Dubai is in the process of constructing a new "medical city" that will be designed specifically for medical tourists (Moody, 2018, p.3).

Hospitality has been studied by many scholars, but they have not been succeeded to link the 'ity' (Pizam, 2007, p.500) factor in relation with hospital and hospitality. A hospital setting where the patient is a sick guest provides an extreme example of the host/guest exchange. According to Pizam (2007, p.500), "the difference between hospitals and hospitality is "ity" but that "ity" can make a significant difference in the recovery of hospital patients. That if applied to a hospital can make it "hospitable" to its customers in which Pizam uses the term customers rather than patients for those who visit hospitals for treatment.

The "ity" factor is nothing less than a philosophy of ultimate service to one's customers and the total dedication to their needs and wants. It is a culture and ideology that permeates the entire organisation (Pizam, 2007, p.500).

In service-centric organisations that practice the "ity" factor, management persistently trains and motivates employees to meet the customers' needs, desires and expectations and to always perform this duty with a smile and a kind word.

Employees are coached and stimulated to be courteous, respectful, concerned, caring, compassionate, helpful and sensitive to the special needs that some customers might have. When all of the above have been implemented the “ity” factor will be accomplished and an organisation will achieve ultimate state of being truly “hospitable” to both its external and internal customers. As Pizam strongly believes that the hospitality industry can finally make a significant and original contribution to other industries by exporting the “ity” factor and redesigning service organisations into “service-ity” organisations that will have the unique and wonderful characteristics that hospitality organisations possess. In doing so they will fulfill Conrad Hilton’s decree: “Fill the world with the light and warmth of hospitality” (Pizam, 2007, p.501).

Patients are sick, vulnerable, stressed, and in a new environment. Visitors might be equally upset (Berry and Bendapudi, 2007). Employees (i.e. administrative and clinical) are also stressed since they are directly or indirectly trying to restore health (e.g. nurses are the employees most likely to burnout, as are front-line hospitality employees) (Belicki & Woolcott, 1996; Price & Spence, 1994). Managing a combination of sick guests and employees at high risk for burnout provides the organisation with additional responsibilities and challenges to retention.

Many hospital administrators have taken notice of the benefits of implementing hotel-style amenities, including private rooms, concierge services, and restaurant-type foodservice menus. Studies have revealed these hotel-style amenities are associated with positive patient experiences (Randall & Senior, 1994; Sheehan-Smith, 2006). However, no study has explored a philosophy of hospitality and programs offered beyond the simple offering of enhancements such as concierge.

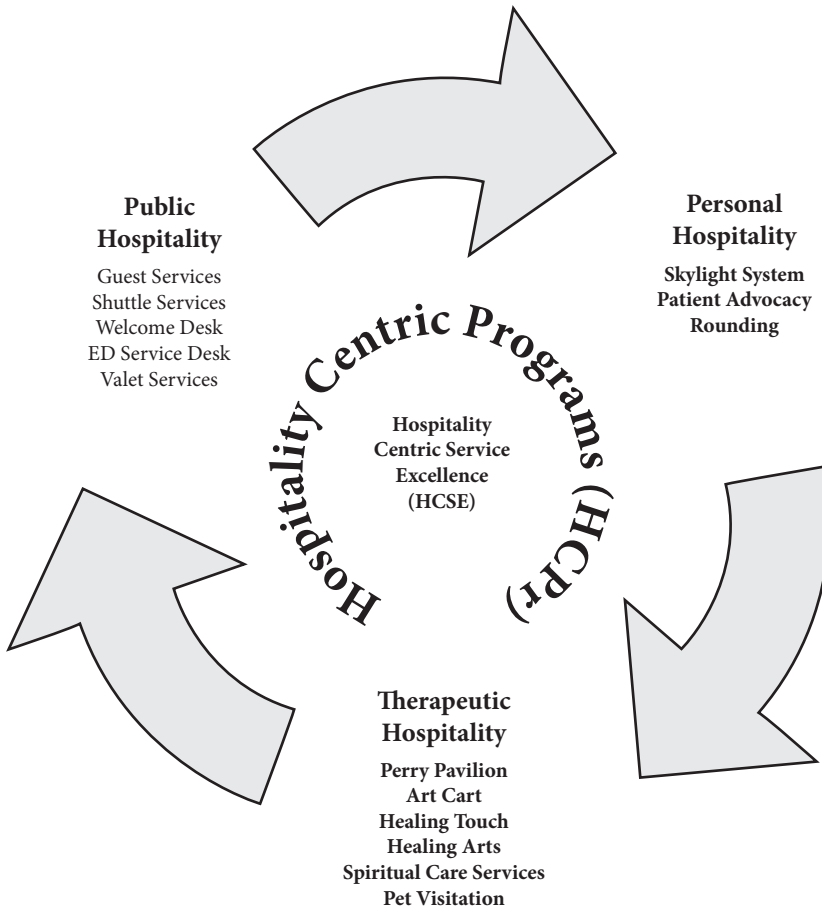
Though few studies have directly studied hospitality as a philosophy applicable organisation wide, a recent hospital case study supported the importance of the alignment of the service mission statement with strategy, systems, and staffing (Ford et al., 2006; in Severt & Aiello, 2008, p. 666). A more traditional recent hospitality research study by Reynolds & Leeman (2007) described how hospitality-based support services (e.g. foodservice, housekeeping, maintenance, and concierge) operated more efficiently when managed together. For the most part, hospitality industry studies have remained focused on the foodservice and amenity portion of the patient experience leaving much room for the further study of a philosophy of hospitality in a hospital setting.

These consumer behaviors are well supported by the theory of planned behavior and the theory of reasoned action (Ajzen, 1985, 1987, 1991; Bagozzi, 1992; in Severt & Aiello, 2008, p. 666). Many empirical studies from various industries (e.g. hotel, banking, restaurants) support the theories and subsequent behaviors (Boulding et al., 1993; Cronin et al., 2000; Hemmington, 2007; in Severt & Aiello, 2008, p. 666).

For a luxury hotel, a medical tourism service could fit well into the services it already offers. For example, after a patient undergoes surgery, he or she could spend an extended period of time recuperating in a luxury hotel. Together with specially designed rooms, the hotel would need to offer good follow up care in coordination with a medical expert. (Heung et al., 2010, p.239). Safety is paramount where health and medical services are concerned and is of primary concern for those travelling to another country to obtain such services. Hence, a well-coordinated partnership between medical institutions and hotels is required to meet the needs of medical tourist. (Heung et al., 2010, p.239).

In this context, Connell (2006b) and Moody (2007) report that hospitals in less developed countries are targeting medical tourists by altering their spatial-material design to create dedicated hospital wings and single rooms that are similar to high quality hotel rooms, while also hiring multilingual staff, arranging airport pick-ups and drop-ups, and providing one-on-one nursing care. The question comes what nursing care is in the context of medical tourism and hospitality.

Patten (1994; in Severt & Aiello, 2008, p.667) recognized the importance of hospitality in health care services as ideal for caregivers. The paper suggested that the caregiver embrace three types of hospitality applicable across the patient experience to include consideration of public, personal and therapeutic hospitality. Public hospitality is basic courtesy exemplified by the courtesy expected in hotels, airlines, and restaurants. For a hospital setting, public hospitality can be translated into everyday interactions in the gift shop, reception desk, or cafeteria. Personal hospitality however goes beyond common exchanges (e.g. personal interactions, self-disclosure and sharing of interests). In the hospital setting, personal hospitality is evident in nursing units where contacts extend over a longer period of time, and in emergency rooms where interactions are short, vital, emotionally intense and intimate. Both of these involve little social distance between caregiver and provider (e.g. housekeeping, volunteer, nurse, nurse assistant, housekeeping, and physician). Finally, therapeutic hospitality indicates a service to mankind with the idea of encompassing a moral/ethical element. Therapeutic hospitality is used to connect people in order to reduce the sense of separation and loneliness, while advocating healing and care. Patten (1994; in Severt & Aiello, 2008, p.667) suggested that nurses embrace a mission of managing therapeutic hospitality within their organisations to enhance both patient satisfaction and progressive healing. In course of studying hospitality in hospital, which is quite essential, Severt and Aiello (2008) have developed a model which is known as Hospitality Centric Service Excellence (HCSE). The following model has given different attributes of hospitality centric programs.



