A Literature Review on Motivation Factors, Behavioral Intention & Perception of Medical Tourists

Presented By: Vaishnavi Padhy (HM-25)

Roll No.: 1231

Certificate Course: Patient Safety & Quality Improvement

What is Medical Tourism……?

- Patients traveling from their own country to another for receiving medical treatment.
- Also known as 'Health Tourism' or 'Wellness Tourism'.
- Mostly medical tourists are from developed countries such as USA, UK, Canada, Japan, Australia, Middle East and Western Europe.
- Primary reasons can be- availability of treatments, quality of healthcare services, shorter waiting periods, low cost of treatment compared to home country, and travel opportunities.
- Countries actively promoting Medical Tourism are- Cuba, Costa Rica, Hungary, India, Israel, Jordan, Lithuania, Malaysia, and Thailand.
- According to analysts, it brought India USD 5-6 billion by mid-2020.

Medical Tourism Process

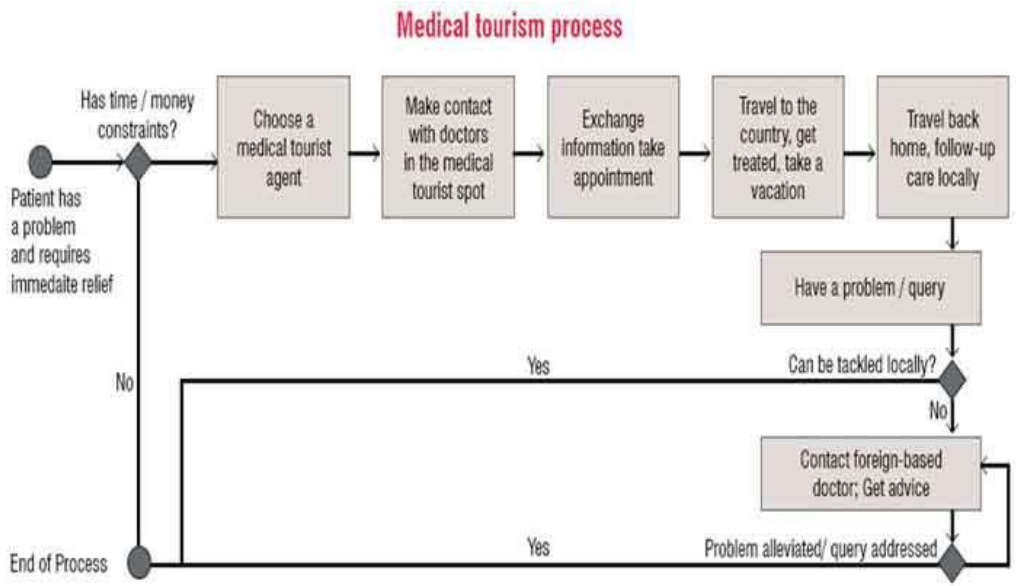
Person seeking medical care contacts a medical tourism provider

Provider requires patient's medical report, local doctor's opinion, medical history, diagnosis; certified doctors and consultants are asked advice on treatment

Expenditure, hospital choice, tourist destination, duration of stay is discussed

Signing consent form and agreements, recommendation letter for medical visa from embassy

Traveling to destination country where the agent looks after their needs



History & Evolution

- Thousands of years ago, Greek pilgrims traveled to Epidauria in Saronic Gulf to offer their prayers to Asklepios (deity of healing).
- Roman Britain people drank water from a shrine at Bath to cure diseases.
- In 1326, iron-rich hot-springs were discovered in Belgium, which later grew into a full-fledged health resort.
- People flocked to spas, sanitariums, hot-springs in different countries as they believed it had health-giving mineral water and could cure any disease.
- In early 1800s, when there were no travel limitations in Europe, people from adjacent countries came to improve their health.
- India's medical tourism dates back to Indus Valley Civilization when people came for Ayurvedic treatment. Susruta was a famous ancient Indian surgeon.
- Florence Nightingale was a pioneer in medical tourism. She directed low-income people to countries where treatment cost was low, as reported in her letters from 1856.

