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Study on Cox's Bazar, Bangladesh as a Prospective Medical Tourism Destination

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ABSTRACT

The choice of a destination is primarily determined by the tourist's motivation to travel; in other words, a destination is chosen to satisfy the particular motivation of a given tourist. Also, majority of people in many developed countries tend to perceive that developing countries do not have high standards of medical care and hygiene. It is anticipated that the findings of this study will assist both the management of Cox's Bazar health-care providers and government entities (such as the Tourism Authority of Cox's Bazar, the Ministry of Tourism, and the Department of Export Promotion) in promoting the country to international medical tourists. The study indicated that medical tourists with lower levels of familiarity (with medical procedures and with Cox's Bazar as a medical tourism destination) tend to engage in greater external search behaviour by consulting brochures and advertising campaigns developed by medical tourism promoters. Despite their indirect relationship to medical tourism, images regarding hygiene and safety/security are also found to influence the desirability of a medical tourism destination.

Keywords: Medical tourism, Destination marketing, Health care providers, Destination choice, Destination image

INTRODUCTION

This study examines the potential of Cox's Bazar in Bangladesh as a tourism destination with particular emphasis on the role of medical tourism in sustaining growth in this area. There was a decline in the competitive edge, previously enjoyed by Cox's Bazar in the leisure tourism market. Cox's Bazar has been one of the most popular tourism destinations in Bangladesh for many years, with most tourists coming from East Asia and Europe. Tourism has thus played a major role in the social and economic development of Bangladesh over several decades. As a result of active promotions, Cox's has established itself as a preferred destination in both the leisure market and the business travel market.

Studies have suggested that the majority of people in many developed countries tend to perceive that developing countries do not have high standards of medical care and hygiene (Marlowe and Sullivan, 2007; Smith and Forgione, 2007). However, there has been little published research on the specific question of consumer behaviour in the context of medical tourism. As a consequence, managerial decisions on medical tourism in host countries tend to be made on the basis of intuition and/or information from relatively unreliable non-research literature. Some reliable research literature has focused on the apparent motives of medical tourists head off abroad for medical treatment—for reasons such as financial issues, waiting times, and the unavailability of desired treatment in the prospective medical tourists's own countries of residence (Awadzi and Panda, 2005; Connell, 2006). However, these studies have not explored the whole decision-making process of prospective medical tourists.

It is anticipated that the findings of this study will assist both the management of Cox's Bazar health-care providers and government entities (such as the Tourism Authority of Cox's Bazar, the Ministry of Tourism, and the Department of Export Promotion) in promoting the country to international medical tourists. Given that destination marketing is a complex undertaking that involves a vast array of actors and influential factors (Hosany, Ekinci, and Uysal, 2007), the study will provide valuable insights into the consumer behaviour of medical tourists with regard to destination choice and destination image.

Definition of Medical Tourism

According to Awadzi and Panda (2005), the term, medical tourism refers to the offshore provision of

medical services in combination with the other tourism opportunities by using comparative cost advantage as the leverage point. This definition of medical tourism assumes that prospective medical tourists are motivated by economic reasons in choosing to receive their desired medical treatment (both obligatory and elective) in overseas countries (Jones and Keith, 2006).

The trend towards such medical tourism has been made possible by the significant improvements that have occurred in the medical services of many developing countries in terms of facilities, equipment, and human resources. These developments have, in turn, been accelerated by the privatisation of the health-care sectors in these developing countries (Garcia-Altes, 2004; Awadzi and Panda, 2005).

Types of Medical Tourism and its Determinants

According to Awadzi and Panda (2005), prospective medical tourists include: (i) the uninsured (those who choose not to insure against health-care costs because they perceive insurance policies to be too high); (ii) the underinsured (those whose insurance policies do not cover the expenses that they actually incur); and (iii) the uninsurable (those whose health conditions and therapies do not meet the criteria for insurance policies in their country of residence). People in these three categories are more likely to search for alternatives in countries where costs are lower (Awadzi and Panda, 2005; Marlowe and Sullivan, 2007). The choice of a destination is a high-involvement' decision associated with a high level of risk (Jang and Cai, 2002). Prospective tourists typically apply significant mental effort in making a destination decision in order to reduce the level of perceived risk (Zaichkowsky, 1985; Hawkin *et al*., 2001).

