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Hospitality and Destination Marketing's Role in Medical Tourism: A Call for Research

Daniel B. Cormany, *University of Nevada, Las Vegas*

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Dan Cormany

Harrah Hotel College,
University of Nevada,
4505 South Maryland Parkway,
Las Vegas, NV 89154, USA
E-mail: Dancormany.medtourism@yahoo.com

Abstract: Like business travel, where the primary focus is on business and travel is the simply the conduit by which it is performed, medical tourism is a growing trend in which individuals journey to foreign countries primarily to secure specific medical procedures or health benefits. The medical tourist is a newly defined segment of the travel industry, and while still small in numbers, is growing rapidly.

This paper seeks to identify research questions related to the hospitality elements that contribute to the medical tourism experience. The answers to these may aid hoteliers, tourism operations, and visitor bureaus better understand, service and market to the medical traveller. To facilitate the research, six broad categories of medical tourists are identified and four components by which each category may be evaluated are suggested. For each of the components that contribute to the medical travellers' experience, potential research areas are proposed to study this growing phenomenon from a hospitality and tourism perspective.

Keywords: medical tourism; medical travel; destination marketing; health travel; health tourism.

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Biographical notes: Dan Cormany is a PhD student at the University of Nevada, Las Vegas, focusing his studies in the Hotel College on medical tourism. His emphasis is on tourism and hospitality's potential roles in serving the medical tourist. Prior to starting these studies, he worked for 17 years as the Dean of students at universities in Ohio, Florida and Hawaii, before embarking on a career change to tourism. His hotel work includes management positions for Loews Hotels, Hyatt Regency and Wynn Las Vegas. He holds a Master of Arts in College Administration and a Master of Science in Hotel Management.

1 Introduction

In 2002, Dr. Mary Maples of the University of Nevada, Reno, coined the term 'silver tsunami' to describe the impending retirement of the US baby boomer generation

(Maples, 2007). This approaching surge in the percentage of older Americans holds ramifications for many areas of society, not the least of which is healthcare.

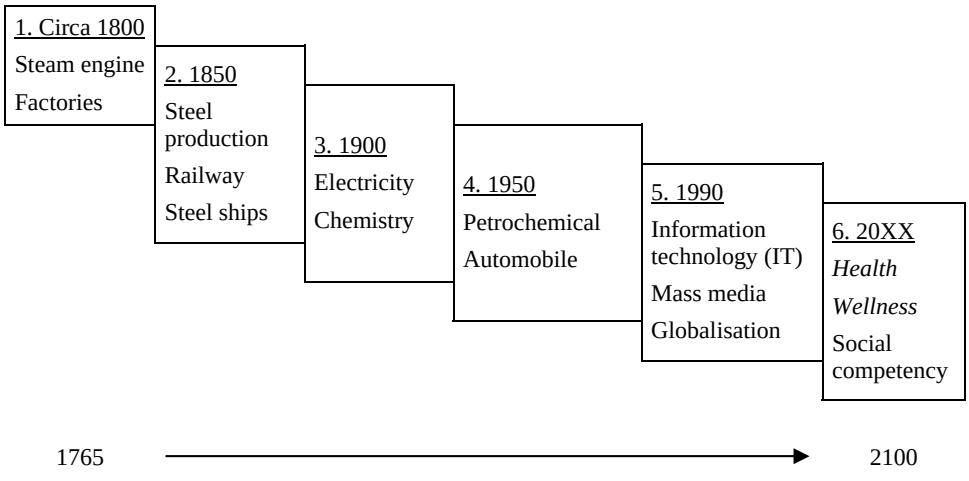
Like tsunamis in the world of nature, it is not difficult to predict the arrival of this silver tsunami, but it is hard to judge in advance its ultimate impact. Likely to intensify its effect are rapidly growing costs of medical procedures in the USA and a steadily decreasing level of health insurance coverage (Kaiser Family Foundation, 2007).

Also contributing is a physician shortage. Since the 1980s, medical schools have been capping enrolment, resulting in a shortage of physicians in the country which the US Department of Health and Human Service's Health Resources and Services Administration predicts to continue to grow to between 55,000 and 191,000 by 2020 (Hidalgo, 2008).

At the same time that expenses soar, insurance levels drop and caregiver numbers shrink in relation to the population size; this is the first generation to reach older age having lived its collective life under the expanded health expectations introduced by the World Health Organization in 1948 with the broad definition of health as "complete physical, mental, and social well-being" (Nahrstedt, 2004). Such a definition has influenced "physical, social, psychological, emotional, spiritual and environmental" approaches to wellness (Edlin and Golanty, 1988) as the simple "absence of disease or infirmity" (Anderson, 1987) is no longer viewed as sufficient. Expectations increasingly revolve around holistic care and maintenance of good health (Douglas, 2001), expectations which further tax the healthcare system.

Indeed, healthcare is identified in the economic model of longwave influences as being a dominant factor for the foreseeable future and medical tourism is a natural extension of the most recent dominant factors of globalisation and growth of the field of information technology (IT) (Nefiodow, 1996) (see Figure 1).

Figure 1 Longwave economy: 'Kondratieff cycles' (following basic innovations)



Note: Emphasis added

Source: Nahrstedt (2004), adopted from Nefiodow (1996)

2 Medical tourism

Together, these factors suggest that a tidal wave may be on its way of change in how Americans may need to seek medical treatment and health maintenance. As the allegorical flood waters start to trickle under the doorways of some aging or under-insured citizens, one response that is growing exponentially on an annual basis is that of 'medical tourism' (Deloitte, 2008; Demicco and Cetron, 2006).