Favorable Places for Medical Tourism (According to MTI)

TOP 10 COUNTRIES FOR MEDICAL TOURISM IN THE WORLD

TURKEY
- SPECIALIZATIONS: Ophthalmic, transplant surgery, cancer, orthopedic care and neurosurgery
- SAVINGS*: 50%-65%
- NUMBER OF JCI ACCREDITED HOSP.: 44

INDIA
- SPECIALIZATIONS: Fertility, orthopedic, cardiac, oncology and organ transplant
- SAVINGS**: 60%-90%
- NUMBER OF JCI ACCREDITED HOSP.: 38

MEXICO
- SPECIALIZATIONS: Weight loss treatment and surgery
- SAVINGS*: 40%-60%
- NUMBER OF JCI ACCREDITED HOSP.: 7

THAILAND
- SPECIALIZATIONS: Plastic surgeries, cardio thoracic, pediatric, neurological and dental implants
- SAVINGS*: 50%-75%
- NUMBER OF JCI ACCREDITED HOSP.: 66

COSTA RICA
- SPECIALIZATIONS: Dentistry, gynecology, plastic surgery, orthopedics and bariatrics
- SAVINGS*: 45%-60%
- NUMBER OF JCI ACCREDITED HOSP.: 2

SINGAPORE
- SPECIALIZATIONS: Cardiology, gastroentrology, liver transplant and orthopedics
- SAVINGS*: 25%-40%
- NUMBER OF JCI ACCREDITED HOSP.: 22

BRAZIL
- SPECIALIZATIONS: Plastic surgery, butt augmentation procedures
- SAVINGS*: 20%-35%
- NUMBER OF JCI ACCREDITED HOSP.: 64

MALAYSIA
- SPECIALIZATIONS: Dental, cardiac and cosmetic plastic surgery
- SAVINGS*: 65%-80%
- NUMBER OF HOJCI ACCREDITED HOSP.: 13

ISRAEL
- SPECIALIZATIONS: Bone marrow transplants, heart surgery and catheterization, oncology, IVF
- SAVINGS*: 45%-60%
- NUMBER OF JCI ACCREDITED HOSP.: 32

UAE
- SPECIALIZATIONS: Orthopedic, long-term care and rehabilitation, cancer and dentistry
- SAVINGS*: 20%-40%
- NUMBER OF JCI ACCREDITED HOSP.: 209

Sources:
Numbeo. *Health Care Index for Country (2019).*
Visa & Oxford Economics. *Mapping the Future of Global Travel and Tourism (2014).*
https://medicaltourism.review/
https://www.jointcommissioninternational.org/about-jci/jci-accredited-organizations/

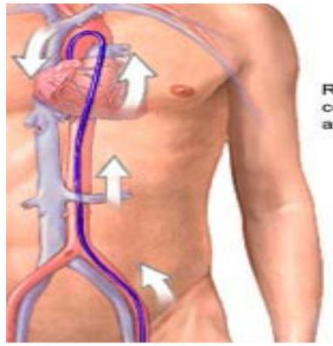
*** Prices are compared with US**

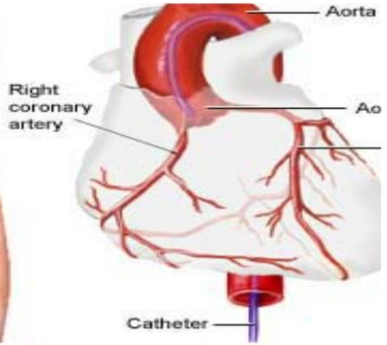
LARANJA

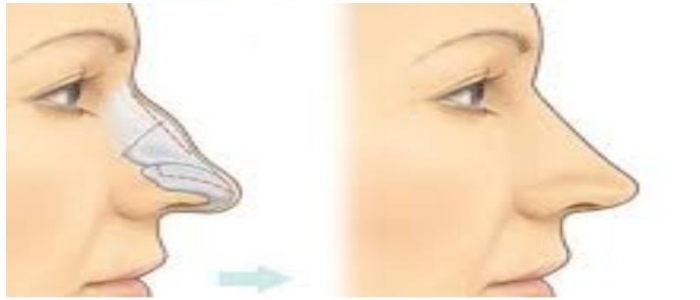
Surgeries associated with Medical Tourism