Several authors have noted that the choice of a destination is primarily determined by the tourist's motivation to travel; in other words, a destination is chosen to satisfy the particular motivation of a given tourist (Mansfeld, 1992; Um and Crompton, 1990). In the case of medical tourists, the motivation is to find the desired medical treatment of requisite quality at lower cost. The whole destination choice process in medical tourism is therefore determined by these two parameters of quality and cost. Although medical tourism is increasing and has become a significant potential source of foreign revenue to developing countries, the relative newness of the phenomenon means that the number of studies on the topic remains limited. The justification for the present study of medical tourism in the Thai context thus rests on two main reasons: (i) the potential economic significance of medical tourism for Cox's Bazar; and (ii) the general lack of research on destination choice in medical tourism. As noted above, signs of decline in tourism in Bangladesh have prompted the country to diversify its market towards alternative forms of tourism other than the leisure market.

As the phenomenon of people from developed countries travelling to developing countries for medical reasons is relatively new, no quantitative research has yet been conducted into the destination-choice behaviour of medical tourists. Most of the studies that have been conducted in this area have examined the motivation of medical tourists and/or the capacity of potential destinations (Vadanabha, 2007; Ramirez de Arellano, 2007; MacReady, 2007; Harryono *et al*., 2006). However, no research has covered the whole decision-making process of prospective medical tourists in choosing a destination for their medical tourism. The present study, which does cover the whole decision-making process, should therefore prove to be very useful for both destination-promotion organisations and health-care providers in performing their marketing functions in Cox's Bazar.

From a destination perspective, medical tourism can be defined as the offshore provision of medical services, in combination with other conventional tourism products, by leveraging a comparative cost advantage (Awadzi and Panda, 2005; Percivil and Bridges, 2006). Destinations or countries that choose to pursue such medical tourism openly promote their health-care services and facilities, in addition to their other conventional tourism attributes (Marlowe and Sullivan, 2007). From the perspective of the travelers, the aim of engaging in medical tourism is to obtain obligatory or elective medical treatment in a country other than their countries of residence (Connell, 2006; Jones and Keith, 2006; Percivil and Bridges, 2006). The term obligatory treatment' refers to urgent, unscheduled therapy for serious illnesses, whereas the term elective treatment refers to scheduled non-essential therapies; in both cases, medical travelers choose to obtain treatment in a foreign country because the desired therapies are unavailable, illegal, costly, or associated with an unacceptable waiting time in the home countries (Jones and Keith, 2006; Strategic and Marketing Magazine, 2007)

Medical tourism is not a new concept. In ancient times people travelled to various spas, hot springs, and rivers seeking cures and/or rejuvenation (Goodrich, 1994). More recently, people from developing countries have travelled to developed countries seeking more sophisticated medical treatment (Awadzi and Panda, 2005). However, the contemporary trend is now in the opposite direction as an increasing number of patients from developed countries travel to developing countries to receive medical treatment. This reversal of the older trend is mainly due to the increasing costs and other limitations of the health-care systems in Western countries (Marlowe and Sullivan, 2007; MacReady, 2007; Deloitte, 2008; McDowall, 2006). Moreover, in recent years, many developing countries have made significant advances in their medical services (Vadanabha, 2007). Doctors and nurses in these developing countries are increasingly well trained to international standards as medical education in these countries has adopted the methods and requirements of Western medical education; in addition, many health professionals in developing countries have been trained abroad in Western universities (Awadzi and Panda, 2005).

Another factor of importance in enhancing the standards of medical care in developing countries has been the large number of modern, privately owned facilities that have been established in these countries. These private clinics possess the latest technologies and are able to offer a range of complex medical procedures at lower cost than in developed countries (Garcia-Altes, 2004; M2Presswire, 2008). These developments, together with trade liberalisation and ease of international travel (Fletcher and Brown, 2002), constitute what have termed the third world advantage (Awadzi and Panda, 2005).

The rapid developments in the medical services of various developing countries in terms of human resources and facilities represent an appealing alternative to prospective medical tourists (Connell, 2006). The medical competence of doctors and nurses in many developing countries is now comparable to developed countries. This is due to the Westernized medical education in developing countries and an increasing trend for health professionals to undertake training abroad (Jones and Keith, 2006). The standards and outcomes of medical procedures offered in developing countries are now comparable to those pertaining in the medical tourists‘ countries of residence (Jones and Keith, 2006).Therefore, people from developed countries are more confident in receiving medical treatments in developing countries.

Medical tourists include a broad range of people who travel to receive medical treatment abroad. Apart from people from developed economies, medical tourists can also include the so-called élite from developing countries and foreign expatriates residing in neighboring countries (Ramirez de Arellano, 2007).