Source: Severt & Aiello (2008, p.667)

For the foreign patient, this may surpass their expectations and experiences of authenticity, as formed by their cultural understandings of medical treatment and care from home. This is hyperauthenticity; it is beyond their expectations. This situation could mean that the medical tourist now views medical services at home to be deficient, though not necessarily less authentic (Connell, 2010, p.114).

Similarly, formalized links with widely recognized “brands” of medical providers and educators, such as Harvard Medical International, the Mayo Clinic, and John Hopkins, are used increasingly to increase brand recognition and trust among patient-consumers.

The development of health tourism requires not only a health-care facility or destination (Carrera & Bridges, 2006) but also the availability of health-related

human resources, technologies, products and services (Law 1996, Kim, Boo, & Kim, 2011). The expansion of the health-tourism market has enabled many countries to design and develop their own health-tourism sectors using existing infrastructure and resources. In addition, as a result of competition, many countries have created lower cost and higher quality health services in order to attract health tourists in a competitive market.

Based on the available data, they devised a model that describes the market structure of the medical tourism industry and considers all of the stakeholders involved. The model also allows consumer benefits, branding, legal framework, infrastructure, product, target market, communication channels, operators, intermediaries, and social issues to be taken into account in the analysis and description of this industry.

Medical tourism appears to be a rapidly growing tourism product and market (Mun & Musa, 2013, p. 167). In capturing the medical-tourism market, Connell (2006) recommended the branding strategy. One of the important branding exercises is perhaps hospital accreditation. For medical tourism, the most sought after hospital tourism accreditation is the Joint Commission International (JCI; a not-for-profit American Organisation that provides standards and qualifications for medical facilities) (Mun & Musa, 2013, p. 168). In tourism, health related services have become a growing market segment and a billion dollar business. For 2010, The Global Spa Summit estimated the global market size of health tourism (medical and wellness tourism) to be US\$ 156 billion (Global Spa Summit 2010). The development in health tourism can be attributed mainly to two driving forces: economic-based driving forces such as exploding costs for medical treatments in industrial nations, and socio-psychological driving forces, such as value changes in aging societies (Boga & Weiermair, 2013, p. 139).

The literature on branding in health tourism is still rather limited. Branding is especially difficult with regards to the sub-sector of medical tourism. In medical tourism, where the focus is curative and the traveller is, by tendency, ill (Hall, 2011; in Boga & Weiermair, 2013, p. 140), the perceived risk tends to be much higher as much more is at stake than in other sub-sectors of health tourism, for example, wellness tourism, where the focus is on wellbeing in general (Boga & Weiermair, 2013, p. 140).

In the context of tourism, Clarke (2000; in Boga & Weiermair, 2013, p. 142) refers to the reduction of the impact of intangibility as one of the benefits of branding. According to him, a strong brand is able to minimize intangibility and perceived risk. Especially in health and medical tourism a strong brand appears to be of great importance. Boga (2011; in Boga & Weiermair, 2013, p.145) expresses, with increasing importance of personal values in the context of the buying behaviour for

health tourism perceived mental intangibility decreases. Accordingly, it seems highly appropriate in health and medical tourism to augment a brand with relevant personal values (Boga & Weiermair, 2013, p.145).

Kim et al. (2011) explained the development of health tourism in relation to four resources: nature, knowledge, artificial, and expenses, and suggested that destinations should produce innovative and specialized products that can attract international demand and differentiate their products and services from other destinations. Smith and Forgione (2007) constructed a two-stage model for medical-tourism product selection: the first stage being the evaluation of the foreign country and the second stage the selection of the health-care facility. In the first stage, it was found that country-specific characteristics influence the country of choice which includes economic condition, political climate, and regulator policies. In the second stage, it was indicated that costs, hospital accreditation, quality of care, and physician training had an impact on the selection of health-care facility. Caballero-Danella and Mugomba (2007) employed 11 factors to explain the comments of medical tourism market: product, social issues, the legal framework, consumer benefits, target market, infrastructure, distribution channels, operators, intermediaries, and communication and promotion. Among those facts, *benefit sought* (Haley 1968; Goodrich 1977; Woodside and Jacobs 1985; Gitelson and Kerstetter 1990; Jang et al. 2002; Pierskalla et al. 2004) and *brand equity* (Aakar 1991, 1996; Yoo & Donthu, 2001, 2002; Kim & Kim 2005) have been often highlighted and examined in many previous studies to measure consumer's intention to purchase products or visit destinations.

Although medical tourism is advantageous for developing destinations in economic terms, it may be disadvantageous for the general health systems of those destinations. If the medical tourism industry grows dramatically, then the physical and socio-psychological well-being of the local population may be placed at risk (Burkett, 2007; Tan, 2007). According to Awadzi and Panda (2006), another negative effect of growth in the medical tourism sector may be the diversion of infrastructure building funds from other areas of the economy. Although the costs of medical procedures in a given destination may be reasonable for individuals from developed countries/regions, they may be prohibitively expensive for the local populace.

Many factors affect travel decisions. In addition to costs, the quality of medical treatment and care is also essential in a medical tourist's decision-making process, particularly when it comes to selecting a hospital. Many doctors in developing countries were educated, and are licensed to practice in developed countries, such as the United States, United Kingdom, Canada, and Australia. The existence of well-trained doctors and specialists who speak their language plays an important role in attracting medical tourists to a particular destination.

Some researchers draw on motivation theory, in which the concept of need takes centre stage, to explain why people travel (Crompton, 1979; Dann, 1977; Pearce & Caltabiano, 1983; Yuan & McDonald, 1990; in Heung et al., 2010). Maslow's (1954; in Heung et al., 2010) five-stage hierarchy of needs, for example, offers a systematic approach to motivation. Five basic needs—namely, physiological, safety, social, esteem, and self-actualisation needs—provide increased motivation in hierarchical order (Jang & Cai, 2002; in Heung et al., 2010); that is, once the most basic human need is satisfied, an individual is motivated to fulfill the next. Based on Maslow's hierarchy of needs, Pearce (1988; in Heung et al., 2010) developed a model known as the "Travel Career Ladder," which represents a ranking system of tourists' learning experiences. Tourists' motivations vary from group to group (Crompton, 1979; Mayo & Jarvis, 1981; in Heung et al., 2010), and individuals may have different reasons for taking vacations. The tourism motivators in Dann's (1977; in Heung et al., 2010) travel decision model, which incorporates push-and-pull factors, can also be linked to Maslow's hierarchy of needs. Push factors are internal to the individual and prompt him or her to travel, whereas pull factors are external and affect the choice of travel destination. This choice may be influenced by many other factors, such as age, income, personality, cost, distance, risk, and motivation. Drawing on Dann's study, Crompton identified nine motives, seven of which are identified as push factors, i.e., the desire for escape, rest and relaxation, adventure, social interaction, health or prestige, and two of which are identified as pull factors, i.e., novelty and education. The destination selection process is related to tourists' assessment of destination attributes and their perceived utility value (Kozak, 2002; in Heung et al., 2010).

Supply and demand

The supply side of the model encompasses all of the efforts, facilities, and services offered by the medical tourism host destination. Several basic factors represent the supply side of medical tourism as a whole. For example, a destination's infrastructure, superstructure, and state-of-the-art medical facilities, and the quality of these facilities and services, should meet patient expectations. To provide an international standard of medical care, a destination needs to have a good communication structure in place, as well as medical staff who speak a variety of languages. Perhaps most importantly, its medical tourism industry should be promoted by government authorities (e.g., through national campaigns or overseas marketing strategies).