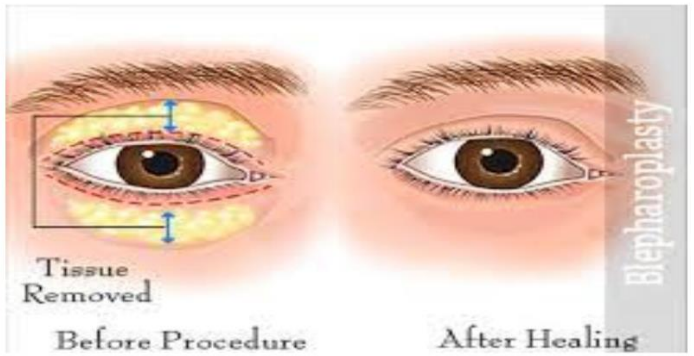
Local Anesthesia

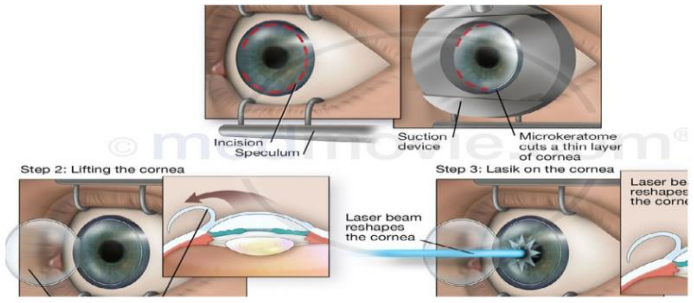
Harvest
from Donor Area

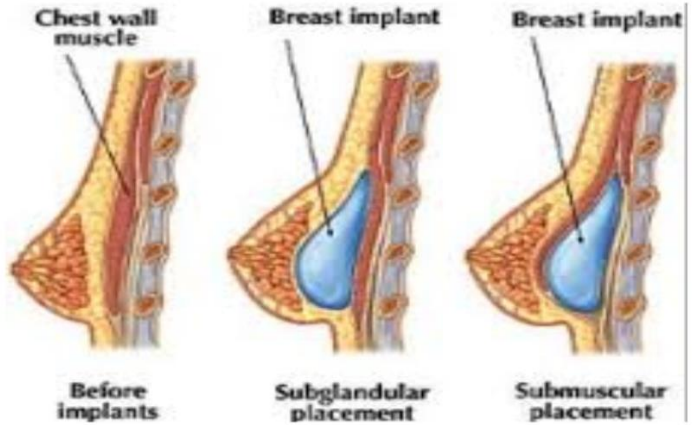


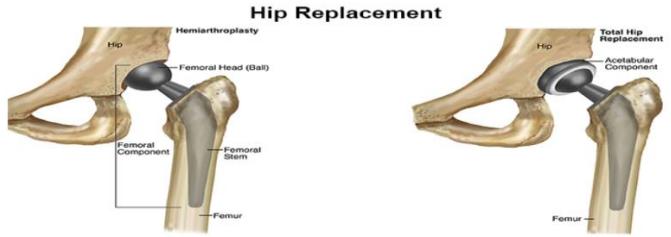


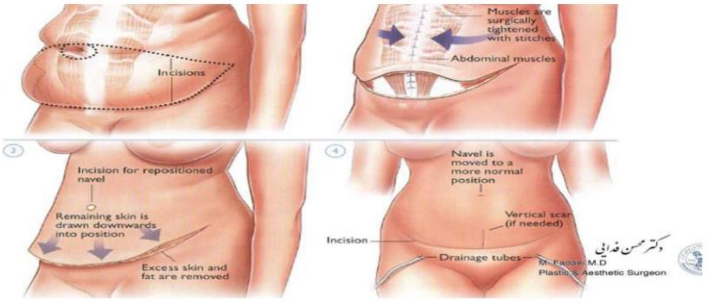


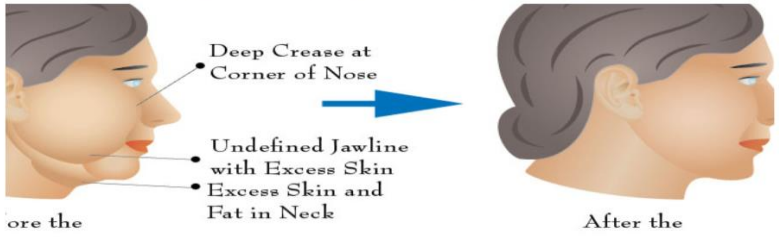


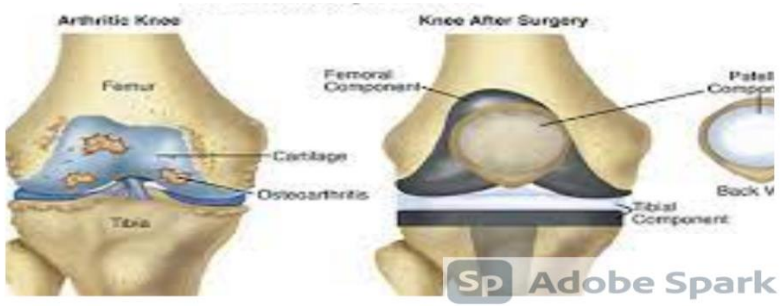












Scope of Medical Tourism in India

- India has recently started 'Medical Outsourcing'.
- NHP of India declared medical tourists as 'export' and eligible for all fiscal advantages granted to export revenues.
- A major selling factor in India is the cost advantage.
- Motto is "First World Treatment at Third World Prices."
- There are a variety of services available, like- radiography, ultrasound, mammography, MRI, digital subtraction angiography, intervention treatments, nuclear imaging, etc.
- Chennai is called the "Health capital of India." It attracts 48% foreign patients and 37-41% domestic patients annually.
- There are 36 JCI and 350 NABH accredited hospitals across India.
- To improve the influx of tourists, the tourism facilitator employs Medical Attachés at Indian Embassies.

Literature Review

- According to (CBS News Online, 2004), Medical Tourism occurs majorly from patients of developed countries traveling to developing countries. Higher treatment cost in developed nations, long waitlists for non-urgent treatments, enhancement in standards of healthcare in the developing countries, easy and affordable international travel are some of the popular reasons for medical tourism.