Medical tourism is when individuals needing or desiring medical procedures are seeking outside-the-country alternatives for medical treatment (Goodrich, 1993). While the primary motivation for much of this travel is usually medical cost savings, these travellers "receive the bonus of vacationing and sightseeing in a foreign country and an exotic culture" (Yim, 2006). Indeed, most of the packages sold to such tourists include not only the medical treatment, but also transportation, on-location assistance, accommodations and a postoperative vacation and recovery time (Bookman and Bookman, 2007).

In comparison to recreational travellers, numbers of medical tourists are not yet large. However, the growth from year to year in the lead countries is an indicator of the increasing strength of this trend.

For example, India expected 300,000 medical visitors in 2007 (Bookman and Bookman, 2007) and has been enjoying a 30% growth rate annually in such medical tourists (Hutchison, 2005), a pace that will allow it to overtake Thailand as the leading destination (Gahlinger, 2008). India projects that it may be earning as much as $2.2 billion a year from medical tourism by 2012 as reported by Bookman and Bookman (2007, p.3) who record an interview with Narsinha Reddy, the marketing manager for the Bombay Hospital, in which he claims that medical tourism will "do for India's economic growth in the 2000s ten to twenty times what IT did for it in the 1990s".

The comparison of the potential economic impact of medical tourism to that of IT is a particularly apt one. If growth of medical tourism continues like these countries anticipate and as current US demographics, healthcare costs and health insurance coverage patterns seem to encourage, not only will the medical industry, but also the hospitality industry need to recognise and understand this growing trend. Medical tourism, virtually unrecognised as an industry ten years ago, is projected to be a $40 billion global industry by 2010 (Forbes, 2007; Moody, 2007). By interesting coincidence, $40 billion was the current revenue generated by all online travel bookings in 2006 (Greenberg, 2007), another industry virtually unheard of fifteen years ago yet now seen as a significant aspect for income by the hospitality industry and changing the way travel is arranged by the average consumer.

Indeed, with projections of continued growth of medical tourists by 15% to 20% per year for the foreseeable future (Schult, 2006) and a current growth at 30% annually for the last two years (Gahlinger, 2008), the phenomenon has attracted the attention of popular media. English language news sources made reference to 'medical tourism' only eight times in 1992; by 2007, the phenomenon's annual reference rate had swelled to 2,335 (Erfurt-Cooper and Cooper, 2009).

Given that attention, it is amazing that the global medical tourism industry has been neglected by researchers of nearly all disciplines (Bookman and Bookman, 2007). What exists focuses primarily on medicine, economics, insurance and legal considerations. Other than personal interest stories of specific individuals travelling internationally

to obtain healthcare, the usual hospitality articles on the topic focus on the 'lifestyle procedures' component of this much larger field, by highlighting wellness spas and 'medi-spas' (meaning spas which maintain a physician on staff) (Johanson, 2004).

It is understandable that hospitality research might begin with wellness spas, as these have been a popular additional revenue centre for many hotels, in which the revenue contribution is easily isolated and analysed. Spas have become a staple in most luxury hotels, with the spa industry doubling in size since 1999 (Gahlinger, 2008). In 2001, spa revenues surpassed revenues of amusement parks, ski resorts, box office receipts and vacation ownership revenues, making it one of the most robust industries in hospitality and leisure (International Spa Association, 2002).

Among spas, medical spas, or 'medi-spas', combining medical treatments with spa and alternative treatments, are the fastest growing of all (International Spa Association, 2004), growing at a rate of 11% to 14% annually. Located in resorts, especially in Eastern Europe, these medi-spas are offering a wide range of medical procedures, in some cases including LASIK eye surgery, dental procedures and wide-ranging forms of plastic surgery (Medical Spas, 2005). Their rapid growth has blurred the line between hospitality and medical treatment, required influxes of sophisticated equipment and have become, on some properties, a part of a designated 'patient care service zone' [Leibrock, (2000), p.219].

This rapid growth raises some interesting marketing and operational questions. Does the comingling of standard and alternative medical treatments add unproven credence to the value of the alternative methods or alternatively lessen the credibility of the traditional methods in the perception of the spa guests? To what extent are these medi-spa services used as follow-up to off-property medical treatment? Due to the need for sophisticated equipment and highly trained personnel, what is the volume necessary to justify such financial investments and does this suggest only larger facilities may undertake such services? Just as some hospitals are outsourcing the hospitality services they wish to offer, are resorts and hotels outsourcing these medi-spa operations, for reasons of liability or expertise, and does this provide an opportunity for collaboration between hotel and medical provider, and a new marketing appeal to the potential medical tourist?

However, medical tourism is much broader than spa treatments and it is in these other aspects that hospitality has not yet taken collective note. It is the purpose of this paper to provide a proposed framework by which initial hospitality research into this broad subject may be undertaken in an organised manner, allowing comparisons to be made between categories of medical tourism travel.