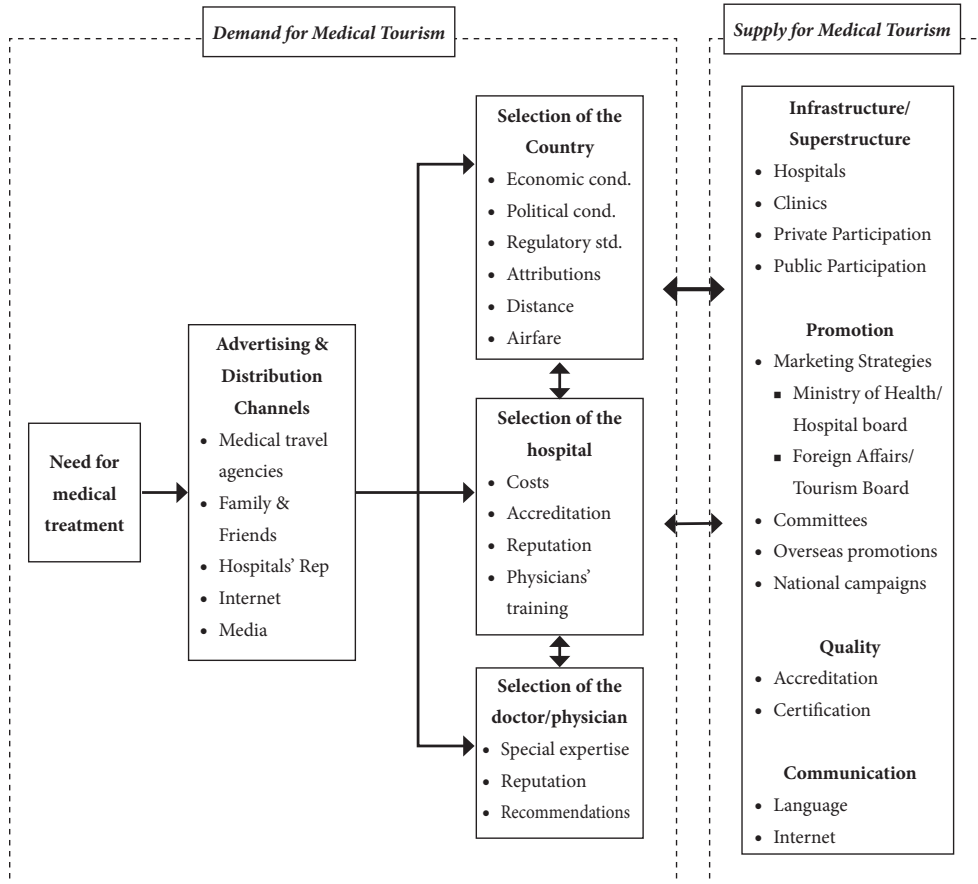
The supply side of Heung et al.'s (2010, p. 246) proposed integrated model reflects the existing situation of the medical tourism industry in terms of the infrastructure/superstructure facilities, promotional activities, quality assurance, and communication facilities that are generally supplied by the private and public sectors. Medical tourism supply in the model focuses on how an individual medical tourist's requirements

interact with the activities of the private, public, and governmental sectors of medical tourism destinations during the selection procedure.

The number of countries seeking to develop medical tourism continues to grow rapidly. The success of medical tourism in Asia especially has prompted growing global interest and competition, and optimism is seemingly unbounded. Singapore, for example, though a relatively high-cost destination, is seeking to attract 1 million patients by 2012, which would generate US\$1.8 billion in revenues, create at least 13,000 jobs (Ai-Lien, 2005; in Connell, 2006, p. 1099) and even restore economic growth after the recession in the IT industry at the end of the century. The governments of a number of countries, including Greece, South Africa, Jordan, India, Malaysia, the Philippines, and Singapore are actively promoting medical tourism (Heung et al., 2010, p. 246).

Whilst most trade in health services takes place outside the framework of existing trade agreement, whether bilateral or multilateral, trade in health services including medical tourism is officially provisioned for under the General Agreement on Trade in Services (GATs). The four modes of supply include; 1. The cross-border supply of services (remote service provision, e.g. telemedicine, diagnostics, medical transcriptions), 2. Consumption of services abroad (medical tourism, medical and nursing education for overseas students), 3. Foreign Direct Education (e.g. foreign ownership of health facilities) and 4. Movement of health professionals (Carrera & Bridges, 2006; in Pocock & Phua, 2011, p.4).

Proposed supply and demand model of medical tourism



Source: Heung, Kucukusta & Song (2010, p. 240)

Heung et al.'s (2010) proposed integrated model comprises two components, demand and supply, to provide a holistic view about the medical tourism market in terms of the medical tourists' decision making process which involves interaction between the two.

The term "demand" in the integrated model refers to the factors that affect tourists' decisions in terms of destination and their medical options. These demand factors represent the expectations of a potential medical tourist based on his or her specific needs, which drive the tourism decision. Such a potential tourist is in need of medical treatment and wants to make the best possible decision. Growing demand for health services is a global phenomenon, linked to economic development that generates rising incomes and education (Heung et al., 2010, p.1).

Medical tourism is a growing phenomenon with policy implications for health systems, particularly of destination countries. Private actors and government in South East Asia are promoting the medical tourist industry but the potential impact on health systems, particularly in terms of equity in access and availability for local consumers, is unclear (Pocock & Phua, 2013,p.1)

This has raised the sense of equity in access to care. In the words of the dean of the King Edward Memorial Hospital in Mumbai, “the need to benefit Indian patients is the main goal, the medical tourism cannot be at their cost” (*The Hindu* April 17, 2005; in De Arellano, 2007,p.197). And another critique has attacked the current policies are undermining equity in both India and countries of origin (Gupta, 2004; in De Arellano, 2007, P.197): Medical tourism... reinforces the medicalized view of health care. By promoting the notion that medical services can be bought or sold from the lowest priced provider anywhere in the globe. It also takes away the pressure from the government to provide comprehensive health care to all its citizens.... The services are cost effective for those who can pay and come from countries where medical care costs are exorbitant because of the failure of the government to provide affordable medical care.

Smith and Forgione (2007 ; in Heung et al., 2010) argued that country-specific characteristics, such as economic conditions, political climate, and regulatory policies, influence the choice of destination; whereas such factors as costs, hospital accreditation, quality of care, and physician training have an impact on the choice of health-care facilities. According to their two-stage model, medical tourists first select a destination and then consider the medical/tourism facilities or infrastructure in that destination.

To provide a better understanding of both the current status of medical tourism and anticipated developments, Caballero-Danell and Mugomba (2007; in Heung et al., 2010) developed a map to document all information collected from the electronic media, newspapers, periodicals, magazines, and academic material (see above figure).

Caballero-Danell and Mugomba (2007; in Heung et al., 2010) also proposed a model that identifies and categorizes three distribution channels that link consumers to destinations: operators; representatives within the target consumer markets, which are also referred to as intermediaries; and word of mouth. Based on Bitner and Zeithaml's (2003; in Heung et al., 2010) argument that traditional service providers such as doctors in a limited distribution area distribute their services directly to consumers, a direct arrow is used to represent consumers' contact with a destination without the need for intermediaries.

Current theoretical models do not adequately explain the medical tourism phenomenon, Therefore, Heung et al. (2010) propose a theoretical framework for

the study of medical tourism that includes both the supply and demand perspectives. They consider each aspect of the medical tourism industry in their proposed integrated model, which is general enough to and could accommodate different types of medical tourists (e.g., those seeking relatively simple procedures such as Lasik eye surgery and those in need of more complex procedures such as heart surgery).

Medical tourism destination

A destination is a place where tourists intend to spend their time away from home. The destination is often considered to be a tourism product in itself. The product could be described as total tourism experience which comprises a combination of all the service elements, which the tourist consumes from the time they leave home to the time of return (Cho, 2000, pp.144-145). Tourism destination is closely related with image (ideas and the beliefs which tourists hold that concentrates on price for travel, accommodation and participation in a range of selected services while staying there). There are two facets of destination images: cognitive and affective images (Baloglu & McCleary's, 1999a; in Chew & Jahari, 2014, p.385). It is noteworthy to mention here as cognitive image refers to beliefs and knowledge about a travel destination's attributes and affective image refers to emotion or feelings attached to the destination. Both images have only recently been integrated to understand destination image (Pyke & Ryan, 2004; in Chew & Jahari, 2014, p.385; Kunwar, 2017, pp.167-168).

People choose to travel to a foreign country for medical treatment for a variety of reasons, and the destination they choose also depends on a number of factors. Smith and Forgione (2007; in Heung et al., 2010) argued that destination-specific characteristics, including economic conditions, the political climate, and regulatory policies, influence this choice. Accordingly, these factors, along with a number of others, constitute the selection criteria on the demand side of our integrated medical tourism model.

Since economic liberalisation in the mid-1990s private hospitals have expanded and found it easier to import technology and other medical goods, thus bringing infrastructures in the best hospitals to western levels. The link to India's highly successful IT industry are also advertised and specific salaries increased, so doctors returned from overseas (Connell, 2006, p.195). India is normally regarded as the contemporary global centre for medical tourism, and it advertises itself as offering everything from alternative Ayurvedic therapy to coronary bypasses and cosmetic surgery (Connell, 2006, p.1095).

Cosmetic surgery, which is rarely covered by insurance policies, is one of the most popular medical treatments in the medical tourism market and, arguably, gave rise to the medical tourism phenomenon (Marlowe & Sullivan, 2007; in Heung et al., 2010).