- The main demand determinants for healthcare are patient's personal income, openness to the outside world, expectation regarding treatment cost in future, and availability of health coverage access in their country; whereas, the demand for medical treatment in a given country is dependent upon cultural affinity, distance from the home country, health services provided, and the reputation of health services in the destination country (Bookman and Bookman, 2007).

Now, coming to literature review of research papers in the domain- motivation factors of medical tourism.

Theory of Motivation

- There are 2 factors influencing tourism decisions- push factor and pull factor.
- Push factors are related to the cognitive process and internal socio-psychological motivation including- escape desires, rest and relaxation, health and fitness, prestige and socialization. (Chon, 1989; Lam & Hsu, 2006; Uysal & Jurowski, 1994; Yuan & McDonald, 2008)
- Pull factors are the external factors which entices an individual to travel to a particular location like historical attractions, physical environment, infrastructure, sports and recreational services, marketed image of the destination. (Kim, Crompton & Botha, 2000; Klenosky, 2002; Uysal & Hagan, 1993)
- Visitors from different nationalities showed varied levels of importance to the different pull factors.
- A research was conducted by Chen, Prebensen and Huan (2008) which identified the tourist's motivation regarding wellness destination. It was observed that relaxation, partaking various activities, recreation and enjoying the nature's beauty are the primary motivations of such a tourism.

The above researches were regarding tourism in general. The push/pull factors pertaining to health and medical tourism also have been studied by a few researchers.