3 Proposed model

Treatments range from lifestyle adjustments to cosmetic and dental surgery to life-saving organ transplants and heart value replacement. As suggested by Bookman and Bookman (2007), and further developed and proposed here, a classification system for medical tourism travel may include three broad areas and six categories:

1 intrusive medical procedures (including three categories):
   a cosmetic surgery
   b medically-required or recommended surgery of non-life-threatening conditions including dental work
   c medically-required or recommended surgery for life-threatening conditions
2 diagnostic procedures (one category, including, for example, stress tests, screenings, cat-scans, 'executive physicals' and electrocardiograms)
3 lifestyle procedures (including two categories):
   a spa treatments and consultations on overcoming addictions, learning stress alleviation and relaxation
   b non-surgical alternative therapies (such as acupuncture, botox injections, Ayurveda or herbal treatments for specific conditions).

It is also suggested that each of these six categories have unique components impacting the hospitality and tourism considerations. For cities contemplating or engaged in attempts to develop a medical tourism component to their region's travel appeal, four broad components need to be considered, as modified from suggestions by Bookman and Bookman (2007).

These four components are:

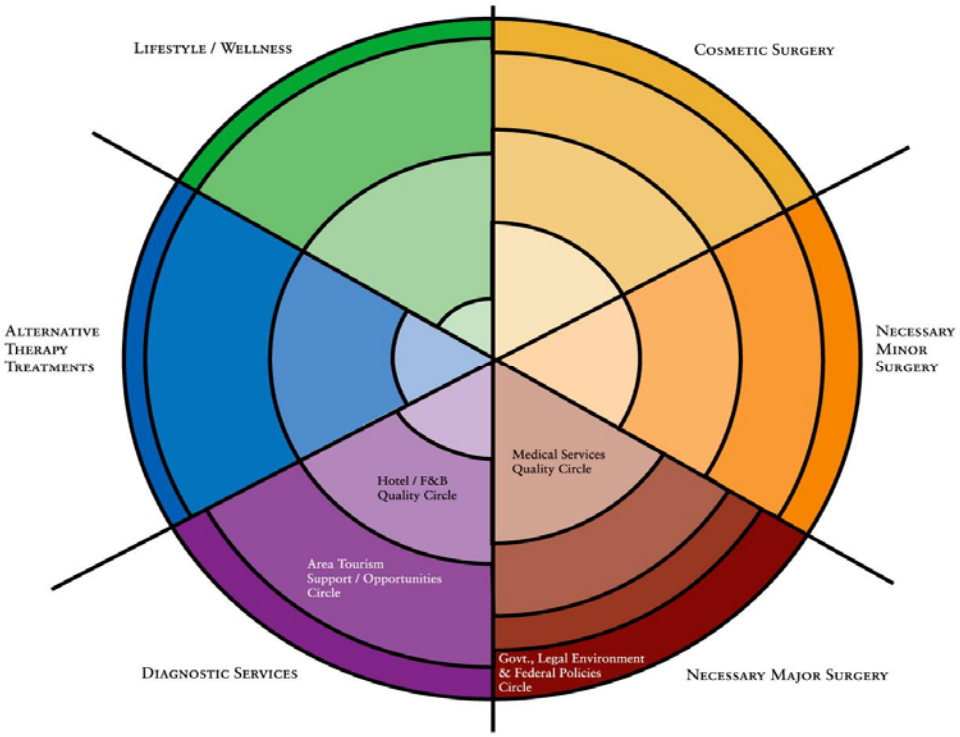
1 healthcare facilities and medical talent
2 hotel and restaurant support and quality
3 general tourism infrastructure
4 governmental policies and laws (both locally and nationally) that support or constrain medical tourism development.

Each of these will be explained and expanded below, but the relative impact of each may vary depending upon the type of medical tourism being considered. For example, tourists travelling for major surgery will understandably be most concerned with the quality of healthcare available; those travelling for lifestyle reasons may be much more concerned about accommodations and tourism opportunities while visiting. Therefore, it is proposed that there are likely different gradations of the four components within each category.

These six categories of medical tourism and the impact the four components may have on each might be illustrated in the following way (see Figure 2).

The relative importance to each medical tourism category of each of the four components (medical care, hotel and restaurant facilities, tourism opportunities and governmental policies) is represented by the portion of each pie slice attributed to it. This relative position is only suggested here, based upon the degree to which each component might seem to logically be factored into the selection of a destination by that sort of medical traveller. These currently are only assertions and a judgment of the correctness of them represent a critical area needing study – is the assumed weight each carries in the guest's location selection process verifiable?

Figure 2 Six types of medical tourists and a suggested weight of factors for each in destination selection (see online version for colours)



Source: Cormany (2008)

Since there is an absence of past research, even the possibilities are speculative until some foundation is built. The hope is that some of these possible research topics may lead to some fruitful discoveries, and even those which result in dead ends help to advance understanding and establish some parameters for further study and foster some additional creative consideration of other topics that may apply to medical tourism research.

4 Innermost circle – healthcare facilities and services quality

The innermost component, that of healthcare facilities, is suggested here as the most key element in the decision making process of the true medical traveller. (Note that this raises a very significant dilemma in approaching the study of medical tourism, and one that needs clarification through study and analysis – when is a traveller classified as a medical tourist as opposed to a tourist to whom a spa, for instance, is just an appealing additional amenity?) Douglas (2001) provides a discussion of this issue, for much travel could be classified as with the intention of relaxing and recuperating from everyday stresses, but for purposes of this paper, the medical tourist is defined as a person whose travel is primarily motivated by health objectives.