The main country for medical tourism in Asia, Thailand became known as a destination for medical tourism as early as the 1970s because it specialized in sex change operations, and later moved into cosmetic surgery. Malaysia became involved after 1998 in the wake of the Asian economic crisis and the need for economic diversification, as did many Thai hospitals, when local patients were no longer able to afford private health care. Singapore has belatedly sought to compete with Malaysia and Thailand, deliberately set rates just below those in Thailand... (Connell, 2006, p. 1095).

Internationally recognized accreditation and certification schemes, such as the Joint Commission International (JCI) scheme, the International Organisation for Standardisation (ISO) scheme, and the Trent Accreditation Scheme (TAS, 2001), are making the standards of medical services worldwide increasingly transparent. Such international accreditation serves to demonstrate that the hospital employs only licensed, well-educated and experienced medical, nursing, and other professional staff (Ramanna, 2006).

Medical tourism destinations

Asia/Middle East	Americas	Europe	Africa	Other
China	Argentina	Belgium	South Africa	Australia
India	Brazil	Czech Republic	Tunisia	Barbados
Israel	Canada	Germany		Cuba
Jordan	Colombia	Hungary		Jamaica
Malaysia	Costa Rica	Italy		
Singapore	Ecuador	Latvia		
South Korea	Mexico	Lithuania		
Philippines	United States	Poland		
Taiwan		Portugal		
Turkey		Romania		
United Arab Emirates		Russia		
		Spain		

Source: MedGenMed (2007, p.33, in Carmen et al., 2014, p.64)

**Top destinations for medical tourism
2012**

**Best hospital in the world who
practice medical tourism**

	Countries	Performances		Hospital	Location
1.	Thailand	leader in cheap cosmetic Procedures	1.	Fortis (formerly Wockhardt) Hospital	Bangalore, India
2.	India	neurology, cardiology, endocrinology, urology	2.	Gleneagles Hospital	Singapore
3.	Costa Rica	cosmetic procedures, dental	3.	Prince Court Medical Centre	Kuala Lumpur, Malaysia
4.	Panama	dental treatment, gynecology, cosmetic surgery, orthopedic	4.	Shouldice Hospital	Toronto, Canada
5.	Malaezia	cardiology, gastroenterology dental surgery	5.	Schoen-Kliniken	Munich, Germany
6.	Singapore	organ transplant, stem cell Transplant	6.	Bumrungrad International	Bangkok, Thailand
7.	Brazilia	cosmetic surgery-the largest no. interventions capita in the world	7.	Bangkok Hospital Medical Center	Bangkok, Thailand
8.	Coreea de Sud	specific procedures of the spine	8.	Wooridul Spine Hospital	Seoul, Korea
9.	Turcia	liposuction, orthodontics, rhinoplasty and breast augmentation, cardiovascular and brain surgery	9.	Clemenceau Medical Center	Beirut, Lebanon
10.	Ungaria	cosmetics, laboratory, ophthalmology, dentistry, general surgery	10.	Christus Muguerza Super Specialty Hospital	Monterrey, Mexico

Source: www.mtqua.org; in Carmen et. al. (2014, p.65)

Medical tourism and authenticity

It is Cook (2010), who studied medical tourism from sociological perspective and focused on authenticity. In this study, authenticity has been linked with Boorstin's (1964), MacCannell's (1976) and Wang's (1999) theory. The author has deeply analyzed and produced the outcome of the study through an interactionist framework of authenticity, considering both constructivist and existential authenticity.

The interactionist approach to authenticity allows a consideration of how individual and social processes are constructed and experienced. For Cook, this is constructivist authenticity that reveals how the objects and subjects of medical tourism can only be authentic if recognized as such. These social practices and processes rely on power relationships and dialectics, such as who has the authority to certify, make decisions and authenticate (Bruner, 1994; Wang, 1999). This contrasts to traditional approaches to authenticity in tourism studies, labelled as objective authenticity (Wang, 1999), where authenticity is considered to be an inherent quality of object that is independent of humans, as witnessed in the contrast between the inauthentic modern and the authentic primitive or pre-modern (for example Boorstin, 1963; MacCannell, 1973, 1976). However, a constructivist perspective would assert that both the modern and the pre-modern could be authentic – it all depends on how the social phenomenon is evaluated and by whom. Consequently, authenticity is a value judgment made by observer(s).

However, the constructivist approach does not acknowledge that medical tourism is not simply perceived and judged; it is also lived, experienced and felt. This is where an existential understanding can assist with analyzing medical tourism. This approach is concerned with the 'degree of congruence between one's actions and one's core self- conceptions – consisting of fundamental values, beliefs, and identities to which one is committed and in terms of which one defines oneself' (Vannini & Burgess, 2009: 104; in Cook, 2010,p.137). The focus is therefore placed on the inner self, rather than external factors or forces. The key to existential authenticity is seeking personal growth and fulfillment to achieve the 'real self' or being true to oneself. Cook refers to the authentic self. As medical tourism is directed towards and takes place on or in the tourist's body, how one internally feels or reacts to the experience in a transformation of self, is vital and important.

In this paper, Cook (2010) explores how constructivist and existential authenticity interplays with the multiple bodies, objects, spaces, practices and places, to render medical tourism a diverse social phenomenon that transcends any simple classification or typological scheme. This includes acknowledging that the tourist has a body (Veijola & Jokinsen, 1994; in Cook, 2010, p.137), which foregrounds how medical

tourism is an industry that has emerged from the tourist's body and is projected onto and performed by the embodied patient/tourist. Addressing how medical tourism is embodied and located deepens and complicates the theoretical shortfalls around this important social phenomenon by unravelling what medical tourism means in practice and experience. Thus, this paper expands on the previous work on authenticity and on medical tourism by explicitly connecting the two and emphasizing the complexities and constructions of medical tourism from the industry and individual patients. To begin, I will briefly explore the relevance of constructivist and existential authenticity, before navigating the multiple definitions of health and medical tourism, to illustrate the ambiguity surrounding these phenomena.

Similarly, MacCannell (1973, 1976) identifies that modern life is characterized by inauthentic experiences that are contrived and alienating. However, where Boorstin (1963) identified inauthenticity in both everyday life and tourism, MacCannell (1973, 1976) believes that the tourist identifies authenticity as residing elsewhere. Consequently, the tourist desire is to temporarily leave behind the everyday, modern experiences of alienation and, with a sense of nostalgia, seek out the real and authentic in other people and places (the primitive). Authenticity is therefore seen to reside in a previous time or in another place, and the objects that are found 'there' in contrast to 'here' (Olsen, 2002: 161). The desire to experience authenticity due to its lack in modern life is, however, a futile attempt. For MacCannell (1973, 1976), tourist destinations are commoditized and distorted to meet the needs of hosts and guests. In constantly encountering this staged authenticity, the tourist continues to seek the authentic only to be confronted by the inauthentic.

As noted by Wang (1999), Boorstin (1963) and MacCannell (1973, 1976) both focus on objective authenticity. This is based on a concern with whether the originals are authentic. Authenticity exists externally to the tourist, being a characteristic that is inherently found within an object, such as a product, an event, culture or place. Here, constructivist authenticity suggests that authenticity does not actually exist, but rather is created through a projection of interests and desires. This means that 'Things appear authentic not because they are inherently authentic but because they are constructed as such in terms of points of view, beliefs, perspectives, or powers' (Wang, 1999: 351). Authenticity is a cultural value that is attributed, rather than intrinsic, to objects or subjects (Bruner, 1994; Olsen, 2002; in Cook, 2010, p. 138). This means authenticity is negotiable – whether it is authentic or not is irrelevant – and dependent on the tourist's experience.

However, Wang (1999; in Cook, 2010, p.139) asserts that constructivist authenticity cannot account for the tourist's personal feelings, experiences and values. As a result, he advances existential authenticity, which focuses on the knowledge and an awareness of self. This approach considers authenticity to be an emotional investment that is

judged in relation to the self, such as whether personal growth has been achieved or if inner desires have been met.

Thus, existential authenticity involves an internal fulfilment while constructivist authenticity is an external projection of expectations. While following Olsen (2002:164; in Cook, 2010, p.139) he believes that the feelings and experiences of existential authenticity are constructed in social processes and therefore can be understood under constructivist authenticity. He believes that by using both concepts of authenticity, the dynamism of medical tourism, such as the interdependency of and relationships between the places, spaces, objects and subjects that practice and embody medical tourism, can be more effectively understood and analyzed.