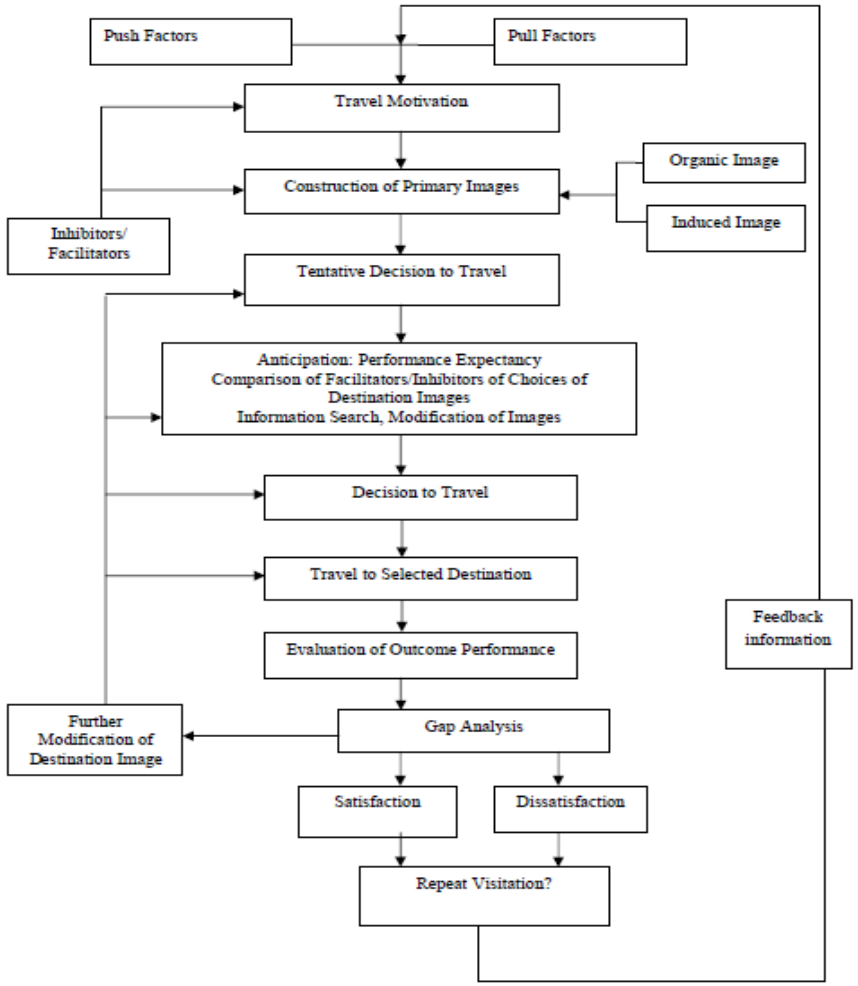
Literature related to Motivation factors for medical tourism

- A study was conducted by John, Surej P., Larke & Roy (2016), to understand the motivation factors of tourists traveling abroad for a treatment. They identified and categorized the factors as 'Push and Pull Factors'. The most common push factors are- less waiting times, low treatment costs, service quality, and international accreditation of hospitals. Common push factors include reputation of service providers, recommendations from friends and family, inadequate insurance coverage, and desire for privacy and confidentiality of treatments.
- Wanlanlai Saipraset (2011) conducted a study to examine the structural relationship of medical tourist's motivation, behavior and perception. She established a model of motivation, behavior and perception, and analyzed the structural relationship among them in international medical tourists visiting Thailand. Using various statistical analysis (frequency count and percentages, independent sample t-test, ANOVA, factor analysis and structural equation modeling, the data gathered was analyzed to test the hypothesis. It indicated that some medical tourists visited because of push factors, and most of them were motivated by both push and pull factors.
- Dangor et al (2015) conducted a research by interviewing Indian-South Africans traveling to India. It highlighted the problems which are there in South Africa's medical infrastructure, therefore determining the push factors for traveling to India.

It can be concluded that there is a research gap in finding the motivation factors of medical tourists visiting India. There are no prevalent surveys accounting the whole of India.