While this important 'healthcare facilities and services' component is primarily under the control of the medical facilities offering services, some of these medical centres are modelling many of their services on hospitality models, including concierge support, ground transportation arrangements, expedited hotel-like check-in processes, personal translators and even some hospital-run recovery centres that resemble resorts more closely than hospitals (Leibrock, 2000). In fact, at least one facility, the Barbados Fertility Centre, has relocated the entire facility to provide seaside views from its rooms (Gahlinger, 2008). A growing interest by medical facilities is to learn and imitate hospitality operations – examples are luxury healthcare options at the Mayo Clinic (Bookman and Bookman, 2007), the Cooperative Care Unit of Tisch Hospital of New York, in-house hotel accommodations of the Rhode Island Hospital (Leibrook, 2000) and the recent construction of a medical hotel by the Yale-New Haven Medical Facility (Polk, 2003). Such efforts may reduce the use of outside hotel facilities for early stages of recovery, but may also provide hotel corporations and hospitality professionals new venues in which to apply their expertise as consultants or facility managers.

An outline of issues included in this medical facilities and services circle include:

1 costs – medical
2 labour available – medical
3 training available – medical (medical schools, nursing programmes)
4 financial inducements for labour – medical
5 English commonly spoken among medical staff (or target market language)
6 facilities:
    a capacity
    b accreditation
    c licensure of staff
    d specialisations
    e staff: patient ratio
    f ambulance service
7 equipment available rental (oxygen, wheelchair, etc.)
8 private nurses available for hire
9 medications:
    a availability
    b safety of medication quality
    c parallels to US medication
10 indigenous disease threats
11 privately operated facilities.

While most of these factors are outside the realm of hospitality and tourism study, they are included here as they provide details on perhaps one method of how to assess the manner in which healthcare is provided in an area, determining whether medical tourism

is a viable target for the area. Additionally, and more germane to hoteliers and those in the tourist sector, is the type of medical tourism model either in place or developing in an area. Currently, these are usually driven by healthcare facilities, but it is conceivable that hospitality and tourism organisations could have a part in shaping how a region's approach develops. The current models include:

- treatment in hospital, then moving to resort (hotel as 'aftercare' provider – the most common current model for surgery patients)
- hospital serving also as a resort (example, Barbados Fertility Centre)
- treatment at resort with medical facilities (example, Palace of the Golden Horses, Kula Lumpur)
- fly-in treatment to medical treatment at airport (example, Munich airport)
- treatment and recovery on cruise ship (example, Renaissance Cruises)
- traditional/alternative treatment provided at clinics or in hotel spa (applicable to any resort with extensive spa facilities and offerings)
- diagnosis at hospital, lodging provided at resort (common model)
- diagnosis done in resort med-spa (common at European spa/hotel facilities)
- diagnosis (begun) on airplane while going to destination (example, Air Emirates)
- lifestyle treatments at resort spa – relaxation, education, corrective behaviour, cleansing and holistic approaches (services found at many spa operations)
- drive in – drive out treatment, not involving traditional tourism/hotel support (particularly common in cross-border services such as dental clinics located in Los Algodones, Mexicali and Tijuana) (Bookman and Bookman, 2007; Gahlinger, 2008; Page and Page, 2007; Woodman, 2007).

Areas of research into treatment provided to medical tourists are numerous and include quality of service and facilities, acceptance by insurance providers, follow-up care when the traveller returns home, utilisation of treatments not recognised in the USA and willingness to provide treatments not ethically condoned within the USA (Bookman and Bookman, 2007; Gahlinger, 2008; Schult, 2006; Woodman, 2007); however, these have only limited or tangential impact on hospitality and tourism operations.

Of more relevance here is the degree to which medical centres wish to absorb hospitality functions for the patient and his/her travelling partners, and the manner in which they wish to provide those functions. Differing models are developing as these private, for-profit medical operations decide whether the added revenue potential, the marketing impact and the additional physical plant commitment are financially wise for their business model. Decisions are being made to:

1 operate in-house such services as housing for family members, providing concierge services, coordinating travel and ground transportation details, offering luxury recovery accommodations, developing in-house restaurants of substantial quality and variety in contrast to standard hospital cafeteria fare

2 whether to plan for such facilities and accoutrements within the facility but outsource their operation

3 whether to rely on current and developing sources in the area to provide such services.

This is perhaps one of the most basic questions of how medical tourism may develop, for a hospitality firm's ability to profit from increasing medical tourism may either come from its own facility development and operation, or facility management for medical centres of their non-medical components. There are currently some expansive hospital offerings – several in Asia offer, in addition to surgical procedures, dental and cosmetic clinics, beauty makeovers, spas and alternative medicine all within the facility (Gahlinger, 2008). There are also frequent citations of partners being accommodated with the patient at the hospital (Grace, 2007).

It may be the potential of an additional revenue stream that has prompted the new OCA Medical Facility in Monterrey, México, to be included as an in-hospital hotel (Karakowsky, 2008). Other large developments, such as Dubai Healthcare City have courted renowned hoteliers to build luxury resorts next to the healthcare facilities they are constructing (DHCC, 2008).

In addition to plush facilities, some hospitals are offering concierge and trip-planning services as part of their amenity package. Frequently cited as a leader in this is Bumrungrad International Hospital in Thailand, where they partner with providers to arrange air transportation, ground transportation, hotel accommodations, translator support, medical records transfer and general concierge support (Bumrungrad, 2008). It appears this service is offered by Bumrungrad primarily for marketing and not revenue generating purposes, but this may be a source of additional revenue for some hospital operations, or outsourced to hotel concierges.