MacCannell asserted that authenticity cannot be found in modern life, the authenticity in medical tourism is located in modern medical facilities and training undertaken in advanced industrial nations. This is then used as the benchmark for all medical services and treatment, thus those located in less developed or pre-industrial societies must reach this standard if they wish to advance claims of authenticity. The modern world, and its spaces (hospitals) and knowledge (medical training) are authenticated, with in authenticity located in less developed countries. However, this authenticity cannot be inherently found. It is a sociocultural construction that is reinforced by uneven power relationships (Cook, 2010, p.143).

In the desire to be authentic, however, medical tourism providers that are not in the West may go beyond this reproduction of authenticity by surpassing the cultural values and expectations typical of the West; they become 'hyper authentic'. Connell (2006b) and Moody (2007; in Cook,2010,p.144) report that hospitals in less developed countries are targeting medical tourists by altering their spatial-material design to create dedicated hospital wings and single rooms that are similar to high-quality hotel rooms, while also hiring multilingual staff, arranging airport pick-ups and drop-offs, and providing one-on-one nursing care. For the foreign patient, this may surpass their expectations and experiences of authenticity, as formed by their cultural understandings of medical treatment and care from home. This is hyper authenticity; it is beyond their expectations. This situation could mean that the medical tourist now views medical services at home to be deficient, though not necessarily less authentic. The tourist's gaze is very sensitive and scrutinizing in uncovering the intricate differences to unveil something that is 'new' (Urry, 1990, 2002; in Cook, 2010, p.144). Alterations to spatial-material organisation and design are not just evaluated through the gaze but are also actively experienced and evaluated through the body. As will be explored, medical tourism is an active, ongoing embodied event and process (Cook, 2010, p.144).

Many hospitals have integrated programs that have enhanced patient stays by adapting strategies used in the hospitality industry (Studer, 2003; in Severt & Aiello, 2008, p. 665). These programs are directed at enhancing the process and people interactions across the patient experience (i.e. Resemble the functional quality aspects of service). This includes enhancing the genuine reception, psychological, and emotional well-being of those consumers involved in the host/guest or patient/provider exchange (Ferguson et al., 1999; in Severt & Aiello, 2008, p.665). Other parallels can be drawn between the host/guest exchange in hotels and hospitals and for some time the two industries have been compared in some regards to amenities offered. Parallels include round-the-clock residential services including bedding, maintenance, security, and foodservice.

For the hospital, the patients may be out-patient, emergency room, or patients hospitalized for an extended period. Most times, the patients will have visitors creating an indirect guest. For most hotel stays, guests are vacationing, on business and have usually planned the trip. In both the hospital environment and the hotel environment the guests and the visitors evaluate their perceived experience and build future intentions (to return or not return, to recommend to others, to not recommend to others) surrounding their unfolding service experience. These consumer behaviours are well supported by the theory of planned behaviour and the theory of reasoned action (Ajzen, 1985, 1987, 1991; Bagozzi, 1992; in Severt & Aiello, 2008, p.666). Many empirical studies from various industries (e.g. hotel, banking, restaurants) support the theories and subsequent behaviours (Boulding et al., 1993; Cronin et al., 2000; Hemmington, 2007; in Severt & Aiello, 2008, p. 666).

Patients are sick, vulnerable, stressed, and in a new environment. Visitors might be equally upset (Berry & Bendapudi, 2007; in Severt & Aiello, 2008, p. 666). Employees (i.e. administrative and clinical) are also stressed since they are directly or indirectly trying to restore health (e.g. nurses are the employees most likely to burnout, as are front-line hospitality employees) (Belicki and Woolcott, 1996; Price & Spence, 1994; in Severt & Aiello, 2008, p.666). Managing a combination of sick guests and employees at high risk for burnout provides the organisation with additional responsibilities and challenges to retention.

Many hospital administrators have taken notice of the benefits of implementing hotel-style amenities, including private rooms, concierge services, and restaurant-type foodservice menus. Studies have revealed these hotel-style amenities are associated with positive patient experiences (Randall and Senior, 1994; Sheehan-Smith, 2006; in Severt & Aiello, 2008, p.666). However, no study has explored a philosophy of hospitality and programs offered beyond the simple offering of enhancements such as concierge.

Patient satisfaction is an important dimension of healthcare treatment. Relatively little is known about the experience and satisfaction of medical tourists. According to Ehrbeck et al. (2008, p.7; in Lunt et al., n.d., p.24), patients report generally high satisfaction with quality of care received overseas but it is not clear that this can be extrapolated outside of the US and to a range of treatments. Patient clinical outcomes and satisfaction do not necessarily go together, and satisfaction is not always the primary indicator for some treatments such as dental work. Similarly, with regard to cosmetic surgery there is evidence that a small percentage of patients may suffer from psychological body-related issues that make such judgments problematic (Grossbart & Sarwer, 2003; in Lunt et al., n.d., p.24). Conversely, Hanna et al (2009; in Lunt et al., n.d., p.24.) note that for a sample of outsourced patients (rather than medical tourists) whilst the majority of patients operated upon abroad obtained comparable functional results with those expected locally, they were often dissatisfied with the overall experience. There is a gap in understanding of patient expectations and how these may be raised by individuals paying a market-price and taking responsibility for choosing a provider (Lunt et al., n.d., pp.24-25).

As related to a goal or philosophy of hospitality, the following quotation provides the key informants open-ended views when asked about hospitality in the hospital:

Most patients share only a few hospital experiences in their lifetime. Due to the high emotional value associated with hospital encounters, there are enhanced memories. These stories are then shared in a positive or negative light. By integrating a strong hospitality component, the first visit can be one of comfort instead of one of fear. I believe the patient's health and experience are stronger with hospitality.

Internally, the Service Excellence Council consisted of department heads, clinicians, and staff workers who met monthly to review services cores and initiatives. Externally, a Hospitality Advisory Board consisted of executives from the hospitality industry, hospitality education and administrators from the larger hospital system.

System theory and health system

In the study of medical tourism, the authors such as Mogaka et al. (2017, p.31) have followed system theory developed by Zakus and Bhattacharya (2007; in Mogaka et al., 2017, p.3). According to this theory, health systems may be viewed as the continuum of inputs, process, and outputs. The input consists of people in need of health care services (health care consumers), those who deliver health care services (care providers) and the systematic arrangements that ensure that care is delivered. In this paper, system theory has been used as a framework to describe how medical tourism interacts with the various components of health care systems and the relationship so produced, and systems ability to change and adapt to response to internal and external forces of medical tourism (Yaseen, 2007 ; in Mogaka et al., 2017, p.3). Medical tourism interacts

and influences public and private agencies that organize, plan, regulate, finance, and coordinate medical care services. These agencies consist of hospitals, clinics, insurance companies and other programs that pay for medical services, all operating in various configurations of groups, networks, and independent practices. Professional schools, agencies and industry associations that research and monitor the quality of health care services, licensing and accreditation institutions and the companies that produce medical technology, equipment, and pharmaceuticals also influence or are influenced by medical tourism (in Mogaka et al., 2017, p.3).

The structure of the health system consist of health care facilities, including hospitals, clinics, health care professionals including specialists physicians, general practitioners , auxiliary and allied staff; and technology that create the capacity to extend health care services to customers depending on the structural resources of health facilities and organisation, while the collective resources and relationship of the health care system determine its structural capacity to carry out health care processes (Mogaka et al., 2017).

Structural and strategic innovations in medical tourism seem to have achieved organisational economies of scale, improved utilisation of resources, enhanced access to capital and extended scope of the market, while the traditional national health systems lack these entrepreneurial innovations, largely dominated by payment systems that rewards in terms of time spent rather than value of care. In medical tourism there is specialisation especially in ambulatory walk-in services, reduced prices and lower costs. Previously unimagined techniques seem suddenly within reach (Turner, 2007a, Turner, 2007b; in Mogaka et al., 2017, p.12).

Although medical tourism serves a fraction of population that can pay the rates, with more empowered patients, more diverse delivery models, new roles and stakeholders and necessary incentives, the market of medical tourism keeps on growing (World-Economic Forum, 2013 ;in Mogaka et al., 2017,pp.2-3).