Perceived Destination Image

- Many studies have been conducted to understand the destination image and its influence on the tourist's behavior, deciding a tourist destination and travel satisfaction.
- It consists of perceptions related to climate, accommodation facilities, friendliness of people, and holistic impression of the place. (Echtner & Ritchie, 1993)
- Thus, it can be said that the image of a tourist destination is the cumulative perception of the individual elements or attributes that make up the entire tourism experience. (Milman & Pizan, 1995)
- Kotler, Bowen and Makens (1996) found that the following structure can be established to know the pull factors of a destination in totality: image→ quality→satisfaction→post-purchase behavior



Perceived Quality

- It is the perception which a tourist has on the quality of service that would be provided to him/her in the destination country. It is different from satisfaction and quality of experience, as it is not a parameter which actually determines the quality of the service. (Baker & Crompton, 2000)
- Mefford (1993) and Moore & Schlegelmith (1994) suggested that two factors influence service quality- the service expected and the service provided.
- In regard to Medical Tourism, a patient's judgement regarding the quality of a service relies solely on whether they perceive it to be excellent or superior on an overall basis. (Gupta & Chen, 1995)
- Jun, Peterson & Zsidisin (1998) identified eleven parameters for measuring the quality of a service. They are- tangibility, reliability, competence, responsiveness, courtesy, communication, access, caring, patient outcomes, collaboration and understanding the patient.

Perceived Value

- Value is defined as the returns gained with respect to the investment. (Zeithmal, 1988)
- It is the ratio of consumer's outcome/ input to that of the service provider's outcome/input. (Oliver & DeSarbo, 1988)
- Perception of service value is influenced by service quality.
- Sweeny & Soutar (2001) conducted a study to analyze the perception of customers on the value of goods by using four parameters- emotional, social, quality/ performance, and price/ value of money.
- Patrick (2002), in his research developed a 25-attribute matrix to determine the five dimensions of perceived value of a service- behavioral price, monetary price, emotional response, quality and reputation.
- Eggert & Ulaga (2002) analyzed if perceived value directly influences customer intentions.

Overall Satisfaction

- Customer satisfaction is the emotional and psychological feeling of receiving the product/ service that a person has hoped and expected to receive. (Pizam & Ellis, 1999, WTO, 1985)
- Similarly, 'Tourism satisfaction' is the mental state of tourists after an experience. (Baker & Crompton, 2000)
- Linder-Pelz (1982) proposed five socio-psychological variables as determinants of healthcare satisfaction. They are-

i. Occurrences: a person's interpretation of events that happened

ii. Value: evaluating a key attribute of healthcare

iii. Expectations: probabilistic beliefs about the likelihood of events exhibiting certain key attributes and their outcomes

iv. Interpersonal comparisons: a person's assessment of the healthcare encounter by comparing with past experiences

v. Entitlement: credence in one's ability to stake a claim on proper and accepted grounds

Behavioral Intention

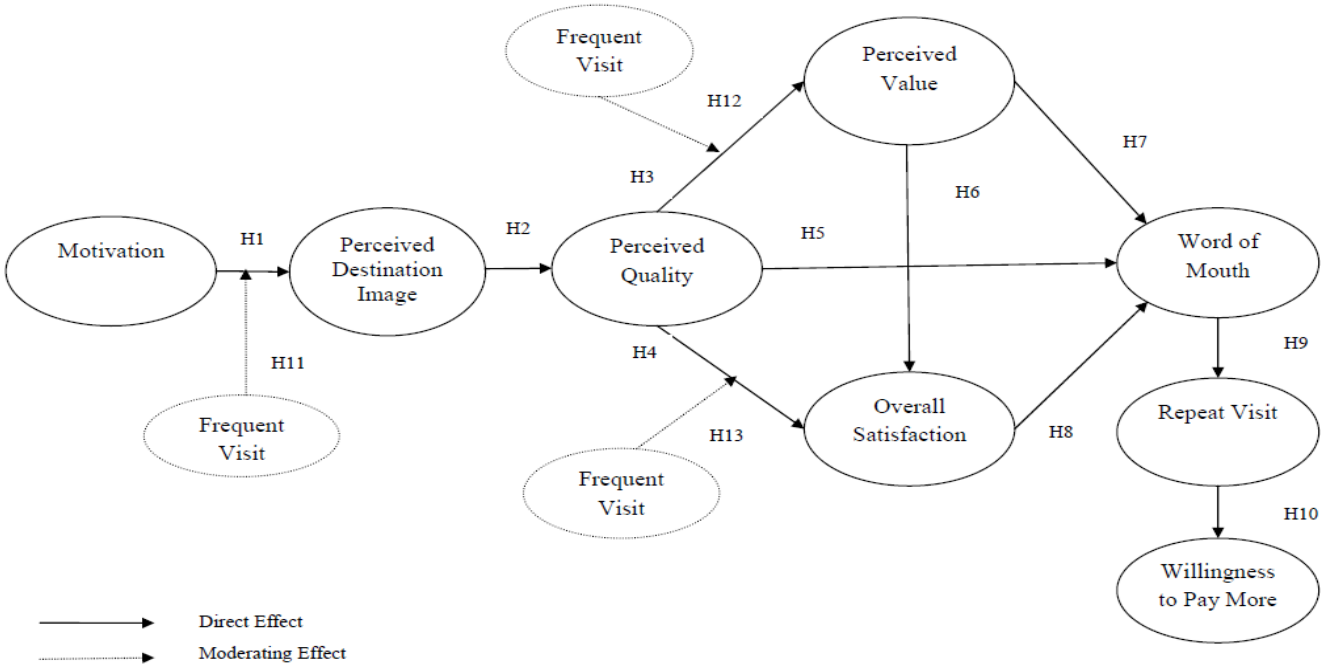
- Behavioral intentions include word-of-mouth (WOM), purchase intentions, price sensitivity, and complaining behavior. (Alexandris, Dimitriadis & Markata, 2002)
- In hospitality and tourism industry, where intangible services are hard to evaluate prior to consumption, interpersonal influence and word-of-mouth are critical factors. (Litvin, Goldsmith & Pan, 2008)
- High guest confidence and communication skills result in greater relationship quality, guest commitment, repeat sales and positive word-of-mouth.