Such developments blur the line between medical treatment and hospitality; however, currently most recovery time in most locations passes at nearby hotels (Bookman and Bookman, 2007; Schult, 2006; Woodman, 2007) – the second circle in the model.

5 Second circle – hotels and food/beverage quality

The second of the concentric circles, that of the availability of quality and appropriate hotel and dining facilities, is suggested as the second most influential aspect, for this defines the level of accommodation possible upon leaving a medical facility. In other cases, this circle also represents the venue at which medical services are provided, in the case of medi-spas or therapeutic spas located within resorts.

However, when the traveller is seeking more serious medical attention, the most common emerging model is that of a hotel as a facility serving the medical tourist briefly before medical treatment and longer during the convalescence process prior to returning home. In essence, the hotel is an 'aftercare' facility, as the guest moves from medical facilities while his or her strength returns, healing occurs and family members supplement the medical travel experience with tourism and relaxation. This recovery period may range from a few days for minor and cosmetic surgery to a couple weeks or more in the case of major surgery. Serving such patient/guests is relatively new ground for many properties and it raises several new considerations.

Physical designs of guest rooms and access to facilities, ability to meet dietary restrictions and staff understanding of needs are some of those vital considerations. Also important are the availability of privacy, service levels and proximity to medical help. For instance, if the guest has noticeable bandaging, seclusion from other guests may be desired by the medical guest to avoid potential embarrassment.

To that specific end, one of the world's first resort chains exclusively catering to recovery after surgery has been developed in Phuket and Bangkok, Thailand. The Bodyline Resorts accommodate recovering patients and their families in an environment where all patients on spending time healing, so no one feels stared at, and staff understand the physical and emotional needs of their guests (Bodyline, 2008).

As discussed below, the way in which a facility is evaluated by the potential medical tourist may be greatly influenced by the sort of medical treatment they are receiving.

The bulk of the potential studies identified later in this paper focuses on this area, for these are directly impacted by, and influencing, the currently developing medical tourism industry. Some factors important in this circle are:

1 costs – lodging
2 costs – food and beverage
3 number of 4/5 diamond-equivalent rooms available (international ratings available?)
4 labour availability – hospitality
5 training available – hospitality
6 financial inducements for labour – hospitality
7 English commonly spoken among hospitality staff (or target market language)
8 availability of potable water in facilities
9 reliability of electricity in facilities
10 licensure and regulation existing for:
    a food and beverage operations
    b hotel accommodations
    c spa facilities
11 dietary accommodations available (gluten free, low sodium, prescribed limits, etc.)
12 internet availability
13 hotel accommodations:
    a disability accommodations
    b private baths
    c elevators
    d room service available (24 hours?)
    e proximity to hospitals
    f heat/air
    g value for services provided ratio

14 presence of spa services:
   a medical personnel associated with spa
   b spa treatments
   c traditional treatments (acupuncture, herbal, Ayurveda. reflexology, etc.)
   d instruction in relaxation, diet and wellness (tai chi, yoga, nutrition, etc.)
   e diagnostic services
   f exercise/workout facilities (Gahlinger, 2008; Leibrock, 2000; Schult, 2006; Woodman, 2007).

It is posited that the relative importance of any of these factors to the medical tourist will be determined by the sort of medical treatment sought and the location of the destination. To date, no research has been found in assessing how important is each of these factors to each of the six categories of medical tourists. Areas of operations, physical plant design, services and marketing to the medical traveller by hotels are shown below. Each of these considerations may be explored for each of the six types of medical tourists:

- What design modifications for medical accommodation are advisable? (Note that this may range from check-in facilities to in-room amenities and lay-out. It may also include 'patient care service zones'.)
- What are the developing models of collaboration between hoteliers and medical facilities?
- How does the presence of medical tourists impact and influence marketing strategies of the hotel to leisure guests? (For example, the comparative appeal of all-inclusive pricing.)
- What lessons in staff training and sensitivity could be gleaned by hotels from medical staff models and what may hotels offer to medical staff training models?
- How does price elasticity vary with medical tourists as compared to leisure or business visitors?
- What is the psychological impact of the presence of medical tourists on the attitudes of leisure guests?
- What marketing decisions, made by area medical facilities, may directly impact an area's potential to attract medical tourists? Hospitality firms, as a support element to medical travellers, need to identify and monitor these, as they may significantly affect the availability of such travellers for hotels. Potential issues may include pricing, accreditation of medical facilities, gain or loss of 'star' physicians, etc.
- Upon what alternative criteria may hotel facilities be judged as appealing to medical tourists in their services and facilities?

Perhaps one reason for the paucity of information for hospitality companies on medical tourism is that medical tourism places hotels and resorts in a unique and new position – that of placing new demands and expectations on those properties without primary control over the overall experience. For leisure travellers, these same properties serve a primary role as host and indeed may be a major reason for the traveller to select one destination over another. Even if a specific destination is the primary motivator for the

guest, the hotel or resort plays a key role in the traveller's ultimate satisfaction with the experience. For business travellers, the property may serve a key role in providing meeting space and food/beverage support for the function attracting the traveller. For the business traveller needing only accommodations while conducting business in the area, the hotel's role is reduced to providing comfortable accommodations and decent service, but there are no additional facility requirements or staffing needs.

In contrast, for the medical tourist, if medical services are provided off-property, these services will ultimately determine the medical traveller's satisfaction with the trip. However, the expectation of the property is that provisions will be made to accommodate that traveller's additional needs. These accommodations may require modifications to the property's physical plant, the addition of staff, and the specialised training of current staff.