Hospitality in hospital

According to Lashley and Morrison (2000), hospitality provides a commitment to meeting guests' needs as the primary focus in commercial operations through a host and guest relationship. The host and guest relationship is further characterized by hospitableness typically extended by the host to the guests then reciprocated by the guest to the host. Hospitableness includes a welcoming attitude and environment (Brotherton, 1999; in Severt & Aiello, 2008, pp.664-665). These two, backed by genuine company actions; go beyond excellent service to create unforgettable experiences (Hemmington, 2007; in Severt & Aiello, 2008, p. 665). Viewed from this lens, an organisation wide philosophy of hospitality is applicable to, and can help improve exchanges for any business.

For hospitals, the use of hospitality goals from another industry may provide helpful incentive for improvement. In the case study explored, the management of the hospital has the goal of comparing hospital style initiatives with those found in top-rated hotels, likely offering enhanced opportunities for synergy (Randall and Senior, 1994; Sheehan-Smith, 2006; in Severt & Aiello, 2008, p. 674).

In suggesting that there was a place for hospitality in the hospital setting, Cassee and Reuland (1983) highlighted the challenge of describing the concept of hospitality and in particular its relevance to hospitals. Initially, it seems that there is a good case for seeing hospitality as an important attribute of a satisfactory hospital stay and further that the more at ease people feel, in the hospital situation, the sooner they recover. To assess how applicable the concept of hospitality is to the hospital situation, a closer examination of the concept is required (Hepple et al., 1990, 0. 305).

During the 1980s, when hospitals and other types of health care organisations began to compete for patients, being hospitable was seen as offering a competitive advantage (Super, 1986; in King, 1996, p. 219). In order to improve patient satisfaction and retention, some hospitals constituted guest relation programs, in imitation of companies such as Marriott and Disney (Zemke, 1987; Betts & Baum, 1992; in King, 1996, p.219). Many of these programs failed to achieve results, and by the late 1980s, guest relations program were labeled as fads (Bennett & Tibbits. 1989; Ummel, 1991; in King, 1996, p.219). One reason for the failure was a narrow focus on training from line employees to be courteous to patients or improving their interpersonal communication and complaint handling skills (Peterson, 1988; in King, 1996, p. 219).

Hepple et al. (1990) reviewed the existing literature for definitions of hospitality and identified four characteristics of hospitality in its modern sense.

- It is conferred by a host on a guest who is away from home.
- It is interactive, involving the coming together of a provider and receiver.
- It is comprised of a blend of tangible and intangible factors.
- The host provides for the guest's security, psychological and physiological comfort.

They examined the concept of hospitality as applied to hospital patients, and they operationalized the four characteristics as "feeling at home". Then they identified 10 factors as measures of this feeling in a hospital setting. The factors included friendly staff, admission procedure, information regarding daily routine, plain cooking and menu choice, privacy, comfortable furniture, recreational facilities and attractive décor. Only some of these, such as menu choice, cooking privacy, furniture and décor concern a home-like setting.

A more traditional recent hospitality research study by Reynolds and Leeman (2007; in Severt & Aiello, 2008, p.666) described how hospitality-based support services (e.g. food service, housekeeping, maintenance, and concierge) operated more efficiently when managed together. For the most part, hospitality industry studies have remained focused on the foodservice and amenity portion of the patient experience leaving much room for the further study of a philosophy of hospitality in a hospital setting.

The traditional standards of service, which were interpreted as personal and individual attention to individual needs can only be maintained in a way specific type of operation for customers prepared to pay the price of such labour-intensive activity (Nailon, 1982, p.138). Broadly speaking, as Nailon (1982) expresses, there seem to be two different types of service which are sought by a range of customers and those can be described as 'hedonistic' or pleasure seeking, which may contain an element of entertainment, and 'utilitarian' which is a substitute for the normal domestic type of requirements (See in detail Nailon, 1982, p.138).

According to Berry (1999 p.247; in Severt & Aiello, 2008, p.675), "great service companies are human companies that humanely serve customers and the broader communities in which they live." The case study above seems to support the assertion of Berry. From this viewpoint, service excellence has to be in place.

The working definition suggested is that the individual patient should feel as 'at home' as possible during their hospital stay. The phrase 'at home' is intended to indicate a standard of security, physiological comfort, and psychological comfort which the patient knows and is satisfied with. This phrase does not make allowance for those who have unhappy, unsatisfactory home lives, however, it is suggested that even such patients would be aware of the concept of 'feeling at home' and are likely to take the phrase in the spirit in which it is intended. The inclusion of the phrase 'as possible' in the definition allows for the judgment of the patient to compare their expectations of hospital hospitality with their experience of that hospitality (Hepple et al., 1990, p.309).

Some groups did find certain factors of particular importance to them, for example those in the thoracic ward studied were very concerned to have plain cooking; this may well be due to their medical condition. Those patients undergoing lengthy hospital stays may be more concerned with recreational facilities than those patients undergoing short hospital stays. However, generally some agreement was found regarding the sequence in which patients regard the hospitality factors as important to a satisfactory hospital stay. This sequence represents the average importance all respondents assign to each factor, starting with the factor considered to be most important and progressing to the factor considered to be least important.

The sequence is as follows: Friendly medical staff, Smooth admissions procedure, Friendly non-medical staff, Information regarding routine, Varied choice on the menu, Adequate provision for visitors/visiting, Comfortable furniture, Privacy, Plain cooking, Attractive surrounding/décor, Clear sign posting, Adequate recreational facilities (Hepple et al., 1990, p.315).

As medical science become increasingly more complex, with sophisticated techniques and more availability of alternatives, it is inevitable that the rift of knowledge and communication, between the professional and the layman, becomes increasingly difficult, and yet increasingly important to bridge. Additional staff may go towards easing the problem but it is the researcher's opinion that awareness of all staff, by training and refresher courses to counter complacency is most important (Hepple et al., 1990). Education within hospitals is, however, a worthy aim, and that the hospital is seen to set a good example of healthy behaviour seems very reasonable; however, the extent of its success, with respect to long-term changes within a community are limited.

With the 'value-for-money' comes the vexed question of quality and service. It is considered that most current definitions incorporate some aspects of quality, either explicitly (Nailon, 1981), or implicitly (Christian in Nailon, 1982) using the word 'comfort'. This is not a specific standard and gives flexibility across a range of service qualities. Both 'quality' and 'service' are difficult to define:

In writing about Quality, Pirsig (1976; in Nailon, 1982, p.138) indicates the problems involved "Quality... you know what it is, yet you don't know what it is. But that is self-contradictory. But some things are better than others that is they have more quality. But then you try to say what quality is, apart from things that have it, it all goes poof! ...What the hell is quality?"

Quality, or more usually service, is invariably linked with an adjective such as 'good', 'bad', 'fast', 'slow', and 'highest' standards of service. But what does this mean? At the utilitarian level, it consists of a routine to establish the narrow definition of limited choice in the situation, such as onions are required with a hamburger and the speed of with which the task is accomplished. In a hedonistic transaction, the boundaries are much wider to meet a personalized requirement, it may involve a discussion, not only the choice of wine but also its vintage (Nailon, 1982, p.138).

Airey et al., (2015) writes, "In fact, a whole industry is devoted to quality as evidenced by concepts such as "Total Quality Care" and symbols such as kite marks provide heuristic guides to quality. In tourism itself, there are many such symbols such as the star ratings of hotels (quality of accommodation) or the blue flagging of beaches (quality of environment (and more recently a range of Web 2.0 enabled consumer quality as exemplified by Trip Advisor. Quality also projects its own scale,

aligning itself at the top and with excellence and implying its polar opposite of inferiority” (p. 141).

Beyond this, healthcare and hospitality research integrating a specific philosophy of hospitality is limited though both are replete with many typical service quality and satisfaction studies. The study starts this conversation, adding hospitality to the discussion as a slight modification from the aforementioned quality and satisfaction research by suggesting hospitality centric service excellence as a new type of excellence beyond service excellence. However, a guiding premise for the study is that service excellence must be in place and delivered in an organisation before hospitality centric service excellence can be achieved.

A frequent complaint of patients is that they feel depersonalized by hospitalisation. Many authors have highlighted this problem, including Kennedy (1983), Illife (1983), Garner (1979), Martin (1984), Robb (1967), Franklin (1974) and also Millard (1984). The extent to which the patient’s individuality is acknowledged depends on the attitude of the health service workers. It is recognized that where patients are made to feel individual and important, and where medical staff assess the ‘whole patient’, including an evaluation of emotional, domestic and social contexts, the recovery time is shorter, and it is suggested that the patient feels more satisfied with the treatment received (Hepple et al., 1990, p.308).