Relationship of Perceived Quality, Perceived Value, Overall Satisfaction & Behavioral Intentions

- Patterson & Spreng (1997) created a model to explain the relationship between perceived values, satisfaction and repurchase intentions.
- Bolton & Drew (1999) developed a model for evaluating customer perceptions of service quality, based on a survey of telephone service customers. They evaluated service quality, performance levels, and service value based on the past experiences and expectations.
- The correlation between service quality, perceived value, customer satisfaction, and behavioral intention was studied by McDougall & Levesque (2000) among dentists, auto repair shops, restaurants, and hairdressers. It was found that customer satisfaction is directly related to future behavior intentions.
- Baker & Crompton (2000) defined performance quality as the parameter of service that can be controlled by tourism provider, whereas satisfaction is the mental state of a tourist after an experience.
- Choi, Cho, Lee, Lee & Kim (2004) developed an integrated model about healthcare consumer satisfaction based on pre-determined correlation between service quality, value, patient satisfaction, and behavioral intention.

Frequent Visit

- Several factors influence the perceptions that an individual has of a destination, including geographic proximity, prior experience, favorable opinion, and knowledge of that country. (Hunt, 1975; Crompton, 1979; Phelps, 1986; Hu & Ritchie, 1993)
- Past experience during the visit, geographic location, knowledge about destination country, and positive perception creates a major impact on tourist's destination image and behavioral intention of choosing a travel destination again. (Crompton, 1979; Hunt, 1975; Hu & Ritchie, 1993; Milman & Pizam, 1995; Phelps, 1986)



Conclusion

In today's world, Medical tourism is becoming an important part of the tourism sector. Many nations are supporting and promoting wellness travel as it benefits both the home as well as destination country in terms of economic and infrastructure development. Low treatment cost, quality of care, legal ramifications, and privacy concerns are all key motivators for medical tourists and to influence the growth of medical tourism in general, according to literature.

However, there is a knowledge void about the factors which motivate medical tourists to choose India as their destination. Such data is essential for drafting right policies and making strategies to ensure the effective development of medical tourism in India.