Prospective medical tourists include:

(i) the uninsured (people who choose not to insure their health, usually because they cannot afford the insurance policies); (ii) the underinsured (those whose insurance policies do not cover the expenses that are really incurred when they receive medical treatment); and (iii) the uninsurable (those who do not meet the criteria to buy insurance policies or whose preferred medical treatment is unrecognised or prohibited in their own countries) (Moody, 2007, Awadzi and Panda, 2005; Marlowe and Sullivan, 2007; Connell, 2006, Cosh, 1997). Americans, in particular, are said to be susceptible to unexpected and excessive medical and dental expenses (Pedersen, 2007; Marlowe and Sullivan, 2007).

Corporates are also one of the targets of medical tourism (Marlowe and Sullivan, 2007; Moody, 2007; Smith and Forgione, 2007). Many of these companies have to pay large medical bills as part of the fringe benefits they provide to their employees. In many cases these involve complicated and costly medical procedures. It can be attractive for these firms to refer employees who require complicated procedures to offshore medical service providers. Retirees who choose to spend their lives as tourists in foreign countries can also be targeted as potential customers of medical tourism (Norra, 2007; Pedersen, 2007; Connell, 2006; Business Line (The Hindu), 2009). Some countries, such as Japan and Singapore, actually encourage their citizens to retire abroad, and these retirees often require medical care on a frequent basis (Connell, 2006).

Motivation for adoption of Medical Tourism

The adoption of medical tourism by these various groups of people can be either preventive behavior or protective behavior (Carter and Kulbok, 2002). Individuals who engage in such preventive or protective health behaviours are motivated to do so by a variety of environmental factors (Carter and Kulbok, 2002). These include health locus of control, social

support, income, education and health status. In particular, health locus of control which refers to an individual's perception of personal ability to control his or her health (Wallston, Stein and Smith,1994; Moshki *et al*., 2007) is important in the context of medical tourism. If a person believes that he or she has a high degree of control over personal health, that person is said to possess a high level of internal health locus of control. These people are more motivated to engage in healthy behaviour (Wallston, Stein and Smith, 1994).

Social support is also an important influence on an individual's motivation to engage in healthy behaviour; individuals who are satisfied with their social support are more likely to engage in health enhancing activities (Callaghan, 1998). In general, the literature suggests that people who have an internal locus of control, good social support, a high level of education, and a large income are more likely to engage in healthy behaviours. Many developing countries, including Bangladesh, now see medical tourism as a lucrative market and are attempting to attract medical tourists from all over the world (Connell, 2006; Chinai and Goswami, 2007; Chow, 2009).

As a result, medical tourism in such countries like Thailand and India has shown two-digit growth per annum in recent years (Connell, 2006). Medical tourism in India is expected to be worth USD$1 billion by 2012 and revenue from foreign patients to Thailand rose from USD$900 million in 2004 to USD$1.25 billion in 2005 (Connell, 2006; Ramirez de Arellano, 2007; Service Promotion Department, 2007). Given the large amounts of money involved, competition among developing countries for medical tourists is expected to intensify (Connell, 2006; Chow, 2009).

In view of the motivations for medical tourism noted above, the two major leverage points for medical tourism destinations in attracting medical tourists are likely to be: (i) price; and (ii) quality of service (Awadzi and Panda, 2005; MacReady, 2007). Prospective destinations are therefore striving to upgrade their medical services and adopt Western protocols to cater to the needs of foreign patients (Connell, 2006; Strategic and Marketing Magazine, 2007). Some destinations are also attempting to position themselves as specialists in particular technologies and therapies (Connell, 2006; Chow, 2009). South-East Asia has emerged as the region with the greatest potential for medical tourism; indeed, four of the world's main medical tourism destinations (Thailand, Singapore, Malaysia, and the Philippines) are in South-East Asia (M2Presswire, 2008, Department of Export Promotion (Manila Office), 2008).

Some countries, such as Taiwan, Singapore, Iran, and Korea, are not only positioning themselves as medical tourism destinations but are also being targeted by competing destinations as potential sources of medical tourists (Choo, 2002; Department of Export Promotion (Jakarta Office), 2007, Department of Export Promotion (Manila Office), 2008; Korea Health Industry Development Institute, 2007). In the case of Singapore, which is seeking to leverage its internationally accredited infrastructure and resources (Chow, 2009, M2Presswire, 2008), reported 571,000 medical tourists visit in 2007. Singapore expects this number to increase to one million visitors (generating more than USD$1 billion dollars) per annum by 2012 (Chow, 2009, Choo, 2002). Singapore offers the latest medical technologies (Chow, 2009), but the country's major disadvantage is the cost of its health-care services, which is the highest among Asian medical tourism destinations (Choo, 2002, M2Presswire, 2008).