Offsetting these additional costs may be opportunities to retain these guests for longer stays than common for either leisure or business travellers. Since air travel is not recommended for at least five days after cosmetic surgery (Gahlinger, 2008), and for more complicated procedures, the wait may be up to a month (Grace, 2007), if the guest does stay at a hotel or resort, his or her bill is likely to be not insubstantial.

Unless the hotel wishes to cater exclusively to medical tourists, such as Bodyline Resort in Thailand, the addition of medical tourists to the property's guest mix may raise a marketing concern. The impact of more than a few medical tourists, possibly in visible bandages or requiring wheelchairs, may be an off-putting sight for leisure travellers sharing the same facility. The Woodmark Hotel, outside of Seattle, has become a popular post-operative recovery centre for a nearby cosmetic surgery clinic. It has handled this issue by creating a private entrance for medical tourists. The Four Seasons Hotel in Chicago has found that medical patients receiving treatment in the same downtown building it occupies with a surgery centre, prefer being given the cover of such privacy (Greenberg, 2007), and recommendations are made that such areas be provided private solariums or lounges, special services such as afternoon high tea and easy access to the resort spa (Leibrock, 2000).

Nonetheless, this remains a potentially difficult balancing act, assuring the comfort of all guests, without isolating or compounding self-consciousness of the medical guests. Properties wishing to afford privacy if desired, and access to all facilities if wanted, may find this to be as great a management challenge as the physical accommodations of medical tourist needs. Studies of non-medical guest attitudes may assist in determining how great an issue this has the potential to be for both marketing and operations.

6 Third circle – area tourism support/opportunities

Depending upon the medical treatment, options for enjoying the sites, culture, weather and relaxation opportunities of an area may also be a consideration in destination selection – especially for routine, minor procedures in which cost savings are the main consideration for an otherwise commoditised medical treatment. These factors, as well as other tourism infrastructures, such as international airport access and ground transportation availability, may be of greater importance in location selection for procedures such as minor cosmetic surgery, dental work and other procedures which do not greatly restrict mobility or require great amounts of rest in order to recover.

Assessment of these destination amenities may not require significant departures from general tourism destination assessment models. Hall (2000) proposes that such destination assessment take into account attractions, amenities and accessibility. A topic of potentially fruitful future research is how this mix of these three elements is similar or different for medical tourists in the six categories of medical travel from that of the leisure tourist.

Specifically, this circle includes topics that impact the appeal of the destination for all potential visitors, either directly, through desired service provisions, or indirectly through impact on that area's ability to provide a pleasant, positive experience for the visitor:

1 costs – general labour
2 commonality of spoken English (or target market language)
3 commonality of written English (or target market language)
4 availability of educated translators
5 airport:
    a direct service from major US (or target market) cities
    b airlines servicing terminal
    c accommodations for disabilities
    d airfare rates
    e frequency of flights
6 local transportation:
    a availability of taxis and limos
    b availability of buses and other public transport in hospital/hotel areas
    c safety of available transportation options
    d accommodations for disabled available
7 reliability of infrastructure:
    a electric service
    b public services
    c waste management
8 safety from crime
9 local political stability
10 distribution of service for:
    a cell phones
    b internet
11 ease of disability/limited mobility manoeuvrability (hills, etc.; pedestrian friendly?)
12 weather appeal for vacation and for recovery

13 destination appeal:
   a city offerings
   b relaxation
   c education
   d culture
   e sight-seeing
   f traditional medicine supplements/alternatives

14 receptivity by locals to Americans (or target market)

15 current awareness/image of locale by Americans (or target market) (Bookman and Bookman, 2007; Edgell et al., 2008).

As with the factors in the hotel and food/beverage circle, these are factors that may be influential in any decision to visit. For purposes of study of medical tourism, the unstudied question is, which of these factors are most critical for different categories of medical tourists and how does the relative weight carried by these factors differ from that which would be assigned by the leisure or business traveller? These factors, it is posited, will vary depending upon the category of medical tourist under consideration.

There is also the question of whether the marketing approach for medical tourism is impacted by different perceptual standards than the marketing appeals available to attract leisure travellers. Marketing in the US has been done to prospective patients for medical facilities since the 1970s (Bashe and Hicks, 2000), so the concept of marketing medicine is established. However, are there perceptual limits to the 'propriety' of marketing medical services? As an example, one clinic in Argentina markets a 'tango and breast enlargement' package, where guests learn to tango and receive breast enhancement surgery (Balch, 2006). Does this combine the cultural vacation appeal of the destination with surgery, or does it seem gimmicky, and reduce the credibility of the area for serious medical tourists? And, does it matter to potential travellers whether such offers are packaged by hospitality operators or the medical facility, perhaps reflecting poorly on the anticipated level of professionalism and seriousness afforded patients if the promoter is the healthcare provider, but providing opportunities for hospitality operations? Answers to the perception of these sorts of packages may direct future marketing efforts for not only the medical facility but the entire medical tourism efforts for the destination.

For study of specific area characteristics and marketing engines of medical tourism, an area may also wish to evaluate:

- How does a destination avoid becoming commoditised in health services offerings, and therefore, evaluated solely by lowest cost?
- What is the destination's general 'brand' image and how does that complement or conflict with its potential for medical tourism development?
- What role might the local destination marketing organisation, 'medical cities' (Stephano, 2009) or the regional or national department of tourism play in development of this market? What are the current or potential collaborative roles between these entities?