The literature review conducted in this study highlights the knowledge gap and attempts to find the parameters based on which a survey can be conducted to fill the aforesaid research gap. The parameters of motivation found from the literature review are- destination image, perceived quality, perceived value, overall satisfaction and future behavioral intentions. The survey can be a questionnaire type composing of questions based on these parameters and asking the respondents to rate them. The results of the analysis from the data collected, can then be used to know the factors that attract medical tourists to India. Once the strengths of India's healthcare system is derived from the survey, it can be used to advertise and attract more medical tourists. It could also give insight to the parameters in which India is lacking, which can then help the hospitals and the government to improve in those fields

PATIENT SAFETY & QUALITY IMPROVEMENT

Definition & Meaning

- **Quality Improvement:** It is the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge. Quality focuses on doing the right things and doing them well for the patients. (Institute of Medicine)
- **Safety:** Freedom from those conditions that can cause death, injury, illness, damage to or loss of equipment or property, or damage to the environment. (National Patient Safety Foundation)

Major events in Quality Improvement & Patient Safety (1854- present)

- **1854:** Florence Nightingale used evidence-based quality improvement to reduce preventable harm in the Crimean War.
- **1910:** Dr. Earnest Codman, a physician from Harvard Medical School & the Massachusetts General Hospital, is considered the founder of evidence-based medicine.
- **1917:** American College for Surgeons (ACS) adopted Dr. Codman's "end-result system" for its Hospital Standardization program, establishing minimum standards for hospitals.
- **1951:** The Joint Commission on Accreditation of healthcare organizations was formed by American College of Physicians, American Hospital Association, American Medical Association, Canadian Medical Association and American College of Surgeons.

- **1965:** Congress passed the Social Security Amendment. Hospitals accredited by the Joint Commission are 'deemed' to be in compliance with most of the Medicare Conditions of Participation for hospitals to participate in the Medicare and Medicaid programs.
- **1966:** Dr. Donabedian published "Evaluating the quality of medical care". It defined the quality of healthcare services using 3 parts- structure, process and outcome.
- **1979:** The Accreditation Association for Ambulatory Healthcare was formed.
- **1989:** Agency for Healthcare Policy and Research was created under the Omnibus Budget Reconciliation Act of 1989. It was renamed as Agency for Healthcare Research and Quality (AHRQ), as part of the Healthcare Research and Quality Act of 1999.
- **1990:** National Committee for Quality Assurance (NCQA) was mandated to offer accreditation programs for healthcare plans.
- **1991:** Institute for Healthcare Improvement (IHI) was founded. It focused on the identification and spread of best practices in quality and safety.
- **1994:** Dr. Lucian Leape published "Error in Medicine". It called for the application of systems theory to prevent medical errors.
- **1999:** Institute of Medicine published landmark report "To err is Human: Building a safer health system".
- **2001:** Institute of Medicine published a follow-up report "Crossing the quality chasm: A new health system for the 21st century". Dr. Peter Pronovost published a simple 5-item checklist that led to significant reductions in central line infections.

Preventable or Mitigable Harm

- The term "Preventable Harm" was first used during the Crimean War in the mid 1800's by Florence Nightingale.
- Around 44,000 to 98,000 people die due to preventable harm in hospitals every year.
- Some common medical errors are: adverse drug events, improper blood transfusions, surgical injuries, wrong-site surgery, suicides, restraint-related injuries/deaths, falls, burns, pressure ulcers and mistaken patient identity.
- Majority of medical errors do not result from individual recklessness or the actions of a particular group; they are caused by faulty systems, processes and conditions that lead people to make mistakes or fail to prevent them.

Strategy for improvement

- Establish a national focus to create leadership, research, tools and protocols to enhance the knowledge base about safety.
- Identify and learn from errors by developing a nationwide public mandatory reporting system and by encouraging healthcare organizations and practitioners to develop and participate in voluntary reporting systems.

- Raise performance standards and expectations for improvement in patient safety through the actions of oversight organizations, professional groups and group purchasers of healthcare.
- Implement safety systems in healthcare organizations to ensure safe practices at the delivery level

Conclusion

- Most problems and errors are property of the system as a whole rather than results of act or omissions of people in the system.
- Performance improvement requires changing the system, not changing the people.
- Focusing on the superficial cause of a problem may address the immediate problem (first order), but may miss the opportunity to fix underlying causes of the problem (second hand).
- When trying to improve a system, it is important to keep in mind, how the whole system is affected when a part is modified.
- "Systems Thinking" is a fundamental tool for resolving a problem or improving performance.

Thank You!