Taiwan (Chinese Taipei) promotes itself as a medical tourism destination by using small-scale procedures as its main selling point (Department of Export Promotion, Manila Office, 2008). However, Taiwan is also a potential source of medical tourists to other countries. Despite the imposition of a compulsory health insurance plan for all citizens, Taiwanese people are still required to spend large sums of money for procedures that are not covered by the obligatory health plan. There are thus opportunities for other Asian medical tourism destinations, including Bangladesh, to attract Taiwanese people to visit their countries for medical services (Department of Export Promotion, Manila Office, 2008). However, the two main obstacles to success in promoting Bangladesh as a potential medical tourism destination for Taiwanese people are the language barrier and the apparently negative perceptions of Thai medical standards held by Taiwanese people (Department of Export Promotion, Manila Office, 2008).

Developing countries are not alone in pursuing the medical tourism market. While continuing to generate medical tourism for other countries, developed countries (such as Canada and Australia) are simultaneously courting medical tourists (Weaver, 2008; Cosh, 1997; Canadian Institute for Health

Information, 2007). In terms of marketing, it should not be assumed that one offering can appeal equally to all prospective medical tourists. Indeed, prospective medical tourists from different countries tend to have particular preferences for certain destinations; for example, medical tourists from Europe are inclined towards India and Thailand, Westerners who are resident in Asia tend to prefer Malaysia and Singapore over other Asian destinations (Connell, 2006). As, with all marketing, the success of a medical tourism destination depends on accurate customer segmentation, careful targeting, and adept positioning (Kotler and Keller, 2006, Decrop, 2000). In the case of the medical tourism market, segmentation should primarily be based on: (i) types of health conditions; and (ii) income (Goodrich, 1994).

In addition, the marketing of medical tourism should take account of the opportunities provided for corporate firms and insurance companies to offer enhanced benefits to their employees/clients at lower costs (Marlowe and Sullivan, 2007). However, marketers should recognize that insurance companies and corporate firms harbour several concerns about the services being offered. These concerns include quality of care, saving potential, sponsor liability, travel-related exposure, and tax implications (Marlowe and Sullivan, 2007).

Challenges faced by Medical Tourism

Destinations that seek to attract medical tourists face certain challenges. In particular, they need to address the concerns that prospective consumers with regard to: (i) quality of care; (ii) costs; (iii) legal liability; and (iv) travel. Prospective consumers of medical tourism products can be conveniently divided into two categories: (i) individual medical tourists; and (ii) health-care plan sponsors (insurance companies or corporate firms) that refer their plan beneficiaries to medical service providers abroad.

The potential benefits to the first group are clear, as long as the desired treatment is outside the ambit of their health-care plans and/or these potential patients are ineligible to benefit from their existing plans. Indeed, there are really only two concerns of significance for this group, the quality of care and the potential for saving. In contrast, the second group of prospective customers, health-care plan sponsors, are not only concerned with the quality of care and the potential for savings, but also with their legal responsibilities for possible post-operative complications and travel issues. For this category of customers, the potential for savings might be offset by financial losses associated with these legal responsibilities. This has consequences for the price of insurance premiums because these potential costs will ultimately be borne by the insurance provider. Finally, because referrals to medical tourism providers must be overtly conducted on an entirely voluntary and non discriminatory basis, it might be difficult to convince some insurance beneficiaries.

CONCLUSION

In summary, Bangladesh needs to promote medical tourism in the country by capitalizing on the high standard of its medical services. The country has embarked on a policy of direct market penetration through the establishment of representative offices in major generating markets. By coordinating with government authorities and insurance companies in the source markets, Bangladesh has sought to increase the likelihood of the country being chosen as the destination of choice for medical tourists.

The study finds that medical tourists with lower levels of familiarity (with medical procedures and with Cox's Bazar as a medical tourism destination) tend to engage in greater external search behaviour by consulting brochures and advertising campaigns developed by medical tourism promoters. They also seek information from insurance companies and personal doctors. Moreover, to evaluate alternative medical tourism destinations, the study finds that prospective medical tourists set certain decision rules. In this regard, quality of care is assessed on the basis of non-compensatory rule, which means that medical tourists avoid visiting destinations whose quality of care is lower than their threshold level. However, the provision of a higher quality of care than this threshold level does not significantly enhance the appeal of a destination. In contrast, saving potential is assessed by a compensatory' decision rule, which means that medical tourists are willing to trade off certain other destination attributes for greater saving potential. Despite their indirect relationship to medical tourism, images regarding hygiene and safety/security are also found to influence the desirability of a medical tourism destination.

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