When faced with the prospect of hospitalisation, reactions vary. In a study of patient reaction to surgery, Janis (1971; in Burns (1980) noted three patterns of emotional responses before surgery each of which indicated a predictable reaction after surgery. The reactions were, to some extent, related to the patient’s personality, however some researchers, for example Moran (1963) and Wolffe et al., (1964) in Burns (1980), claim that prehospitalisation information can reduce the negative responses to some extent. Leary (1983), describes some reasons for anxiety which will affect people going into hospital (Hepple et al., 1990, pp.308-309).

Tourism service facilities

Other industry players include a growing number of “medical facilitation” companies, which assist patients by arranging care with particular hospitals, air travel and transfers, concierge and translation services if required, and tours in the destination country (Whittaker, et al., 2010, p.339). Airlines, hotels, travel agents, and resorts are all involved in the industry, many with dedicated arrangements with particular hospitals. The industry has also spawned representative associations that lobby stake-holders such as insurers, governments, and regulators to promote the industry, such as the Medical Tourism Association, which itself provides a certification program for medical facilitator companies, the International Medical Tourism Association based in Singapore and HealthCare Tourism International in

the United States, which accredits facilitator companies, hotels, and tourism operators (Whittaker, et al., 2010, p.339).

The principal corporate hospital chains employ teams of interpreters, though India has benefited because of its widespread English-speaking ability. Thailand's Phuket hospital provides interpreters in 15 languages and receives about 20,000 international patients a year, while the now famous Bumrungrad International Hospital in Bangkok claims to employ 70 interpreters, all of its staff speak English and it has 200 Surgeons certified in the United States (Connell, 2006, p.1095).

Goodrich and Goodrich (1987) defined health-care tourism as "the attempt on the part of a tourist facility or destination to attract tourist by deliberately promoting its health care services and facilities, in addition to its regular tourist amenities" (p.217 ; in Heung et al., 2010, p.237), thus emphasizing the supply side. Van Sliester (as cited in Hall, 1992) placed stronger emphasis on the demand side and viewed health tourism as comprising three elements: staying away from home, health as the primary motive, and occurring in a leisure setting.

Hospitality service facilities

Service disciplines developed from the fundamental belief that services are different from goods and require novel ideas, approaches, tools, and strategies (Berry and Parasuraman 1993). Health care illustrates just how much services can differ. Health care is a deeply troubled but critically important service sector. It costs too much, wastes too much, errs too much, discriminates too much (Berry & Bendapudi, 2007, p. 112).

Although numerous support services affect the customer—the patient in this case—those typically considered as hospitality-related support services are food-service, housekeeping (sometimes called environmental services), and maintenance (Anderson, 1988; in Reynolds & Leeman, 2007, p. 183). Foodservice typically carries the largest labor cost owing to its size and organizational reach; it is also the one hospitality service that generates revenue, usually from sales in the cafeteria. Housekeeping, which is also labor intensive, does not have the same apparent impact on customers; nonetheless, it plays a very important role, given the critical importance of sanitation in a health care setting (Raynolds & Leeman, 2007, p. 183).

Hospitality-related support services in health care organizations have traditionally operated independently within a firm's overarching operating structure. For example, managers and employees are hired and trained to provide a specific service, whether it is foodservice, housekeeping, or maintenance. It matters little that the foodservice employee scrubs the dining room floor exactly as the housekeeper cleans the lobby floor or that many of the services draw from the same labor pool. This silo approach is the natural evolution within an industry where the most visible support

service—foodservice—established operating standards less than 200 years ago and was recognized as a unique segment (i.e., on-site) within the foodservice industry only a few decades ago (Reynolds, 1997; in Reynolds & Leeman, 2007, p. 182).

Additional advantages cited by study participants include:

- contributes to meeting the hospital's mission;
- increases foodservice employees' pride in their job;
- improves food temperatures;
- eliminates nursing staff's responsibility for meal delivery;
- provides more food choices;
- decreases plate waste;
- decreases the number of complaints about food;
- empowers the patient;
- improves food quality; and
- decreases food cost.

The main disadvantage cited by 52% of the management level participants was increased cost, mainly a result of the greater number of full-time equivalents required to provide room service (Sheehan-Smith, 2006, p. 584).

One of the objectives of the present study was to identify best practices in hotel-style room service. A best practice can be defined as any practice, know-how, or experience that has proved valuable or effective in a specific setting or within one organization that may have applicability in other organizations (Hiebler, Kelly, & Ketterman 1998; Reynolds, 2003; in Sheehan-Smith, 2006, p. 585).

Sheehan-Smith's (2006) study shows that many hospitals undertook such a massive change in their meal delivery process. First was the hospital administration's desire to be more patient-oriented. They viewed the implementation of hotel-style room service as a component of their overall customer-service strategy. Second was the quest to improve patient satisfaction. Third, administrators looked at this new meal-delivery process as a means to gain a niche in a very competitive market. Each of the hospitals in the study was the first to implement hotel-style room service in either their city or surrounding geographical area (Sheehan-Smith, 2006, p. 583).

Though numerous studies have explored meal-distribution systems and patient satisfaction with foodservice quality, this study is one of the first to focus on room service in some hospitals of the United States of America (Sheehan-Smith, 2006, p. 584).

Foodservice has been included as a component of care in most hospitals in the United States since the 18th century (American Dietetic Association, 1984, pp. 17-27; in Sheehan-Smith, 2006, p. 585). Throughout the years, the type of food served to patients and the method used to deliver it has changed, yet as one study participant claimed “that old stigma of hospital food” appears to remain constant. If the small sampling of facilities in this study is any indication, hotel-style room service may contribute to eliminating that old stigma because the patients “think they’re in a four- or five-star hotel.” (Sheehan-Smith, 2006, p. 585)

Medical tourism and globalisation

In 2005, for example, India, Malaysia, Singapore and Thailand attracted more than 2.5 million medical travellers (United Nations Economic and Social Commission for Asia and the Pacific-[UNESCAP], 2008; in Heung et al., 2010, pp.236-237) and Singapore, India, Thailand, Brunei, Cuba, Hong Kong, Hungary, Israel, Jordan, Lithuania, Malaysia, the Philippines and the United Arab Emirates are now emerging as major health-care destinations. Many other countries, including Colombia, Argentina, Bolivia, Brazil, Costa Rica, Mexico, and Turkey are also in the process of making themselves attractive health-care destinations particularly for cosmetic surgery (Singh, 2008; in Heung et al., 2010, pp.236-237). At present, however, Asia remains the main region for medical tourism (Connell, 2006).

Due to the major changes in the world economy, tourism has had a significant growth, hence its feature given by numerous authors as a “phenomenon typical of the modern world” or a “constituent of daily life” (Iordache, 2013; in Carmen et al., 2014, p. 63). Rising cost of health care in industrialized countries increased willingness to move patients for high quality health services to emerging and developing countries, at prices much lower. However, improved communication technology, in particular by extending the Internet, the development of medical knowledge and technology services enlargement may be associated with medical tourism. Actually, in this century medicine is taking a globalizing process: hundreds of thousands of people travelling along and across the world in search of cheaper medical care or other services in the field.

Medical tourism and marketing

The competition for health and medical tourists’ money, and attempts to create ‘niche’ markets, has led to a diversification of the types of health and medical interventions on offer. These range from superficial treatments (such as facials and massages) to highly invasive and risky surgical procedures (such as open heart surgery and organ transplantation), or a combination of both (such as cosmetic tourism, which can encompass invasive and non-invasive cosmetic enhancements and some forms of dentistry) (Cook, 2010, p.136).

Governments can also promote medical tourism as part of national tourism marketing campaigns. In addition, they can support this niche area by developing policies that decrease marketing expenses in foreign countries through tax deductions, by providing financial support for equipment, by setting aside land for medical tourism without affecting public health services, and by supporting overseas investments in this type of tourism (UNESCAP, 2007).

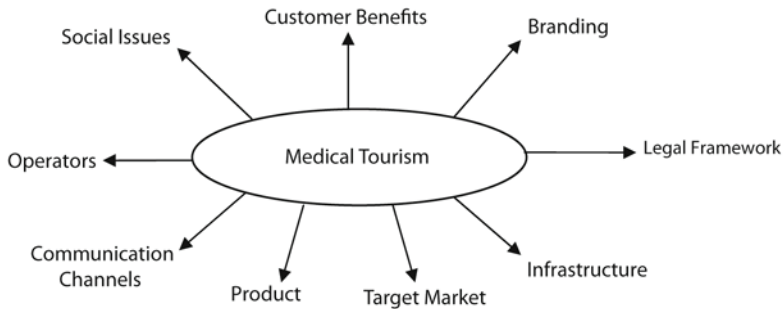
Medical tourism is an emerging global industry, with a range of key stakeholders with commercial interests including brokers, health care providers, insurance provision, website providers and conference and media services.