- What are the 'pull' factors (Dann, 1977) in operation when tourists select a specific location for medical treatment and how do these differ from motivational pull factors for leisure visitors?
- Does medical tourism keep more revenue in the local area than leisure tourism?
- What is the impact and attitude of local residents to the development of medical tourism in their community?
- To what extent does medical tourism contribute or detract from the economic vitality of the community?
- Can destination management through the inclusion of medical tourism even out the ebb and flow of seasonal tourist visitation patterns?
- Can medical tourism provide a counter to the cycle of destination maturity and subsequent tourism decline?
- Is there a psychographic profile of the medical traveller and how does that profile change depending upon which of the six general reasons for medical travel are being considered? Is the destination better suited to attract a particular psychographic profile of visitor and does that profile fit the sort of individual who may be seeking the primary medical care being offered.
- Are medical tourism destinations any more or less susceptible to the public perception aftermath to a natural or man-made disaster? (For instance, was travel to Mumbai after terrorist attacks any more or less diminished among medical tourists than other visitors?)
- How do the underlying theories of medical marketing and destination marketing converge or diverge?
- Is the destination too greatly relying on only one of these:
    a Accessibility.
    b Price.
    c Location features.
    d Source country regulations (such as Medicare).
    e Can any or all these be matched by competing countries/regions?

[Note that currently Medicare is not paid to any out-of-country facility, but Hospital Angeles in Tijuana is negotiating to permit Medicare coverage for provision of its treatments. If this is eventually approved, it will be the first foreign site to receive such payment, and certainly give it a competitive advantage for attracting some patients (Gahlinger, 2008).]

7 Fourth circle – government, legal environment and federal policies

Finally, predicted by the author of little conscious consideration for most medical travellers, is the underlying governmental policy toward supporting and encouraging

tourism. However, without such policies, the chances of an area developing a medical tourism offering of any sort are minimised.

In fact, these may be the most significant factor in the development of the region's viability as a medical tourist destination, for the underlying economics, legal system, civil liberties, national level of crime, sanitation, dependable support by utilities, and ease of access to the country all shape and determine that area's viability for any sort of tourism development (World Economic Forum, 2000).

While these of great importance in the development of medical tourism offerings, by the time the individual traveller is considering a destination, the majority of these factors are either in place or developing; otherwise, the destination would never reach the level of attention for the traveller's consideration.

Some of these national factors overlap with considerations of the specific city being considered by a medical tourist, such as level of crime, provision of utilities, etc., but it is suggested here that consideration of these factors on both a local and national level is advised, for they have an impact on both a local and national scale. As an illustration of this using an example from the USA, some US citizens would consider their regions fairly safe and secure, but might hesitate to visit areas reputed for high crime levels, such as Newark or Detroit. Similar gradations exist in other countries, and by including these overlapping categories in both circle three and four, these gradations are taken into account.

Some factors on this list are considerations for corporations considering expansion into an area to develop hotels or other services to foster and capitalise on expanding medical tourism. Other factors will be of interest primarily to those studying medical tourism from a legal, sociological or economic perspective. National factors include:

1 political stability of country
2 stability of labour force – union strike potential
3 currency fluctuations
4 access to money/credit
5 safety of country
6 respect for individual rights:
    a culture of tolerance
    b gender equality
    c protection of disabled
    d freedom from unreasonable arrest
7 legal system:
    a established laws
    b evenness of enforcement
    c ownership rights
    d legal recourse:
        - protection of patients
        - malpractice recognised

   e accounting and financial disclosure
   f tax system
   g recognition of patents and intellectual property rights
8 ease of access:
   a need for visa (by residents of target market)
   b visa access
   c visa processing time
9 type of market (economic model):
   a capitalism
   b privatisation
   c regulation/deregulation of areas impacting healthcare and tourism
10 cultural strain:
   a likeness of source and host country cultural
   b host country's citizen attitudes toward source country (Bookman and Bookman, 2007; Edgell et al., 2008; Godfrey and Clarke, 2000; Mathieson and Wall, 1982).

Since these factors are beyond the influence of hospitality and most tourism organisations, they are not the focus of this paper, but are noted here as valuable for their importance to broader tourism study and destination assessment.

One governmental aspect does have direct relevance to medical tourism destination marketing. That is the departments or ministries of tourism that labour to develop a destination's appeal. As governmental or quasi-public bureaus, they must consider the greater good for the region they are supporting.

Economically, does medical tourism aid an area in broader ways than other niche tourism? Not only are stays likely to be longer, but both medical and hospitality operations benefit, so is greater local employment enhanced? A common concern of international tourism destinations is the amount of money that does not stay in the area due to much of it being captured by global hotel chains, but generally medical dollars remain within a country, usually in the specific area in which the services are rendered (Bookman and Bookman, 2007); does this make this sort of tourism more beneficial than other forms to the economic growth of the area? Is this a strategy to inoculate an area from economic downturns if leisure travel drops off? If an area develops a reputation as a medical tourism destination, what impact could that have on its appeal for leisure travellers?

Additionally, in marketing terms, what are the differences in appealing to potential medical guests and leisure or business guests? While much of current tourism marketing aims at the upper levels of Maslow's hierarchy of needs, does medical tourism address the lower, more basic levels, and as such, require an approach not commonly used in tourism marketing (Page, 2009)? Besides quality of medical service and overall cost, are there destination characteristics that make an area more or less appealing to medical tourists than to leisure tourists?

For instance, while many travellers gravitate toward warm, sun-drenched settings for leisure getaways, most cosmetic surgery patients must stay out of the sun or risk scarring during their healing process (Schult, 2006), so is the appeal to such travellers better based upon other features of the area? Would this seem to indicate that certain areas more readily lend themselves to certain categories of medical tourism than others? What criteria are of most significance to the traveller in making these determinations?

An area known for medical tourism may benefit from a destination appeal that is not as significantly impacted by seasonality, but conversely, makes its self vulnerable to rapid swings in visitor appeal if there are public medical missteps by the caregivers. Such a perceived breach of trust could present recovery challenges to the area's tourism unlike that found in nearly any other form of tourism – the entire medical tourism industry being based upon the promise of quality medical care – and this vulnerability may be longer lasting than nearly any other public perception catastrophe an area could endure. To illustrate this point, the notoriously poor and fraudulent cancer treatment received by Steve McQueen in the late 1970s in México remains a cited example of why some still regard Mexican healthcare with suspicion (Gahlinger, 2008). An area banking on medical tourism as a revenue-generating effort could be rapidly devastated by such a high profile medical failure.

Finally, in seeking to best serve the area it represents, what are acceptable ratios of tourism patients to local patients needing medical care? While extending beyond the reach of the average tourism bureau, hinging on the answer to this question is possible local acceptance or resentment of efforts to promote medical tourism. If the local sensibility is that outsiders are being given preferential treatment in the availability of medical services, the perception may poison the long-term ability of an area to maintain such tourism as negative attitudes toward such travellers may take root (Bookman and Bookman, 2007).

8 Suggested starting points for research

As each concentric circle of the proposed model has been described, several areas of potential exploration for researchers have been mentioned. These span the disciplines of marketing, psychology, sociology and economics, as each of these disciplines have contributed greatly to general tourism research (Holden, 2006), but the theoretical models they offer to explain traveller behaviour or destination development have not yet been demonstrated as applicable to the medical tourist.

Table 1 Potential medical tourism research topics by academic discipline

Psychology	1	What are the 'push' (Dann, 1977) motives for medical travel? In other words, what are the factors that cause individuals to decide to travel for medical care?
	2	What are the 'pull' (Dann, 1977) motives for selecting a destination for medical treatment? In other words, what are the elements perceived to be present at a destination which compels the medical traveller to choose it?
	3	Are there common elements that differentiate the medical traveller from those who consider and ultimately reject the concept of travelling for medical care? In other words, is there a psychographic profile of medical travellers that differs from those deciding not to travel for such needed or desired care?

Table 1 Potential medical tourism research topics by academic discipline (continued)

Marketing	1	Where does the potential medical traveller obtain information on services offered? Is this information considered adequate by the potential medical traveller, or are there resources and messages currently not available that would help the potential traveller to reach a decision?
	2	Does the decision to purchase medical services abroad follow the same consumer decision-making models as the decision to purchase other goods and services or is the process different when healthcare is the goal? In other words, are the unconscious or affective elements of the purchase (Zaltman, 2003) operating to the same degree when consumption of healthcare is considered?
	3	To what extent do the non-medical elements of a destination factor into the selection of a destination for medical care? Is pricing for these elements more or less elastic than that of the same element for leisure travellers?
Sociology	1	How does the development of medical tourism affect attitudes of the residents of a host destination? Is its growth viewed as a positive that enhances medical quality for all, an economic boom for an area or as in intrusion that creates an inequality in access to quality medical care?
	2	What role does culture play in assessing the viability of a destination by the medical traveller and in trip satisfaction for those who travel to countries which hold differing values toward patient care, diet, concepts of privacy, etc.?
	3	What are the current perceptions of the concept of travelling for medical care within societies and are these changing as the field of medical tourism grows?
Economics	1	Are the multiplier effects of expenditures by medical tourists the same or different for a local economy to those of leisure tourism? In simple terms, is income that is generated by medical tourism which stays within a community remaining at a different percentage than that which results from leisure travellers?
	2	As more destinations seek to enter the field of medical tourism, are there strategies destinations can employ to avoid becoming commoditised?
	3	Is medical tourism less subject to travel drop offs due to economic down-turns than leisure tourism, since such travel is a means to an end (that being healthcare), rather than an end in and of itself?

In such virgin territory, starting with foundational questions would appear prudent. To that end, it is proposed that answering the following questions may provide the basis for allowing research to then extend in a number of directions (see Table 1).

9 Conclusions

Medical tourism is being avidly pursued by many regions, but its ultimate success or failure within an area may teeter as much on comprehensive answers to these questions as to the quality of medical care and hospitality services offered. The phenomenon of medical tourism has many financial and medical-need drivers propelling its growth, but as a new concept, has been compared to the internet boom of the late 1990s (Bookman and Bookman, 2007). Currently, it is a wild and uncharted frontier, with many regions wishing to capitalise on its potential, but as of yet, the criteria by which to determine the

feasibility and appropriateness of its offering to some or all of its six categories by an area has not been identified. Identifying the models and options for medical, hospitality and regional tourism bureaus is suggested as a first step in the creation of such a feasibility model. By examining each of these areas in the light of the needs of the six types of medical travellers, a framework may be developed to help organise future medical tourist studies.

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