From marketing materials (both print and web-based sources), it is apparent that the range of treatments available overseas for prospective medical tourists are wide, including:

- Cosmetic surgery (breast, face, liposuction)
- Dentistry (cosmetic and reconstruction)
- Cardiology/cardiac surgery (by-pass, valve replacement)
- Orthopedic surgery (hip replacement, resurfacing, knee replacement, joint surgery)
- Bariatric surgery (gastric by-pass, gastric banding)
- Fertility/reproductive system (In vitro fertilisation -IVF, gender reassignment)
- Organ, cell and tissue transplantation (organ transplantation; stem cell)
- Eye surgery
- Diagnostics and check-ups.

Collectively, not all of these treatments would be classed as acute and life-threatening and some are clearly more marginal to mainstream health care. Some forms of plastic surgery would be excluded from health spending (e.g. for solely cosmetic reasons); other forms of medical tourism (e.g. IVF) would be counted within the remit of health trade (OECD, 2010; in Lunt et al., n.d.,p.11).

Smith and Forgione (2007) developed a two-stage model that indicates the factors that influence a patient's decision to seek health-care services abroad. Their model suggests that there is no dominant factor that affects such a decision; rather, all factors seem equally at play. In the first stage of the model, the factors involved in choosing a destination are identified. Then, in the second stage, those involved in choosing a health-care facility are evaluated.

Figure: Market description

Source: Caballero-Danell & Mugomba, 2007; in Heung, et al. (2010, p. 241)

The marketing of medical tourism may not be compatible with conventional tourism advertising, and relevant organisations must assess the most effective presentation, choice of media, and channels of communication for its promotion (Henderson, 2004, p. 117). It can be seen that medical tourism flows consist of foreign patients from developed countries that hospitals are turning to emerging markets in Asia, Europe and Latin America, except Africa and Oceania, the main driver being cost advantage (Carmen et al., 2014, p.65).

Building on its experience in selling its labour and expertise in information technology on the international market, India is following Thailand in promoting “in-tech” healing to become a global health destination. The country has already established a reputation in cardiac care, cosmetic surgery, joint replacement and dentistry and is actively working to expand into other areas that may attract well-healed foreigners and the 12 million Indian expatriates who can combine regular to India with non-emergency medical procedures. India also hopes to capitalize on its traditions Auyurvedic and other non-allopathic treatment which might contribute a special niche and attract another clientele (Pocock & Phua, 2011).

Policy of medical tourism promotion

While writing about policy of medical tourism promotion, Carmen et al. (2014, p.67) have followed the works of different authors such as Zarrilli (2002); (Caballero-Danella & Mugomba, 2007); Bookman and Bookman (2007); Brenzel (2004); and Chanda (2001). All their works have proposed the following six policies for promoting medical tourism.

1. *Incentives such as reducing tariffs* on imports of equipment for hospitals (for example, in the Philippines, in 2004, they are included in the Investment Priorities Plan), reduced import duties for equipment needed medical tourism (e.g., India) and incentives provided directly by hospitals (e.g. in Malaysia,

the government provides incentives for private hospitals which have foreign patients, through tax cuts).

2. *Promotion by governments, of policy investment* assets for developing a general improvement of road transport network, electrification and communication systems and infrastructure development specific medical tourism industry including hotels, resorts and hospitals. In India, for example, the Ministry of Health and Family Welfare and the Ministry of Tourism has actively developed infrastructure policies and tools to promote industry growth the government being involved in some way.
3. *Encourage cooperation in the public sector* by forming alliances between ministries of health, tourism, commerce and offices that deal with migration tourist patients. For example, the success of Cuban medical tourism is due to the strategy of the Ministry of Health coordination and collaboration with institutions in the areas of tourism, trade and industry.
4. *Establish partnerships between the public and private sectors.* Zarrilli (2002) points out that while the ultimate goal of the public sector is to provide a fair and appropriate health care for all citizens, private sector primarily objective is to maximize profits by attracting patients from abroad. Therefore, medical tourism success can only be achieved through collaboration between the two sectors. Bookman and Bookman, (2007) point out that although formal partnerships have been implemented in the medical tourism industry, many medical tourism destinations have informal and voluntary cooperation between the public and private sectors.
5. *Government incentives or subsidies to attract private sector investment* are essential for the sustainable growth of medical tourism industry. Brenzel (2004) acknowledges that both sectors can mutually strengthen the public health system. In countries where medical tourism industry is being led by the private sector, the role of governments should provide a legal framework for private entrepreneurs to target support (financial, technical know) without local people's access to health services is not jeopardized.
6. *Subsidize the public and private sectors in healthcare* This suggests that the cross-subsidisation, a portion of the revenues from the provision of healthcare for foreign visitors can be allocated to improve quality and access to medical assistance of domestic population. It can be achieved, for example, by taxing income from "export" of health services. Moreover, many authors suggest that cross-subsidisation could be implemented by providing free or at least subsidized places by the local population, while foreign patients are required to pay (Bookman & Bookman, 2007).

There are, however, challenges. Connell (2006b; in Cook, 2010, p.143) outlines that medical tourism providers in less developed countries face the difficulty of convincing patients from developed countries of their authenticity, such as the quality of treatment, provision of care, quality of outcome, standards of safety, and institutional and healthcare management. Creating methods that provide authority to authenticity is one mechanism through which this can occur. For example, certification from Western accreditation bodies has become integral to medical tourism authentication, exposing how cultural values are key in the construction of authenticity. Various hospitals in India and the health and wellness group, Manipal Cure and Care (MCC), have sought accreditation from the Australian Council on Healthcare Standards International (ACHSI). This is because 'Accreditation is important as benchmarking of service and recognition by an independent organisation instills confidence and acceptance.

Conclusion

The financial rewards from medical tourism have created an increasing international interest in this phenomenon from governments and the healthcare industry. As part of this competition, various locals seek to exhibit their distinctive features to separate them from their opponents. Along with the increasing affordability of international travel, these mounting options have allowed patients to access medical procedures of choice without the restriction of national borders and healthcare policies. Despite these developments, academic attention has been scarce, with a limited focus placed on defining medical tourism and breaking it down into typologies. However, this approach provides little insight into how medical tourism is structured, experienced and embodied. By theoretically examining medical tourism in the framework of authenticity, this paper begins the journey towards understanding the complexities of this phenomenon.

The readers may get confused with the various terminologies which are used by different scholars, such as health tourism, healthcare tourism, wellness tourism, xenotourism, spa tourism and medical tourism. Though the previous authors seem to be valid in their spaces, the researchers should aware of all those different typologies if they are studying medical tourism. This study focuses on both tourism and hospitality which are embodied within each other and where there is a symbiotic relationship between medical tourism and hospitality in hospitals. In one's absence the other one cannot survive. Those who studied medical tourism or healthcare tourism didn't touch on hospitality provided to hospital patients. Likewise, those who studied hospitality in hospitals also ignored the dimension of tourism. This study also suggests the stakeholders to understand the cross-cultural behaviour or intercultural communication between the hosts and the guests.

While there is a debate around the usefulness of authenticity in tourism studies, I have demonstrated in this paper that constructivist and existential authenticity can explain the process of medical tourism from the view points of the provider and the consumer. For example, the medical tourism industry seeks to authenticate its services and practice through reproduction and accreditation.

However, these places, spaces, practices and objects cannot be separated from the embodied patient, who is at the centre of medical tourism. For this reason, medical tourism is not the search for a particular geographical locale, to connect with a lost or pre-modern time, to gaze passively on a site, or to discover the inherent authenticity of an object. It is not motivated by a desire to witness or observe cultural events or activities. Rather, medical tourism is based on a tourist's embodiment as it exists and as they want it to be. They travel for a service and a product that is focused on and marketed towards their current embodied state and what they desire it to be. The outcome of their tourist experience is associated with their body, such as a change in their appearance or shape (cosmetic tourism), improved blood circulation to and from the heart (heart valve surgery), correcting physical movement or pain (hip or knee replacement surgery), or a reduction of debilitating disease symptoms or to lessen disease progression (stem cell tourism and xenotourism).

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